Erasmus+

Project n. 2021-1-IT01-KA220-VET-000033303

CHARACTERISTICS OF MULTIFAMILY GROUPS IN MENTAL HEALTH

Co-funded by the European Union

ASL ROMA 1

The publication ‘Characteristics of Multifamily Groups in Mental Health’ presents a comprehensive research study focusing on Multifamily Groups in Italy, Belgium, Spain, and Portugal. This volume encapsulates the outcomes of the initial phase of the project ‘Multifamily Groups in Mental Health’ (FA.M.HE), financially supported by the European Union through the Erasmus+ Program.

Five project partners collaborated in its development: the ‘Associação para Investigação e Desenvolvimento da Faculdade de Medicina’ in Lisbon, serving as the research coordinator, the ‘Laboratorio di Psicoanalisi Multifamiliare’ and the ‘Azienda Sanitaria Locale Roma1’ in Rome, the ‘Asociación de Psicoterapia Psicoanalítica de Pareja, Familia y Grupo Multifamiliar’ in Bilbao, and the Z.ORG KU in Leuven.

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1 INTRODUCTION

The spread of Multifamily Groups (MFG) is considered one of the most significant innovations in public and private mental health services. Emerging after the 1950s, collaboration between patients, family members and operators through recurring meetings of multifamily groups progressively demonstrated effectiveness in terms of results. In the new century it has gained ground, evolving in parallel with the joint development of family therapy and the systemic approach. Today it includes various theoretical models and constitutes a consolidated practice, supported by evidence that confirms its validity.

The MFG opens a new phase in the treatment of mental disorders by promoting an interactive dynamic that makes "users" and their family members aware of the bonds of interdependence in which they are involved. This allows them to reflect and compare their situations with those of other participants.

This process takes place through collective meetings based on a few rules: all individuals are "listened to, understood and respected to the extent that they feel they can count on each other's help and, therefore, on each other's opinion, even if different" from one's own, all of equal value. Within the group “a situation is built in which everyone can look from the outside at the role they play in their own lives and the way in which they carry it out: children, parents and caregivers, their own children and/or parents”. Key themes of participation in the MFG include "sharing", "comparison", "exchange", "support" or "help".

A relationship is established based on trust, empathy, respect, acceptance of oneself and others and on the spontaneity of human contact. This climate is influenced by the relational, especially empathetic, qualities of the caregivers, starting from the group conductor-facilitator.

This figure stimulates and regulates dialogues by giving the floor to all those who request it, facilitating the rapid circulation of ideas and favoring a succession of interventions based on 'free associations' so that everyone can learn, by analogy or imitation, from the experiences of others . Additionally, participants can mirror each other in the experiences that others present to the group.

The conductor can be assisted by other operators who abstain from any judgment towards suffering people and their families and abandon their "cognitive certainties to immerse themselves in the world of affections and emotions, accepting to float freely together with everyone else"; they can then discuss as a team what happens so that the experience of continuous learning in the Group unites operators and family members.

The MFG strengthens the taking charge of the family as the sphere of the "designated patient", removes it from isolation and enhances it in therapeutic cooperation, as an active part of recovery projects. At the same time it stimulates the search for "self help" among family members. It is no coincidence that the majority of MFG family members are also present in self-help groups; moreover, these can also be the outcome of a process of multifamily groups that gradually become autonomous. It has been said that “the art of MFG is helping families to help themselves” so “when this happens the group can function on its own”.

The initial product of the FA.M.HE. project is the present volume "Characteristics of multifamily groups in mental health", which provides detailed information on a sample of MFGs in the countries involved, illustrating the functioning, characteristics, organizational aspects and territorial distribution of MFGs, regardless of the theoretical orientation that distinguishes them. The main requirement to be included in the research was the participation in the MFG of at least two

generations, including people undergoing healthcare treatment; furthermore, psychotherapeutic intervention had to be prevalent in the group.

The results of the research conducted by the project partners were elaborated starting from the analysis of the data obtained from the answers to a questionnaire intended for the public and private representatives of MFGs operating in the various countries, from the subsequent creation of focus groups involving handlers and family members participants in the groups, as well as a bibliographic research on these topics, carried out in six languages.

The final objective of these activities, which as a whole can be defined as a pilot investigation on MFGs, was the creation of this volume, organized as a sort of "practical guide" aimed at all those who for various reasons wish to delve deeper into knowledge of multifamily methodology.

This volume, therefore, is addressed to a wide audience (operators and users of Mental Health Services but also students and teachers of academic courses, Volunteer Associations, local Social Services) which over time can constitute networks for the diffusion and support of multi-family culture as well as encouraging the creation and activities of dedicated Communities of Practice, through which to exchange, deepen and develop the multifamily experience.

The volume is composed of seven chapters, as well as final appendices, structured in such a way as to provide a complex but easy-to-consult overall picture.

In chapter 2 a brief presentation of the research synthetically describes the reference context, the tools and methodology adopted and the implementation times.

The activities carried out by each partner in their own country are presented in chapters 3 to 6, according to a common index that allows their easy comparative reading, including the different institutional and social realities.

The results are presented in chapter 7 through a comparative analysis of the data collected; their presentation in synthetic tables favors the description of an effervescent and growing intervention model, due to the plurality of services that adopt it, the variety of theoretical reference models, the organizational typologies but also for the broad consensus it receives from the of those who have direct experience of it.

The volume ends with a series of Appendices: from 1 to 5 there are the results of the bibliographic research on MFGs carried out by the partners in their own language while Appendix 6 collects the results relating to the international bibliography. Appendices 7 to 9 present the tools used in the survey.

2 RESEARCH DESIGN

The spread of Multifamily Groups (MFGs) is considered one of the most significant innovations in public and private mental health services. Emerging after the 1950s, collaboration between patients, family members and operators through recurring meetings of multifamily groups progressively demonstrated effectiveness in terms of results. In the new century it has gained ground, evolving in parallel with the joint development of family therapy and the systemic approach. Today it includes various theoretical models and constitutes a consolidated practice, supported by evidence that confirms its validity.

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The research ‘Multifamily Groups in Mental Health’ involves multiple components: a Survey directed to conductors and/or facilitators of the MFGs, two or more focus groups encompassing conductors/facilitators and users/families, and a web-based investigation to analyse both national

(in each country's language) and international bibliography pertaining to the application of multifamily groups in mental health.

A questionnaire, crafted by the AIDFM partner in Portugal in collaboration with all partners, was developed through a fusion of literature review insights, inputs gathered from interactions with multifamily group conductors, and considerations based on the elements required by Google Forms, the platform chosen for disseminating the questionnaire. Prior to implementation, researchers from the four countries reviewed and refined the questionnaire. It comprises two main sections. The first section focuses on the identification of professionals conducting the survey, details of the institution/organisation, and its geographical location. The second section delves into the characteristics of MFGs, encompassing their theoretical framework, intervention types, qualifications of conducting teams, supervision/intervision methods, participant traits, MFG features (group type and size, use of phases, COVID-19 impact on continuity, premises characteristics, etc.). The questionnaire concludes by inviting respondents to share their comments on MFGs.

Subsequently, each partner translated the questionnaire into their respective languages - Italian (Italy), French and Dutch (Belgium), Spanish (Spain), and Portuguese (Portugal) - and adapted it into a Google Forms questionnaire. Participation was voluntary, offering respondents the choice to remain anonymous.

Partners introduced the project through letters soliciting questionnaire participation, reaching various target groups such as government agencies, MFG experts, mental health authorities, professional organisations, recognised family groups, and family associations. Each partner meticulously identified and listed relevant potential participants for outreach.

Upon obtaining the survey results, every country conducted a qualitative and descriptive analysis. The 'Associação para Investigação e Desenvolvimento da Faculdade de Medicina' (AIDFM) in Lisbon took responsibility for data processing, coding the obtained responses to translate raw percentages from Google Forms. Additionally, partners highlighted key intersections within the answers, and AIDFM processed them.

Upon the conclusion of the field research, as outlined by the project, each partner conducted focus groups involving two specific target groups: MFG conductors/facilitators (therapists) and MFG users/families. Partners collectively agreed upon a unified methodology - the SWOT Analysis - enabling participants to articulate their viewpoints concerning the designated focus. This method scrutinised the strengths and weaknesses, both internal and external, within the context.

Concurrently with the questionnaire development, partners initiated a comprehensive literature review pertaining to multifamily intervention in mental health. This enabled the partners to establish focused and defined web research, aligned with the research goals and the Intellectual Output I of the project. Various keywords such as Multifamily Groups, Multifamily Psychoanalysis Groups (MFPG), Multifamily Psychoanalysis, Multifamily Therapy, Multifamily Group Therapy, and Multifamily Group Treatment were identified, translated into respective languages, and augmented with country-specific terms.

The research was conducted across different national languages and extended beyond national borders for each language, encompassing other countries. Google, Google Scholar, PubMed, Hall, and Cairn were utilised as search engines, and the findings were collated using the Zotero management software, adhering to the APA (American Psychological Association) 6th edition

citation style.

The international bibliographic research on multifamily groups categorically identified three subtypes:

- Psychoeducational and cognitive-behavioural groups;
- Systemic and dynamic groups;
- Psychoanalytic groups.

The research methodology was meticulously devised in accordance with the project's directives and the agreed-upon methodological guidelines established between partners, elucidated in chapter 7.3.1.

The partners are responsible for the data contained in their national report.

After collecting and analysing the data provided by each partner, Portugal compiled a synthesis report, which summarises all the results and conclusions.

3 ITALY REPORT

3.1 ITALIAN SITUATION

Following the significant deinstitutionalisation process initiated by the closure of mental health asylums, the European Union (EU) has been dedicated to establishing personalised social networks to aid individuals facing mental health challenges. Documents like the 'Green Paper on Mental Health' (2005), underscore the pivotal role of family members within these networks. According to the 'User empowerment in mental health' (2010) from the World Health Organization (WHO), 95% of caregivers are family members of mental health service users.

The latest 'European Action Plan for Mental Health 2013-2020' emphasises the crucial involvement of families in mental health treatments and recommends innovative therapeutic interventions, emphasising inclusivity, accessibility, and sharing. Despite these advancements, families often face isolation and stigma. The 'European Framework for Action on Mental Health and Wellbeing' (2016) acknowledges the fundamental role families play in these social networks, emphasising the need for targeted interventions to strengthen and support them.

Despite innovative methodologies tailored to address various needs and enhance societal integration, multifamily groups are still not widespread. In Italy, the Mental Health Services' interventions appear inadequately defined and uniform, although, on several occasions, continuous and supportive activities aimed at families affected by mental suffering have been recognised as 'good practice'. In fact, from the analysis of the data related to the territorial psychiatric activity, contained in the Mental Health Report, published in 2021 by the Ministry of Health, it is highlighted that only a mere 5% of interventions directly address families, despite 47% of users residing within or connected to families (of origin or acquired). Out of the total 5%, 4.2% concerned interviews with family members, 0.7% involved informative/psychoeducational meetings, and only 0.1% accounted for family psychotherapy. Notably, multifamily interventions, where several families participate in group interventions, are conspicuously absent from this report, despite their long-standing presence in scientific literature. However, recent years have witnessed a gradual but steady diffusion of multifamily culture, involving diverse mental health operators at clinical and training levels. For example, in 2022, five out of the ten Mental Health Departments in the Lazio Region initiated specialised training courses focused on multifamily interventions. These courses were open to all operators across various services, and approximately 200 individuals participated. While these developments are initial indicators, they underscore significant challenges stemming from institutional, cultural, and ideological barriers that continue to hinder the stabilisation and formal establishment of multifamily practices.

In response to these observations, the 'Multifamily Groups in Mental Health' (FA.M.HE) project commenced in March 2022. Its inaugural phase involved constructing a comprehensive Guide to Multifamily Groups encompassing the diverse realities present in partner countries: Belgium, Italy, Portugal, and Spain. The project commenced with field research, comprising the creation, distribution, and analysis of a questionnaire aimed at conductors of active MFGs in these countries.

The questionnaire sought to delineate the operational dynamics of various MFGs in the four participating countries, irrespective of their theoretical or methodological orientations. The emphasis was on delineating their characteristics, organisation, and dissemination, with the primary criterion being the involvement of at least two generations, including individuals undergoing mental health treatment.

3.2 SURVEY – MFG CHARACTERISTICS

3.2.1 Institutional/Organisational Context

Despite initiating a substantial number of contacts, only a few health professionals responded comprehensively. Out of the numerous contacts made, 38 questionnaires were received, with 35 being deemed valid and complete. While this figure warrants a thorough analysis (planned to commence at a subsequent stage), it appears connected to a general reluctance or indifference towards sharing active experiences across numerous services or institutional areas, similar to previous surveys. There seems to be an underestimation of the importance of information in the field of mental health.

The majority of the establishments involved in the research are publicly owned, accounting for 72% of the sample, while 24% are affiliated with private entities, leaving the remaining 4% representing the private sector. The type of assistance is mainly outpatient, 84.8% of the total, divided between Mental Health Centres (61%) and Private Social Associations/Organisations (24%); 9% of residential assistance is represented by Therapeutic Communities, and 6% by hospital wards (Psychiatric Diagnosis and Treatment Services).

3.2.2 Properties

The questionnaires, as a whole, seem to represent the various theoretical-methodological orientations in Italy, proportionally to findings in other studies. Specifically, the questionnaire revealed four typologies: Multifamily Psychoanalysis (61%), Psychoeducation (21%), Systemic orientation (12%), Psychodynamic orientation (9%), and 1 MFG categorised as 'Other.' The noticeable prevalence of Multifamily Psychoanalysis reflects not only its effective adoption nationwide but also underscores the heightened engagement and research motivation among MFG conductors from the Italian Laboratory of Multifamily Psychoanalysis (LIPsiM). Notably, LIPsiM stands out as one of the few national associations actively involved in disseminating, studying, and training within the multifamily context.

3.2.3 Conduction

Regarding the management method, 97% of the represented groups employ a team-based approach. Among them, 58% involve a group conductor/facilitator supported by various co-conductors/facilitators, constituting a hierarchical setup, while 39% have a non-hierarchical team structure with only a co-conductor/facilitator. Psychotherapists constitute the majority of management teams (93% psychologists and 48% psychiatrists), with other mental health professionals also being integral members (39% nurses, 30% social workers, 18% educators, and 6% psychiatric rehabilitation therapists). The inclusion of various professionals underscores the necessity of tailored training courses for non-psychotherapy practitioners, foreseeing the acknowledgement of specialist qualifications.

The training of psychotherapists within these teams aligns with the theoretical-methodological orientations of the represented MFGs. It emphasises the complexity as different conductors possess diverse training backgrounds: 45% have psychoanalytic training, 52% in psychodynamics, 24% in group analysis, 54% in family systemic, and 36% in cognitive-behavioural psychotherapy.

Supervision, which involves reflecting on and evaluating work by an external expert, occurs in 55% of MFGs. Most of this supervision takes place internally, with direct supervisor participation in the group (10 MFGs). Three groups use external supervision (classic model), while five groups employ

both approaches. Almost all examined MFGs (93%) engage in post-group intervision/meetings, representing a further method of supervision derived from the group analytic and family-systemic experience, designed to exchange impressions, emotions and reflections within the management team. These responses underscore the multifaceted nature of multifamily functioning and the depth of group exchanges, requiring specific spaces for meta-reflection and elaboration. They also highlight the need for harmonising and integrating interventions conducted in various forms by the management team.

3.2.4 Participants

The majority of participants fall into the adult age range by birth (86%), followed by the adolescent range (26%). In 72% of cases, there are two generations present, and in 27%, there are three generations involved. The relationships primarily revolve around child/parent connections in 97% of instances, followed closely by parent/child dynamics in 91%, and in 66%, with another member of the nuclear family. These findings suggest a greater emphasis on the child/parent bond compared to other familial relationships (spouse, siblings), similar to what is expressed in nuclear family therapies.

Most MFGs are involved in the treatment of psychiatric pathologies (71%). Both heterogeneous and homogeneous groups show a significant predominance of psychotic disorders, with 81% and 90%, respectively. Additionally, mood disorders account for 74%, while personality disorders constitute 67% of cases. Traditionally used for severe psychiatric pathologies, multifamily interventions have expanded to address pathological addictions (35%), eating disorders (26%), and psychosomatic disorders (19%).

The majority of MFGs are open groups (79%), allowing participants to enter or leave at any time with a variable group size. There are fewer closed groups (15%), with predetermined start and end points and no changes in composition. A smaller portion (6%) comprises slow-open groups, where composition changes occur only in specific cases. These percentages align closely with the presence of different phases of intervention in MFG meetings: 78% do not incorporate phases, while 26% do. This likely links to the chosen methodological approach, akin to psychoeducational interventions, which involves specific phases, requiring the definition of the intervention's start and end, and relatively stable participant composition. However, most of these groups (86%) involve people being treated in all phases of the intervention.

3.2.5 Structure and Functioning

In 75% of responses, MFGs typically consist of a medium-sized group ranging between 10 to 30 participants, and face-to-face participation is required in 78% of cases. The majority hold meetings on a weekly (56%) or bi-monthly (37.5%) basis, while only 6% gather monthly. The duration of these meetings is commonly 90 minutes (58%) or 120 minutes (39%), with just one group lasting an hour. These quantitative insights could provide operational guidelines, highlighting factors in the context that may enhance the optimal functioning of MFGs, potentially constituting a set of ‘good practices’.

Regarding the environment for MFG meetings, responses suggest an overall adequacy of physical settings to accommodate multifamily dimensions. Around 67% occur in multipurpose rooms and 24% in activity rooms, with 97% acknowledging their suitability in terms of dimensions and comfort. Privacy and confidentiality are ensured in 94% of cases, and 96% use a circular seating arrangement, essential for fostering exchange and inclusivity in the multifamily context. Attention

to these tangible aspects of the physical environment seems crucial in establishing a climate of safety and comfort within the complexities of multifamily dynamics. The duration of MFGs over time appears highly variable and is only partially linked to the reference methodology, such as Psychoeducational MFGs. Most groups do not seem to have a definitive end, and interruptions or suspensions are primarily associated with recent pandemic constraints (77%) and, to a lesser extent, limitations in human resources (32%). These external causes are not necessarily attributable to internal methodological choices within the MFGs themselves.

3.2.6 Referral

The final element of the questionnaire addresses a crucial aspect regarding the functionality of Multifamily Groups within their respective contexts. It delves into the theme of Referral, a pivotal topic that emerged during the two parallel focus group discussions and has been frequently highlighted in the literature. A majority of referrals (82%) stem from within the institution, while 36% come from external sources. This data may suggest a strong rooting of MFGs within the context of belonging. However, it could also signify a limited interaction with the broader external community, potentially indicating a lack of awareness or recognition of this treatment methodology beyond the confines of the institution.

3.3 FOCUS GROUPS

3.3.1 Focus Group with MFG Conductors

3.3.1.1 Participants

As per the project's agreement among all partners, following the completion of disseminating and collecting questionnaire responses, a focus group was arranged. This focus group targeted a representative selection of conductors involved in the research. The selection process for this sample was based on voluntary participation, initiated by sending an e-mail requesting availability to all colleagues who had previously filled out the questionnaire.

3.3.1.2 Methodology

Focus Group 1 took place on January 27, 2023, conducted online via the Zoom platform from 9.30 to 12.30, and was completely recorded. Ten colleagues out of a pool of thirty-four accepted the invitation, with nine attending the session; one colleague faced a professional emergency and could not attend on the specified date. The selected sample represented diverse theoretical-methodological orientations and mirrored the geographical distribution of the general participant pool, encompassing experiences from both the public and private sectors. The session was mediated by a coordinator and included two observers.

The methodology employed was the SWOT analysis, allowing each participant to identify, based on their own experience, strengths and problematic elements/difficulties within their own reality and cross them with opportunities and possible obstacles generated by the external context. The analysis focused on three significant elements common to the majority of MFG experiences highlighted in the questionnaires:

- Participation of at least two generations, incorporating individuals undergoing mental health treatment;
- Presence of a management team;
- Activation of an exchange space between conductors immediately following the MFG meeting (Post-Group).

3.3.1.3 Results

Below is a summary of the findings from each focus:

Focus 1: Participation of at least two generations

Strengths:

- Overcoming defensive oppositions, we/you, parents/children, ill/healthy;
- Enhanced comparison and the possibility of mirroring;
- Inclusion and sense of belonging.

Weaknesses:

- Discontinuity in the participation of the entire nucleus;
- Difficulty in self-expression;
- Fear of conflict.

Opportunities:

- Resource savings (human and economic);
- Channelling and redefinition of family requests/claims;
- Knowledge and sharing of the intervention model.

Threats:

- Difficulty in referral; preference for parent(s) over the nucleus;
- Concerns about excessive stimulation for the 'patient';
- Persistence of individual-focused classic psychiatric perspective.

Focus 2: Presence of a management team

Strengths:

- Improved exchange management and greater containment;
- Mutual support, dividing the 'emotional load';
- Intervention continuity;
- Projection breakdown.

Weaknesses:

- Risk of disharmony or inconsistency;
- Potential delegation to a single 'therapist'.

Opportunities:

- Enhanced sharing of the Individualised Therapeutic Project;
- Overcoming isolation and integration among settings;
- Integration among professionals.

Threats:

- Staff shortage;
- Institutional resistance;
- Lack of knowledge about the method.

Focus 3: Post-Group

Strengths:

- Meta-reflection on the experience and critical issue sharing;
- Integration of different points of view;
- Verification of consistency between model and intervention.

Weaknesses:

- Inability to recognise critical elements by participants.

Opportunities:

- Continuous training and accreditation;
- Team reorganisation possibilities.

Threats:

- Difficulty recognising this moment as integrated in the work of MFGs;
- Failure to respect the border, institutional intrusions and emergencies;
- Limited implementation of reflective practice in other institutional spaces.

3.3.2 Focus Group with MFG Users

3.3.2.1 Participants

A focus group was conducted comprising 10 to 15 participants involved in MFGs for various reasons (patients, parents, family members, and caregivers). During this session, topics similar to those addressed in the focus group involving MFG conductors were evaluated. Furthermore, the comparison and potential alignment of responses from both focus groups could be used to validate the research outcomes.

To facilitate in-person attendance, an initial selection was made, involving MFG members from the research operating in the province of Rome. Subsequently, the sample was constituted through direct invitations extended by conductors to the regular users of these groups.

3.3.2.2 Methodology

The focus group took place on February 8, 2023, from 09.30 to 12.30 at the LIPsiM headquarters in an in-person format. Eighteen users were invited, and twelve attended the meeting. The sample was representative of the different figures of MFG users operating in both the public and the private social sectors. The session involved a coordinator and two observers.

Similar to the focus group for MFG conductors, the meeting employed the SWOT analysis method. The analysis was conducted using two out of the three topics defined for comparison between conductors, considered more evaluable by users:

- Participation of at least two generations, incorporating individuals undergoing mental health treatment;
- Presence of a management team.

The third focus proposed to the sample of conductors/facilitators, regarding the activation of a post- group session, proved challenging for evaluation by the users, as it typically involves a moment within the multifamily meeting reserved for the management team.

3.3.2.3 Results

Below, is a summary of the findings from each focus:

Focus 1: Participation of at least two generations

Strengths:

- Enhanced empathy among family members;
- Dialogue is made possible in otherwise difficult circumstances;
- Containment of expressed emotions;
- Mirroring and mutual recognition;
- Possibility of recognising oneself in different roles;
- Helps establish parental boundaries.

Weaknesses:

- Limited participation of complete households;
- Concerns about potential harm;
- Reluctance to expose oneself in front of family members.

Opportunities:

- Addressing and responding to family needs;
- Offers a cost-effective opportunity.

Threats:

- Limited information about MFGs;
- Insufficient training for operators;
- Organisational challenges within the Service that may impede MFG effectiveness.

Focus 2: Presence of a management team

Strengths:

- Facilitation in the circularity of exchanges;
- Less directivity in conducting;
- Management team as a model for the entire Group;
- Stimulus for dialogue.

Weaknesses:

- Excessive turnover;
- Risk of fragmentation/confusion.

Opportunities:

Integration between different professional figures;

Less 'personalisation' of the intervention.

Threats:

- Staff shortages;
- Difficulty sustaining commitment due to excessive workloads.

An additional note: At the end of the meeting, participants suggested organising similar moments of exchange and comparison in the future, as they found them beneficial for deepening their own experiences and enhancing multifamily practices.

3.3.3 Focus Group Conclusions

The comparison conducted among the participants allowed for a deeper exploration of various aspects related to the proposed topics. Although suggested from the quantitative evidence derived from the analysis of questionnaire results, these aspects were not thoroughly evaluated in their qualitative complexity.

Consensus was reached among participants regarding the prevalence of strengths, perceived as internal potential, in contrast to critical issues perceived more as initial resistance to multifamily intervention rather than actual negative aspects. Specifically, the simultaneous presence of multiple generations, family members, and Mental Health Service users appeared as the most critical aspect during initial engagements with MFGs. The presence of several generations was considered the defining element influencing exchanges and the prevailing atmosphere within the Group, enhancing complexity, and facilitating goal attainment. Similar considerations arose regarding the presence of a management team, which seemed to evolve gradually rather than being a formal establishment.

ven across various interpretations (lead conductor with facilitators, co-management team, coordinator with observers), identified weaknesses related to this focus appeared to resolve themselves in the course of practice, particularly concerning the distribution of emotional burdens

and the optimisation of trade-offs.

Regarding the third focus directed at conductors, participants acknowledged the importance of a shared reflective moment concerning the intervention's implementation. This scheduled moment, integrated into Multifamily Psychoanalysis Groups (MFPG), would ensure the necessary harmonisation/consistency of the management implemented in plural form. Notably, no internal critical elements were identified concerning this aspect.

Regarding obstacles in the external context, there seems to emerge, as a transversal datum, a cultural/ideological difficulty in proposing a clinical intervention that brings both family members and users together. This challenge was amplified and supported by a lack of knowledge of multifamily experiences. Consequently, the design of multifamily training interventions should encompass specific preparatory actions targeting the culture and functioning of institutional contexts.

Alongside the evident theoretical-methodological differences characterising diverse experiences, a strong convergence on the proposed topics, which can be considered as common elements characterising the multifamily experience, appears significant. The simultaneous participation of at least two generations, the presence of a management team, and the activation of dedicated reflective moments appear to assume the role of good practices and inescapable process variables in establishing Multifamily Groups.

3.4 BIBLIOGRAPHIC RESEARCH

The bibliographic research carried out by LIPsiM concerning the Italian context highlighted the keywords that yielded a better index of contents, both quantitatively and qualitatively: Multifamily Groups, Multifamily Psychoanalysis, and Multifamily Therapy. This research led to the selection of recurring bibliographic items within a first index, subsequently divided into two lists (see Appendix 1):

1. Italian bibliography: this specific task of LIPsiM revealed the presence of articles, monographs, books, and book chapters. Most entries pertain to Multifamily Psychoanalysis, with the only operational manual being a text on multifamily psychoeducational intervention.
2. International bibliography translated into Italian: this compilation gathers translated foreign publications into Italian, considered particularly representative of multifamily intervention models in Italy. It was deemed appropriate to retain these entries, to provide easily accessible information for the final recipients of the Guide to Multifamily Groups.

3.5 CONCLUSIONS

The primary objective of the ‘Multifamily Groups in Mental Health’ research, the Intellectual Output I of the FA.M.HE project, is to enhance understanding of the diverse Multifamily Groups in mental health. This encompasses their territorial diffusion, existing models, and characteristics. In this sense, the first significant fact that emerged from this research concerns the confirmation of the differentiation of the multifamily experience into two main areas:

1. Psychoeducational Multifamily Meetings, focused on mental health problems, providing information on their management.

2. Therapeutic Multifamily Meetings, delving into the psychic suffering within the family context and not only of the person who manifests mental health problems, trying to deepen and overcome difficulties that arise through the contribution of each participant.

A predominant percentage within the second strand pertains to Multifamily Psychoanalysis Groups (MFPG), as previously emphasised during the results analysis phase. At present, it is pertinent to highlight not only the greater effective diffusion of this methodology across the national territory (at the moment there are approximately 60 active MFPGs in various regions), but also the continuous work of comparison, research and training carried out by LIPsiM.

The existence of an associative structure, which provides a network of support, stimulus, and in-depth analysis of MFGs concerning the treatment of psychic distress, emerges as a pivotal factor in disseminating and appropriately developing such a complex intervention tool. Moreover, concerning the organisation of suitable training sessions for MFPG conductors/facilitators (according to the Intellectual Output of the FA.M.HE project), a beneficial action towards the project's objectives could involve establishing a European associative structure. In parallel with the practices of LIPsiM in Italy, this effort would provide support and online platforms for these programs.

Regarding the design of adequate training courses, it should be taken into consideration how the questionnaire data and focus group discussions highlight that MFGs are, in almost all cases, carried out by a management team, whose composition is often heterogeneous, encompassing varied professional backgrounds in academic training, roles, and clinical experience. This situation presents an engaging challenge in devising training programs that must consider not only the various dimensions of management but also the creative integration of diverse skills exhibited by different professional figures. Therefore, a crucial aspect appears to be the definition of transversal skills essential for establishing a solid and coherent management team, alongside the precise construction of a theoretical reference framework.

One recurring characteristic mentioned in the questionnaire regarding multifamily experiences is the existence of a dedicated reflective space immediately following the MFG meeting. This space is intended for discussions among conductors, as emphasised in the analysis of the collected data. Despite being considered a fundamental moment by all tenants and an essential component of multifamily work, this space faces numerous obstacles in being safeguarded and acknowledged within the institutional framework. In fact, the analysis of the answers provided by the conductors present in the focus group dedicated to them highlights their perspective. While conductors do not recognise any internal criticality relating to this practice, noting only its advantages, they do report a series of external obstacles attributable to resistance within the institutional context. These barriers encompass a lack of respect for boundaries due to institutional intrusions and clinical emergencies, coupled with a deficiency in the Mental Health Services' readiness for reflective practice.

Consistent insights emerged from focus group discussions concerning the participation of at least two generations and the inclusion of individuals facing greater difficulties - a prerequisite for involvement in the research. Irrespective of theoretical-methodological orientation, these elements are predominantly erceived across multifamily experiences, often signifying significant aspects of the intervention. The inherent complexities faced in managing these aspects are considered natural, whereas external obstacles, often organisational or structural, are attributed to genuine institutional resistance.

To enhance comprehension and dissemination of multifamily work, it becomes crucial to consider these cultural/ideological difficulties when devising clinical interventions that unite family members and users. Multifamily training courses should integrate preparatory moments focusing on the culture and functioning of mental health care and supportive contexts. Such a multifaceted information/training intervention encompasses multiple tiers of training involving individual operators, work groups, and institutional contexts.

4 BELGIUM REPORT

4.1 BELGIAN SITUATION

Belgium has three official languages (Dutch, French, and German). The country is organised into several levels of authority: the federal state, the federated states (three regions based on territory and three communities based on language), and local authorities (provinces and municipalities). Authority over the health care system is divided between the federal government and the states.

The Federal Public Service (FPS) Public Health is responsible for the overall organisation and planning of the health system. Within the federal level, the National Institute for Health and Disability Insurance (NIHDI) administers compulsory health insurance through social security contributions.

The states are the main competent authorities for mental health care, care for the elderly, care for the disabled, primary and home care, rehabilitation, health promotion and disease prevention. For cooperation between the federal government and the states, interministerial conferences are organised regularly.

The budget for health insurance and health policy is determined during negotiations between the representatives of the authorities, patients (via the health insurance funds), employers, employees and the self-employed. Healthcare providers are involved in decisions on tariffs and reimbursements of medical services. These decisions are set out in national agreements or agreements between representatives of health care providers and the health insurance funds.

Organisation of Mental Health Care

Mental health care in Belgium is mainly characterised by a vertical structure with the following actors:

- The federal FPS Public Health;
- The federal NIHDI administration;
- The state administrations (Communities and Regions).

These bodies - in cooperation with the Mental Health Care Consultation Platforms - are responsible for managing psychiatric health care in mainly residential structures:

- The Psychiatric Hospitals (PZ);
- The Psychiatric Departments in General Hospitals (PAAZ);
- The Psychiatric Care Homes (PVT);
- The Sheltered Living Initiatives (IBW);
- The Centres for Mental Health Care (CGG).

In parallel with these institutions, there are quite a few healthcare structures with an NIHDI agreement, such as psychosocial rehabilitation centres and crisis centres.

In Belgium, the mental health care situation is quite complex. For example, the federal government is responsible for funding psychiatrists and psychiatric departments in hospitals, while the Communities and Regions are responsible for organising and funding outpatient mental health care.

Deinstitutionalisation

As in most industrialised countries, the mental health care sector in Belgium has been reformed several times since the late 20th century. These reforms aimed to treat people with mental health problems as much as possible in their environment and social structure, allowing patients to remain in their familiar surroundings for as long as possible.

The focus was thus placed on increasing integration of care in the living environment rather than in psychiatric institutions (deinstitutionalisation).

Innovative health care initiatives

Article 107 of the Hospital Act is a funding technique that allows beds in general and psychiatric hospitals to be decommissioned and the funds thus authorised to be invested in innovative care initiatives such as mobile teams. The staff freed up by the decommissioning of beds can be deployed in alternative care provision. In practice, this involves mobile crews for specialised care in the home environment or intensification of residential care.

4.2 SURVEY – MFG CHARACTERISTICS

4.2.1 Institutional/Organisational Context

The questionnaire was disseminated among four target groups:

The first group consisted of 'experts' in MFGs. 'Experts' were defined as researchers who had published on Multifamily Groups in Belgium. Based on the bibliographic study, four experts were selected for Flanders and three experts for Wallonia. The experts were approached by mail with an invitation to meet by phone/Zoom/in person (in September 2022) and five of them accepted this invitation. Subsequently, the project was introduced verbally, and they were asked to distribute a letter of introduction to their network, their willingness to complete the questionnaire once it was ready was probed. After a month, the experts received the link to the questionnaire on Google Forms (in October 2022). In Flanders, a response was given from three experts, and two answers from their network. In Wallonia, responses were received from two experts.

A second target group consisted of psychiatric hospitals. All psychiatric hospitals were listed, including 32 hospitals in Flanders and 26 hospitals in Wallonia. The psychiatric hospitals were contacted by telephone and asked for the responsible/coordinator of the therapeutic/psychological service within the hospital (in September 2022). These managers/coordinators were verbally introduced to the project and asked to distribute a letter of introduction to their staff (in October 2022). After one month, the managers/coordinators were contacted again by e-mail, with a reminder to participate in the project and a link to the questionnaire on Google Forms (in November 2022). Out of the 32 hospitals contacted in Flanders, no answer was received from 12 of them. It was discovered that 11 hospitals lacked any experience or knowledge about MFGs. Two hospitals stated that they had a group in the past, but not at the moment - one group still filled out a questionnaire. In the end, a total of 16 completed questionnaires were received from 7 different hospitals. The family groups in Flanders are spread across the 5 provinces. All MFGs (except one in an outpatient group practice) are organised from a psychiatric hospital. Seven out of eighteen Flemish groups take place within residential care, while six groups are located in a department offering both day hospital/ambulatory and residential care. In addition, 4 groups possess only day hospital/ambulatory care. In Brussels, 1 MFG was found at the University General Hospital, which takes place in a residential ward where outpatient therapy is also possible. Out of the 26 hospitals

from Wallonia, no response was received from 8 of them. Moreover, 9 hospitals reported having no experience or knowledge of MFGs, and 2 hospitals indicated they did not have time to cooperate – one of the latter did not specify whether they knew MFG while the other stated that they had experience. In the end, 6 multifamily groups were identified in 6 different hospitals. All questionnaires from Wallonia came from psychiatric centres spread across the 5 provinces. It was observed that 3 out of 6 Walloon groups offered both outpatient and residential care, 1 group offered only residential care, and 2 groups offered only day hospital/outpatient care.

Thirdly, a list of 44 professional organisations, associations and institutions was generated based on a web survey. The professional organisations received an e-mail with a brief explanation of the project, a letter of introduction and a link to the questionnaire on Google Forms (in October 2022). Additionally, they were asked to distribute this information to their members. Neither in Flanders nor Wallonia was a response received through a professional body.

A fourth target group consisted of 29 family organisations, 16 of which were in Flanders, and 13 in Wallonia, both found through a web survey. The family organisations were contacted by phone or e- mail and given a brief explanation of the project. They received the introductory letter and the link to the questionnaire on Google Forms (in October 2022) and they were asked to disseminate this information to their members. Neither in Flanders nor in Wallonia were responses received from family organisations.

In conclusion, 18 Dutch-speaking and 6 French-speaking MFGs were identified.

4.2.2 Properties

In Flanders, 66.7% (12/18) of the groups start from a systemic vision. Among these, 27.8% (5/18) exclusively use a systemic background, while 27.8% (5/18) combine systemic therapy with a psychoeducational background (such as behavioural therapy or the Maudsley model). Moreover, 11.1% (2/18) combine a systemic approach with a psychoanalytic background (such as psychodynamic or Garcia Garcia Badaracco). In addition, 11.1% (2/18) of the groups rely exclusively on the Maudsley model, 5.6% (1/18) apply only psychoeducation, 5.6% (1/18) rely exclusively on behavioural therapy, and 5.6% (1/18) exclusively follow the Garcia Garcia Badaracco model. In Flanders, 83.3% (15/18) of the groups have psychotherapy goals and 61.1% (11/18) want to offer psychoeducation. In 55.6% (10/18) of the cases, the group hopes to offer each other support.

In Wallonia, 83.3% (5/6) of the groups start from a systemic therapeutic vision. In 33.3% (2/6) of the cases, this is combined with a group therapy background, in 33.3% (2/6) with a psychoeducational vision (one of which according to Maudsley's model), and in 16.7% (1/6) of the cases with a psychodynamic vision. Only 16.7% (1/6) work exclusively according to a psychodynamic model. In Wallonia, all groups indicate that they focus on providing support and self-help to peers. Most of the groups have therapeutic objectives, except for one group, which explicitly states that it does not want to offer therapy. Moreover, 66.7% (4/6) of the groups want to offer psychoeducation.

4.2.3 Conduction

In Flanders, 61.1% (11/18) of the groups work only with co-therapists, while in the remaining 38.9% (7/18) there are one (or two) group conductors. In all Flemish groups, there is a psychologist (or pedagogue) who, in 55.6% of the cases (10/18), works together with a nurse. Moreover, in 33.3% (6/18) of the groups a social worker is present, in 27.8% of them (5/18) a psychiatrist, in 22.2% (4/18) a psychomotor therapist, in 11.1% (2/18) of the cases a dietician, a creative or drama therapist, or an expert by experience. In one group (6%) an educator participates.

In Wallonia, 66.7% (4/6) of the groups work only with co-therapists, while in the other 33.3% (2/6) there is a group conductor. In the majority of the Walloon MFGs (83.3% or 5/6), the central axis is a doctor-nurse, complemented in 50% by a psychologist or an educator, and in 16.7% (1/6) by a social worker. Only 1 group (16.7% of the total) is supervised by only one psychologist. In Flanders, there are 29 types of therapist backgrounds, 48.3% of the total (14/29) being systems therapists, 20.7% (6/29) being cognitive-behavioural therapists, 10.3% (3/29) being psychodynamic therapists, 6.9% (2/29) being psychoanalysts, 3.4% (1/29) being group therapists, and 10.3% of them (3/29) being other types of therapists.

In Wallonia, there are 15 types of therapist backgrounds, 33.3% of the total (5/15) being systems therapists, 26.7% (4/15) being cognitive-behavioural therapists, 13.3% (2/15) being psychodynamic therapists, 13.3% (2/15) being group therapists, and 13.3% of them (2/15) being other types of therapists.

4.2.4 Participants

The questionnaire aimed to ensure that all groups accommodate at least two generations. In Flanders, patients are absent in 11.1% (2/18) of the groups, while in Wallonia, this occurs in 50% (3/6) of the groups. The sample of 24 MFGs can be categorised into five groups based on pathology and age stage:

1. Regarding eating disorders, all groups, both in Wallonia (1) and in Flanders (5), focus on adolescents and young adults.
2. Concerning addiction care, in Flanders there are 2 groups for adolescents/young adults and 2 groups for adults. In Wallonia, no specific group was found within addiction care.
3. Regarding psychosis care, 2 out of the 3 groups in Flanders focus on the transition age (from 15 to 30 years old). In Wallonia, no MFGs were found within psychosis care.
4. Focusing on affective disorders, 1 Flemish and 1 Walloon family group were found.
5. While in Wallonia the heterogeneous groups are mainly aimed at an adult audience (3, in addition to 1 group aimed at adolescents/young adults), in Flanders 4 heterogeneous groups can be found exclusively among adolescents/young adults.

4.2.5 Structure and Functioning

Different types of groups can be clustered around a particular pathology:

1. 25% (6/24) of the groups focus on eating disorders, with 5 in Flanders and 1 in Wallonia. These are primarily closed groups, except for one slow-open group. Among them, 4 groups (3 Flemish and the Walloon) draw inspiration from Maudsley's model, grounded in cognitive principles. These groups convene 8 to 10 times per full day, with decreasing frequency throughout the year. Despite following the same model, each group varies in session frequency and distribution. The remaining 2 Flemish groups addressing eating issues adopt a systemic perspective. One meets weekly for two months, while the other gathers fortnightly for 2 to 3 hours.
2. 16.7% (4/24) constitute closed groups catering to addiction treatment, structured in recurrent series of 4 to 5 sessions. Sessions run for 1.5 to 2 hours on a fortnightly basis.
3. 12.5% (3/24) of the groups focus on psychosis care. One group follows McFarlane's psychoeducational model, conducted in a closed setting with a predetermined series of six

sessions. These sessions start fortnightly, and then continue monthly, followed by a three-month interval. Two groups are influenced by Garcia Garcia Badaracco's approach, each with distinct formats: one operates with a fixed group across four sessions, meeting every three weeks (the first three being online and the last meeting taking place in-person). The other group is open, gathering for 1.5 hours fortnightly.

4. 8.3% (2/24) of the groups focus on affective disorder care. The Flemish group adopts a psychoeducational approach in a slow-open setting, allowing participation in weekly sessions based on indication. Meanwhile, the Walloon group is open, meeting monthly for two hours.
5. 29.2% (7/24) of the groups are heterogeneous and very diverse. In Flanders, one group meets quarterly for 'family evenings' with a psychoeducational objective. Another slow-open group, targeting dual diagnoses of addiction and personality disorders, meets fortnightly for 1.75 hours. Additionally, a third group is closed for six sessions, meeting fortnightly, and a fourth group is open and gathers fortnightly. In Wallonia, three open groups share a similar profile inspired by Serge Mertens de Wilmars' work. These groups target adults, convening monthly for 2 hours. Another heterogeneous group in Wallonia is in the formation stage, intending to establish a closed monthly group.

In both Flanders and Wallonia, two-thirds of the groups are of medium size, while the remaining 33.3% are small. However, one group in Flanders stands out with more than 30 participants. Regardless of size, the venues are tailored to accommodate the group and ensure confidentiality. Participants typically arrange themselves in a concentric circle, except in four Flemish addiction groups and the psychoeducational affective group where they sit at a table.

The oldest among the groups is the Flemish psychoeducational affective group, established in 2000. Following this, a notable surge in groups addressing eating problems occurred, with the first in 2003, followed by two in 2007 (one Walloon and one Flemish). Subsequently, there has been a gradual emergence, with one group starting annually for the past decade, and currently, three groups are in their initial phases.

Regarding interruptions, 44.4% (8/18) of the groups in Flanders and 33.3% (2/6) in Wallonia have never faced interruptions. Conversely, due to the pandemic, 33.3% (6/18) of the groups in Flanders and 66.6% (4/6) in Wallonia had to suspend activities. Furthermore, 22.2% (4/18) of Flemish groups experienced interruptions owing to staff shortages. Post the hiatus, most groups resumed onsite meetings. However, one group requested pre-registration from participants, and another continued using the online medium. A minor proportion, 8.3% (2/24) of the groups, have not yet been able to restart.

4.2.6 Referral

In the Flemish groups, internal referrals are the exclusive norm, except for the ambulant group. However, in the Walloon groups, there's a distinct pattern: only one group relies solely on internal referrals, while the other four groups welcome both internal and external participants.

4.3 FOCUS GROUPS

4.3.1 Focus Groups with MFG Conductors

4.3.1.1 Participants

Following the completion of questionnaire dissemination and compilation, as agreed upon in the project's definition phase, a focus group was arranged, targeting a representative sample of conductors involved in the research. Experts from each region (French and Dutch) were contacted via email, and dates were scheduled based on their availability. The initial focus group for the French-speaking participants occurred on January 10th, and for the Dutch-speaking participants on January 13th, 2023, each session lasting 90 minutes. Invitations were subsequently sent by mail to all respondents of the questionnaire: 18 from Flanders and 9 from Wallonia. Respondents were given the liberty to invite MFG colleagues, resulting in a group of 14 participants for Flanders and 16 for Wallonia, including the moderator and two observers.

For the subsequent in-depth focus group involving MFG therapists, both experts and respondents received invitations again. The French-speaking session was scheduled for February 20th, and the Dutch-speaking session for February 21st, 2023, also lasting 90 minutes. Respondents were encouraged to invite MFG colleagues themselves. Additionally, one extra French expert was invited for the Walloon group, and an experienced MFG therapist for the Flemish group. Consequently, the Flemish group comprised 13 participants, and the Walloon group consisted of 10 participants, including the moderator and two observers.

4.3.1.2 Methodology

Two focus groups were organised in each region, with an interval of approximately a month between them, resulting in a total of four meetings involving MFG therapists (two in Dutch, two in French). During the first meeting, a SWOT analysis was conducted based on the results of the questionnaire. In the second meeting, a deepening of the findings from the first focus group took place. Each focus group was led by an external moderator, accompanied by two observers. The meetings were conducted via Zoom and recorded. An anonymised transcript of the recordings was created and sent to the participants.

4.3.1.3 Results

Here's a summary of the findings from each focus:

Focus Group 1: French-speaking, SWOT analysis:

Strengths:

- MFGs align with a paradigm shift within mental health care, where families are given the utmost attention, alongside patients and caregivers;
- It aids in destigmatisation, facilitating connections within and outside psychiatry for both family members and other involved social workers;
- MFG originates from a relational ethic, addressing concerns about one another;
- Embraces a community approach, creating a microcosm that mobilises collective support;
- Participants experience mutual support and solidarity within the group;
- Peers often exhibit greater openness towards each other than to counsellors, resulting in fewer defensive barriers and increased receptivity to emotional learning;
- Engaging in a 'helper' role for others within the group often leads to new insights about

one's situation;
- The multiplicity of perspectives allows individuals to recognise themselves in others, and to differentiate oneself from others. Through the process of identification and differentiation, one gains insight into their unique situations;
- Facilitates intergenerational division of responsibilities: parents focus on their parental competencies, while children engage in their developmental tasks of separation/individuation;
- Emphasises trans- and inter-generational dialogue, fostering communication in real-time;
- Offers a wide range of methodologies within MFGs:
    - Group dynamics: closed for security, open for diversity;
    - Pathology focus: homogeneous for cohesion, heterogeneous for freedom;
    - Process evolution: parallel for hope (similar collective evolution), divergent for cross-fertilisation (different point in evolution);
    - Therapeutic goals: direct and clearly stated, or indirectly generated from the framework for therapeutic effects.
- Complements other therapeutic forms such as individual therapy, individual family therapy, and group therapy;
- Provides valuable learning opportunities for professionals.

Weaknesses:

- Not everything can be worked in a group: it is sometimes necessary to organise individual family meetings in parallel;
- Difficulty managing indication in potentially large and diverse groups;
- Potential for amplification or acting out of guilt within the group dynamics;
- Variances in participants' progress, such as relapses or negative developments, can adversely affect others.

Opportunities:

- Exploring the potential role of MFGs within primary care.

Threats:

- Time-consuming process to embed MFG culture within an organisation;
- Organisational challenges like finding suitable venues, additional MFG therapists, and scheduling;
- Requiring attentive efforts to effectively engage families within the MFG setup.

Focus Group 2: Dutch-speaking, SWOT analysis:

Strengths:

- Aligns with the current trend of focusing on both patient and system in counselling, positioning counselling as a 'bridge' rather than a 'wall';
- Counters family members' feelings of powerlessness amidst illness by fostering a sense of collective treatment;

- Acts as a form of empowerment, enabling families to highlight positive attributes within one another;
- Encourages mutual support among peers, granting them more authority to provide advice than counsellors;
- Facilitates healing through bonding, (h) acknowledgement, and the sharing of experiences within the MFG setting;
- Offers opportunities for indirect learning by observing other families, prompting introspection and learning about one's situation at a comfortable pace;
- Encourages self-care and boundary setting within the family structure, enhancing intergenerational alignment;
- Provides a platform for addressing stagnant family dynamics, enabling individuals to feel heard and understood in novel ways by other parents/youngsters;
- Embraces diversity in patient/second-generation involvement:
    - Patient invited but absent;
    - Patient as the inviting party;
    - Family's participation linked to the patient's involvement;
    - Patient relieved that the family has a separate space where they do not need to participate.

Weaknesses:

- Timing is crucial for MFG participation, potentially unsuitable during personal capacity limitations (e.g., during crises or overwhelming situations, exposure to heavy stories from others);
- Requires careful indication and distinct group demarcation (age, disease stage) for recognition, cohesion, avoiding chronic imagery for younger participants, and preventing older participants from confronting loss-related mourning;
- MFGs might foster peer comparison, leading to heightened Expressed Emotion;
- Poses a risk of exacerbating underlying conflicts.

Opportunities:

- Integration of MFGs within the psychologists' convention;
- Offers substantial cost efficiency for institutions.

Threats:

- Potential conflicts for therapists who also engage with patients or families individually;
- Requires at least two therapists, potentially a third based on group size;
- Risk associated with overly large groups;
- Financial implications: inability to charge the system if the patient does not participate;
- Importance of linking MFGs with a broader mental health context to prevent isolation.

Focus Group 3: Dutch-speaking, in-depth analysis:

Focus 1: Dealing with different requests for help within 1 system:

- Some places require patient agreement to invite networks for admission;
- Specific models employed:
    - Psychoeducation: provides structure and phases for addressing various queries.
    - Attachment-Based Family Therapy model: initial focus on bonding/connection/restoring trust, before working on symptoms;
    - Initial phase: make explicit various, personal help questions; second phase: choose 1 help question on which the group focuses;
    - Use of a 'worry box': anonymous submission of subjects, randomly drawn for discussion.
- Individual (family) therapy as a complement:
    - Prepares for MFG participation, eliminating resistance from both family and patients, and aligning joint help requests;
    - Runs parallel to MFGs for addressing overly family-specific help requests.
- Information sessions for networks to interpret the MFG framework;
- Discussions within MFGs on participant commitments' effects.

Focus 2: Resisting MFG engagement:

- From patients/family:
    - Catch up by: motivational preparation in individual family discussions, use of non-verbal techniques during MFGs, and feedback solicitation during individual family discussions.
- Direct dialogue can lead to tension:
    - Specific to MFGs is the use of indirect communication: age/role/lot peers can help answer questions about which direct communication is not yet possible within the family.
- From therapists:
    - If certain themes do not belong in MFGs, deemed too personal or intimate for discussion.

Focus 3: Need for supervision/intervision:

- Evaluation with the participants:
    - Questioning in the MFG: 'How did everyone experience this?';
    - Use of feedback forms, filled in by the users at the end of the session.
- ‘Debriefing’ among the co-therapists:
    - To discuss necessary adjustments and readjustments for the future;
    - Alignment among co-therapists;
    - Acknowledgment of personal familial and vulnerable sides.

Focus 4: Current MFG needs:

- Exchange of practical examples, good practices, techniques, and exercises;
- How to gather enough participants - stable inflow;
- How to deal with adult children.

Focus Group 4: French-speaking, in-depth analysis:

Focus 1: Dealing with different requests for help within 1 system:

- Freedom to work with different help requests from different members of a system;
- No requirement that two generations are present within 1 system, but rather that two generations are present within the group for the sake of the importance of 'system-crossing'/inter- and trans-generational identifications: age/role/mates can help distinguish between own feelings and those of family members;
- The group as a place to talk about the meaning of absent family members.

Focus 2: Resisting MFG engagement:

From patients/family:

- Psychiatric illness/hospital stigma, creating shame and guilt:
    - The rule of 'confidentiality' of the group ('what is said within the group stays in the group') is threshold lowering: it puts people at ease faster;
    - Emphasise horizontality/equivalence between patient - family - caregiver: meeting here as 'human beings'.
- Fear that family members will 'use' MFGs as a function of being right: fear that MFGs will reinforce family dynamics;
- Fear of revealing taboos or family secrets;
- Anxiety when not given immediate, concrete handles.

From therapists:

    - Fear of destructive forces:
        - Escalation of aggression or conflict that cannot be borne by the group;
        - Use of substances prior to MFGs so that under the influence.

Focus 3: Need for supervision/intervision:

- 'Debriefing' among co-therapists:
    - How did you feel at the beginning of the session, and how do you feel now?
    - What has touched you? What has been difficult?
    - Have you found your place in your group?
    - What are you leaving with?
- Move from 'debriefing' following the group to 'in' the group: closing the session with a brief reflection on the questions above;
- Impact of the MFG in the broader context (team, hospital, community);
- Intervision as a learning opportunity with therapists from different MFGs.

Focus 4: Current MFG needs:

- Demand for intervision for MFG therapists from different MFGs;
- Garcia Garcia Badaracco training model:
    - MFGs are not part of a university curriculum, being taught as a short module in the

Systemic Therapy course.

- Framework for welcoming MFG therapists-in-training:
    - Create a network for internships;
    - Group open to receive MFG therapists-in-training;
    - Minimum commitment: participation of 3 consecutive MFGs.

4.3.2 Large experimental group with MFG potential users

4.3.2.1 Participants

The large group of patients, family members and therapists was put together by participants at the ISPS Low Countries Study Day, on January 27th, 2023. The group consisted of 2 moderators, and 94 participants, and was carried out only in Dutch.

4.3.2.2 Methodology

The large group comprised a mixed audience where all participants were invited to share questions, comments, and experiences about MFGs, without questions to guide them. It was led by the two researchers. The meeting was hybrid, via Zoom and in-person, and was recorded. An anonymised transcript was made of the recording.

4.3.2.3 Results

These topics appear spontaneously:

- Mentality shift in mental health care. The question is no longer: 'How can we get the family to participate?', but rather: 'How can we participate in something that is already there?'
- It is important to start with the person who has the demand, which is often the family (while the patient with psychosis is often a care refuser):
    - The family is also entitled to care;
    - The family can speak from their own name (about themselves) - this ensures safety for the patient;
    - The patient is also entitled to boundaries: if psychosis is understood as the absorption of unprocessed generational pieces, then distance is necessary to become oneself;
    - From contact with relatives, a question may arise indirectly with care refusers.
- It is important to involve the family from the outset, or to put it another way, it is evident that the counsellor, as an 'outsider to the family', works with the system as a whole, both with the family and the patient:
    - As a function of preventing a crisis/escalation/confidence breakdown;
    - Role of trust with family (need not breach professional secrecy);
    - Being attentive/outreach;
    - Often from a non-therapeutic angle:
        - Nurse: ward tour, home visit;
        - Activities: doing things together;
        - Psychoeducation;
        - Peer contact: similes or a centralised family group (without patients);
        - Soteria house.
- What might be resistance from families to participate in therapeutic activities (Open Dialogue conversation, Multifamily Group)?

    - Shame;
    - Fear of confrontation, of facing something;
    - Having to be vulnerable.
- Break, distance and boundaries need not be radical:
    - Temporary: so that a crisis can subside;
    - At the same time physically distancing themselves on the one hand, and 'keeping a line open' in other ways on the other hand;
    - Use of different functions/roles within an interdisciplinary team.
- Importance of being in touch with your own vulnerability/unprocessed generational pieces as a counsellor.

4.3.3 Focus Group Conclusions

During four focus groups and a large experimental group with MFG potential users, in two national languages (Dutch and French), 5 experts in MFGs were reached, in addition to 22 care providers with experience in MFGs, and a group of 94 interested care providers, patients and family members. A SWOT analysis was conducted as well as an in-depth analysis on some key issues of MFGs. Multifamily groups align with a paradigm shift within mental health care, where families are given utmost attention, alongside patients and caregivers.

The therapeutic technique of MFG demonstrates extensive applicability across diverse therapeutic frameworks, methodologies, target groups, and treatment contexts. Its potential is promising due to the following opportunities it offers:

- Significant cost efficiency for institutions;
- Feasibility of implementing MFGs within primary care (article 107);
- Feasibility of integrating MFGs within the conventions of psychologists.

However, the implementation of MFG faces several external challenges:

- Establishing an MFG culture within an organisation demands time;
- Organisational challenges include securing suitable venues, recruiting additional MFG therapists, and scheduling convenient times for all participants;
- Engaging families requires focused attention;
- Financial implications arise when the patient does not participate, affecting the system's ability to be charged.

MFGs operate from a relational meta-psychology and ethics, addressing psychopathology within its relational context. It fosters a communal space where individuals can gather, fostering mutual support and solidarity. Such a setting contributes to destigmatisation, extending its impact beyond the MFG to affect the ward, institution, and broader community.

Trans- and intergenerational dialogue is central to MFGs. The framework gives rise to different types of relationships (transmissions): horizontal connections among participants (multi- and trans-generational), vertical interactions towards therapists and a holistic engagement directed towards the group as a whole.

The experiential learning within MFPGs is characterised by:

- An in-vivo learning situation, in which learning to communicate is central;
- An indirect learning process: rather than direct confrontation or communication, alternative insights and experiences are often offered through other age/role/potential peers. On the one hand, the multiplicity of perspectives allows participants to recognise themselves in others. On the other hand, it grants individuals the ability to differentiate themselves from others. Through this process of identification and differentiation, one gains more insight into the uniqueness of their personal situation. Because each participant can develop and appropriate these insights at their own pace, this can result in greater openness and receptivity to emotional learning;
- The learning process involves all participants: patient, family and caregiver.

However, inherent pitfalls in MFGs deserve attention:

- Threshold: difficulty in participation due to shame, guilt, and stigma among patients and family members;
- Diverse help questions within the same system, raising questions about patient consent or refusal regarding family participation;
- Sensitive content: crises or challenging subjects might be difficult to address in a larger group setting, leading to potential challenges like family secrets or taboos;
- Dynamics: destructive family patterns may be reinforced within the group (increasing expressed emotion (EE)); differences in the evolution of participants (e.g. due to relapse, negative evolution) may negatively affect other participants;
- Organisational challenges: open MFGs might lead to large, diverse groups lacking cohesion (e.g. young participants may be put off by a chronic image, or old participants may face mourning for what is lost).

These pitfalls can be avoided by developing and strengthening specific MFG competencies:

- By using specific therapeutic techniques and a clear framework, a safe and open climate can be created, in which various requests for help can be granted. These techniques can be placed on a continuum: going from a highly structured framework (application of psychoeducation, info-sessions, etc.), in which the therapist occupies a vertical position as an expert, to a framework focused on diversity. The latter encompasses the freedom of participation of family members in the function of regulation of distance/proximity, and heterogeneous audience, among others, with the therapist in a horizontal position as an equal participant;
- By increasing the carrying capacity of MFGs, parallel individual family sessions are less necessary: crises and difficult themes can be carried out and worked on by the group. As a result, the MFG therapist gets less into role confusion, while simultaneously being an individual (family) therapist;
- The potential of a large, diverse MFG can develop through a sufficiently large team of MFG therapists.

For competence development of the MFG therapist, the following needs are highlighted:

- Need for theoretical education and training;
- Need for clinical placements, with a clear framework for MFG therapists in training;
- Rather than supervision, the need and added value of intervision, in which MFG therapists from different MFGs come together, is cited;
- Debriefing among MFG therapists following MFGs is common practice, in which personal experiences of MFG therapists are probed;
- In some MFGs, the session ends in a group with a reflection on the process and/or the opportunity for individual feedback (via a form). This can give MFG therapists tools to further refine techniques and methodologies.

4.4 BIBLIOGRAPHIC RESEARCH

In Belgium, the focus was on the French and Dutch languages (see Appendix 2 for French and Appendix 3 for Dutch), excluding German.

For the French language, the scope included Wallonia (Belgium) and France, excluding other French-speaking countries. In the Dutch language, emphasis was placed on Flanders (Belgium) and the Netherlands, excluding other Dutch-speaking countries.

In the French research, terms such as 'Thérapie Multi-Famille (TMF)', 'Thérapie Multi-Familiale', 'Le Groupe Mutifamilial (MFG)', 'La Consultation Multi-Familiale (CMF)', and 'La Thérapie Sociale Multi-Familiale (TSM)' were utilised. Articles, monographs, books and book chapters, and PhD thesis were gathered from Belgium, France, Canada, and Switzerland.

For the Dutch research, terms such as 'Multiloog', 'Meergezinsbehandeling', 'Groepsgezinstherapie', and 'Familiediscussiegroep' were employed. Articles, monographs, books and book chapters, and PhD thesis were gathered from Belgium and the Netherlands. Notably, many publications by Dutch researchers were issued in English, and these references were included in the international bibliographic research conducted by the Italian colleagues (see Appendix 6).

4.5 CONCLUSIONS

The primary objective of the research 'Multifamily Groups in Mental Health', being the Intellectual Output I of the FA.M.HE project, is to increase knowledge of the various Multifamily Groups within the mental health field. The focus is on their territorial diffusion, different existing models, and their specific characteristics.

In Belgium, 24 multifamily groups are distributed across all provinces, primarily affiliated with psychiatric hospitals. The MFG therapists predominantly adopt a systemic therapy approach. Regularly, this is complemented by cognitive or psychoeducational perspectives, while a smaller fraction incorporates a psychoanalytic viewpoint. Although all groups mention organising peer supervision, actual supervision is not implemented.

Distinct variations between Flanders and Wallonia are noticeable. In Flanders, MFG sessions are always supervised by a psychologist, often in tandem with a nurse. Conversely, in Wallonia, MFG sessions are usually led by a doctor-nurse duo. Additionally, in Flanders, work is often done around a homogeneous pathology, and often with an adolescent audience. For instance, groups dealing with eating disorders apply the Maudsley model, while psychosis care employs the McFarlane or Garcia Garcia Badaracco model, and addiction care implements the psychoeducational model. In

contrast, Wallonia tends to have more heterogeneous groups catering to adults, following the methodology outlined by Serge Mertens. An interesting observation is that all Flemish groups exclusively rely on internal referrals, while in Wallonia, most groups accept both internal and external participant referrals.

The common consensus among conductors, participants, and family members highlights that MFGs align with a paradigm shift in mental health care, where families are given utmost attention, alongside patients and caregivers. MFGs start from a relational meta-psychology and ethics: psychopathology is approached within its relational context. Multifamily Groups create a community where people can meet, experience mutual support and solidarity. Such a place has an anti- stigmatising effect, extending its influence beyond the immediate MFG sphere to impact wards, institutions, and the wider community.

Multifamily Groups, as a therapeutic technique, exhibit wide applicability across various therapeutic frameworks, methodologies, target groups, and treatment contexts. Interestingly, MFG sessions are often conducted by caregivers from diverse professional backgrounds. The external difficulties faced in implementing MFG encounters primarily revolve around organisational levels.

Despite diverse practices, there are many competencies that all MFG therapists seem to share. For competence development of the MFG therapist, the following needs are highlighted:

- Need for theoretical education and training;
- Need for clinical placements, with a clear framework for MFG therapists in training;
- Rather than supervision, the need and added value of intervision, in which MFG therapists from different MFGs come together, is cited;
- Debriefing among MFG therapists following MFGs is common practice, in which personal experiences of MFG therapists are probed;
- In some MFGs, the session ends in a group with a reflection on the process and/or the opportunity for individual feedback (via a form). This can give MFG therapists tools to further refine techniques and methodologies.

5 SPAIN REPORT

5.1 SPANISH SITUATION

Multifamily Groups (MFGs) were introduced in Spain towards the end of 1984 in the municipality of Guecho near Bilbao, within the province of Vizcaya. This initiative took place in a Day Hospital at an Experimental Centre (Consorcio Uribe Costa de Salud Mental), where innovative treatments, especially those designed by García Garcia Garcia Badaracco for mental health institutions (Community of Therapeutic Psychoanalytic Multifamily Structure and Multifamily Psychoanalysis1), were implemented. Thanks to the collaboration between the Basque Foundation for Research in Mental Health (OMIE) in Bilbao and the Institute of Multifamily Psychoanalysis in Buenos Aires, this approach was disseminated in Spain and brought together numerous families. In recent years, there has been a proliferation of such groups with various theoretical orientations across different European countries. The project 'Multifamily Groups in Mental Health' (FA.M.HE) is actively involved in constructing a 'Guide to Multifamily Groups' based on the experiences of the project partner countries: Italy, Belgium, Portugal, and Spain.

5.2 SURVEY – MFG CHARACTERISTICS

5.2.1 Institutional/Organisational Context

The questionnaire was distributed to various relevant associations with experience in MFGs, such as the Association of Psychoanalytic Psychotherapy of Couples, the Family and Multifamily Group (APyF), Jorge García Badaracco[1] Study Centre, the Basque Association for Mental Health (OME-AEN), the Google Multifamily Group, and 38 MFG coordinators from public and private institutions. A second target area included 5 professional associations (Psychiatrists, Psychologists, Psychoanalysts, etc.), 14 social associations, and 424 associations of relatives of mentally ill persons. Finally, the questionnaire was also disseminated in public and private hospitals and outpatient care centres (day hospitals, therapeutic communities, mental health centres, outpatient clinics with psychiatric care).

After numerous contacts with MFG conductors/coordinators, 28 forms were received, some of which were filled out by professionals overseeing several MFGs. Upon individual form review, errors in understanding some questions were observed, affecting the percentage results. To address this, corrections were made by adjusting to the new responses provided by coordinators/conductors through telephone communication.

Regarding geographical distribution, there was an irregular concentration of MFGs, with a high concentration in some provinces and an absence in the majority. Nine MFGs were found in Madrid (4 in the community and 5 in the city of Madrid), 9 MFGs in Vizcay (6 in Bilbao and 3 in Guecho), 2 MFGs in Granada (1 in the province and 1 in the capital), 2 MFGs in Barcelona (city), 2 MFGs in Elche (1 in the city and 1 online for the community), 1 MFG in Malaga (Marbella), 1 in Navarra (Pamplona), and 1 in Alicante (city).

The significant observation in Spain is that, out of 50 provinces and 2 autonomous cities, MFGs are found in only 8 provinces, despite evidence that MFGs are conducted in other provinces as well. The territorial imbalance is attributed, according to professionals, to the limited interest of

[1] Jorge García Garcia Garcia Badaracco (1990) Comunidad Terapéutica Psicoanalítica de Estructura Multifamiliar. Tecnipublicaciones. Madrid, Spain.

institutions in incorporating this therapeutic resource for ideological reasons. Most institutions tend to favour a biomedical orientation, supported by cognitive-behavioural psychology, which excludes psychoanalytic thinking. Furthermore, during the focus group debriefing, participants noted that the actual number of existing MFGs is much higher than the 28 that responded to the questionnaire, estimating around 60 MFGs. They were unsure about the reasons for the absence of many colleagues, as most participate in the Google Group on MFG where the information was shared. Regarding the administrative structure of the institutions/organisations conducting MFGs, there is a balance between public (46%) and private (54%) entities. Concerning the types of services and care, the majority are institutions providing outpatient care (26 out of 28), such as Mental Health Centres, Social Centres, Day Hospitals, and Private Consultations. Only two institutions offering residential services (Hospitals) were reported.

5.2.2 Properties of MFG

In Spain, the theoretical and methodological orientation of the MFGs is primarily aligned with the Multifamily Psychoanalysis framework developed by J. García Garcia Garcia Badaracco (89%). In 64% of cases (18 out of 25), this model is the exclusive reference, while in 25% (7 out of 25), it is combined with other orientations, such as systemic, psychodynamic, interfamilial, operating group, etc. The Interfamily theoretical framework was mentioned as the sole option in 3 responses. It should be noted that, even though Multifamily Psychoanalysis is the dominant model, it may implicitly incorporate elements from other psychoanalytic approaches and other disciplines.

5.2.3 Conduction

In terms of the academic qualifications of the respondents, 57% hold qualifications in psychiatry, 43% in psychology, and 7% in social work. All groups incorporate psychotherapeutic interventions, combined with other types of interventions, such as support groups (50%), psychoeducational (21%), counselling (21%) and self-help (11%). These proportions can be attributed to the predominant focus of most institutions/organisations within the field of Mental Health.

The team responsible for conducting the sessions comprises various members from multidisciplinary teams of mental health professionals. The leadership can be undertaken by one or two individuals and includes co-therapy. Some groups include 'observers' who document session activities and subsequently share their observations during post-group meetings, serving as a valuable learning tool. Concerning the academic qualifications of professionals involved in MFG, there is a predominant presence of psychologists (85%) and psychiatrists (79%). This is followed by other health specialties, with 35% being nurses, 28% being social workers, and 35% representing various educational and social specialities.

Regarding the training of the conducting team, a diverse range of psychotherapeutic experiences is evident, with a notable prevalence of therapies derived from psychoanalysis (80%). These include multifamily psychoanalysis, group analysis, psychodynamic therapies, operating groups, etc. Additionally, a systemic family theoretical framework is observed in 12 groups, and cognitive-behavioural approaches are present in 4 MFGs. This pattern underscores the effectiveness of psychoanalytic-rooted therapies in comprehending family and group phenomena.

Concerning the composition of the conducting team, it is noteworthy that 35% of teams operate with one group conductor alongside co-therapists, 21% collaborate with different group conductors in co- therapy, and 35% engage in co-therapy without a designated group conductor. In terms of supervision, there is a prevailing preference for internal supervision, accounting for 43%, compared

to external supervision at 25%. In certain instances, both supervision procedures are employed (10%), while a substantial 43% do not undergo any form of supervision. Almost all groups perform intervision (96%), except one MFG in the sample. This type of supervision aligns with a tradition in psychoanalytic co-therapy of groups and families, where professionals involved in the session convene post-group to exchange impressions about the proceedings. It serves as an alternative method of task supervision.

5.2.4 Participants

In 64% of the MFGs, there is no specified age range, encompassing participants from 16 years to old age. Conversely, 36% of the groups delineate a specific age range for participants, with a substantial portion consisting of adult groups (32%) and 8% comprising adolescent and children's groups. It is noteworthy that some responses indicate potential misinterpretations regarding the specified age range of participants.

In terms of the generational composition of these groups, a majority involve two present generations (70%), while 30% involve three generations, characterising the diversity of participants.

The connection between individuals undergoing treatment and their relatives highlights the prevalence of filial paternal links (100%), closely followed by fraternal relations (93%). To a lesser extent, other members of the nuclear family are involved (57%), alongside participants from the extended family (64%) and close relatives (37%). This section underscores the profound familial dedication to individuals in treatment. These emotional bonds, characterised by interdependencies, frequently impede the autonomy and development of children. However, the involvement of families in the treatment process is crucial for addressing situations that have entrapped the children and generated intense suffering.

Regarding heterogeneous groups, a diverse array of pathologies is evident, with prominent instances of affective disorders (85%) and personality disorders (81%). Following closely are psychotic disorders (73%), anxiety disorders (73%), psychosomatic disorders (61%), eating disorders (58%), post-traumatic stress disorders (50%), addictive disorders (39%), obsessive- compulsive disorders (69%), and non-psychiatric pathologies (27%). Additionally, other pathologies are included (27%). The engagement with a broad spectrum of clinical conditions, encompassing the entire range of psychiatric diseases, underscores the recognition that underlying problems, pertaining to interpersonal connections (interdependencies), exist in any pathology. Addressing these issues is essential for enhancing the well-being of families, extending beyond psychopathological diagnoses.

Concerning homogeneous MFGs, they are observed to be limited, as even groups categorised by the age of the patient (e.g., families with adolescents or children) exhibit diverse pathologies. The identification of solely two groups specifically centred on only one pathology is noted (1 MFG focusing on Psychosis and 1 on violent behaviour).

5.2.5 Structure and Functioning

Continuing with the characteristics of the MFGs, concerning the type of group, a nearly equal distribution is observed between open groups (50%) and slow-open groups (46%), with only one closed group (4%). This distribution is attributed to the medium and large size of these groups, which tend to persist over time, allowing families to enter and exit according to their needs. Semi-open groups also conform to these conditions, featuring a more measured and regulated incorporation of families. Based on the survey and subsequent clarification, it is elucidated that the duration of all groups is indefinite (100%). Once established, these groups become institutionalised

and endure over time, sustained by the ongoing commitment of participating families.

Concerning the frequency of these groups, the majority convene fortnightly (39%), followed by weekly (32%) and monthly (29%). Generally, the frequency depends on the availability of professionals and the policies of the institution. In the survey, 30% of the respondents initially indicated that they work with development phases. However, a clarification during a subsequent telephone contact revealed that only one group operates in phases. Regarding the duration of MFG sessions, the range spans from 60 to 120 minutes. The most common duration is 90 minutes (71%), followed by 14% of groups operating for 75 minutes, 11% for 120 minutes, and one group conducting sessions for 60 minutes. The session duration is typically influenced by the availability of therapists.

The groups are conducted during working hours in 82% of cases and outside working hours in 18%. The latter is attributed to the varied schedules of the team members. In 94% of MFGs, at least two generations are represented. Instances of non-participation are linked to free assistance and specific situations preventing attendance. Regarding the group size, 64% fall into the medium category (with up to 30 participants), while 36% are considered large (with more than 30 participants). This distribution is primarily influenced by the characteristics of the place where these groups are held and the flow of participating families.

Regarding the group room, 70% utilise multipurpose rooms, while others make use of various available spaces, such as a psychotherapy room (14%), an activity room (1%), and 1 group is conducted online. The majority affirm the appropriateness of the rooms concerning sound levels (96%) and capacity based on the number of participants (100%). Only one room is reported as not suitable. Privacy and confidentiality conditions are deemed ideal in all responses, ensuring the protection of participants' privacy. The prevalent seating arrangement is in a single circle (85%), while in some cases, the seating is organised in concentric circles based on the room size and number of participants (19%). Other provisions are considered irrelevant.

Before the pandemic, all MFGs were conducted in person (100%). In the post-COVID-19 era, with the easing of pandemic-related restrictions, 82% of the groups resumed in-person sessions, marking a decline in the online modality for 19% of the groups that had temporarily replaced numerous face-to-face sessions. Additionally, 11% of the groups continue with a mixed modality. Regarding the existence and continuity of these groups over the years, it is noteworthy that they operate without a predetermined end date. The duration spans from 38 years (dating back to the first group of this nature in Guecho, in 1984) to 1 year (for the most recent group). The substantial number of years and accumulated experience serve to validate the efficacy of this therapeutic resource.

Throughout their extensive residence, the majority of groups experienced interruptions (64%), while 35% managed to maintain continuity by adopting the online modality. The primary reasons for interruptions were mainly attributed to the pandemic (89%), or occasionally for institutional reasons (1%). The duration of interruptions broadly aligned with the time of pandemic restrictions, varying across institutions from 7 months to approximately 2 years. Those who continued online experienced a brief hiatus of 2 months during the summer.

5.2.6 Referral

The majority of patients and families (93%) are referred from within the organisation. Some MFGs exclusively receive participants from outside the organisation, while others have a mix of internal and external referrals. This pattern indicates a positive reception within the organisational context

and a relative acknowledgement beyond the institution.

As a concluding remark on the survey, there is an observed similarity in qualitative responses and a variance in the formal aspects of these groups' actions (quantitative responses). The similarities in working methods can be attributed to the foundational influence of García Garcia Garcia Badaracco's ideas on the development of this approach in Spain. Starting from the initial experiences in Guecho (Vizcaya) and Elche, these methods were disseminated across a significant area. The variations in formal aspects align with the characteristics of the institutions and the practical possibilities for conducting these groups (such as location, availability of professionals, etc.). Undoubtedly, the pandemic significantly altered the way these groups had been operating before, transitioning from in-person to online participation. The current trend indicates a shift back towards restoring face-to-face participation.

5.3 FOCUS GROUPS

5.3.1 Focus Group with MFG Conductors

5.3.1.1 Participants

After the completion of the questionnaires, a focus group centred on the responses was organised. Fourteen out of the 23 invited professionals participated in this phase of the investigation, with the remaining individuals excused due to professional commitments.

5.3.1.2 Methodology

The focus group took place through a video conference on February 6, 2023, from 16.00 to 18.30, using the Zoom platform. The session was recorded with the explicit consent of all participants. The meeting was facilitated by a coordinator and an observer.

The sample comprised professionals engaged in MFG, relying on the ideas and experiences advocated by Multifamily Psychoanalysis (J. García Garcia Garcia Badaracco). These professionals have enriched their practice with other theoretical contributions (Group analysis, General Theory of Systems, Theory of Attachment, Open Dialogue, etc.). The uniformity in the basic theoretical framework is attributed to the extension of multifamily groups in Spain, originating from the inaugural experience in Bilbao (Vizcaya) in November 1984. This expansion continued through the dissemination of courses offered by the Basque Foundation for Research in Mental Health (OMIE) and the Institute of Multifamily Psychoanalysis in Buenos Aires. Over the last two decades, more than 600 Spanish professionals (Mires and Pires) have received training in this approach.

For the assessment of this activity, including its strengths and weaknesses, as well as potential opportunities and threats, a SWOT analysis was employed. This analysis is informed by the experience of conductors/coordinators in the field.

The discussion centred around three main topics, aligning with the qualitative responses from the questionnaire:

- Participation of two or more generations, encompassing individuals undergoing psychiatric treatment.
- The functioning of the Multifamily Group (MFG) driving team.
- The exchange among conductors after the session (post-group).

A preliminary note: The participants refer to the importance of the emotional climate, an aspect

not explicitly addressed in the questionnaire, and the type of interventions, emphasising the 'conversation' over interpretations aimed at unveiling the unconscious.

5.3.1.3 Results

The following findings were compiled:

Focus 1: The participation of at least two generations.

Strengths:

Regarding the participation of two or more generations, most of the conductors/coordinators agree that a notable strength lies in the distinct and enriched dynamics of Multifamily Groups (MFG) compared to groups exclusively comprising relatives without patients. In these groups, which are usually psychoeducational, the focus tends to be on the illness of the 'absent', i.e., of designated patients, inadvertently contributing to the stigmatisation of mental illness. In contrast, in MFGs where two or more generations are involved, the toxic relationships (pathogenic interdependencies) in which family members are 'trapped' become clear in the present moment of the meeting. This allows for in-depth exploration and work on these complex family dynamics.

The participation of multiple generations is also noted for bringing forth a diversity of family models, contributing to the breakdown of established stereotypes. It is observed that medium and large groups exhibit greater emotional resilience, facilitating the addressing of more challenging and traumatic situations.

Weaknesses:

Professionals highlight the discontinuity in the participation of the entire family and the disruptive behaviours exhibited by certain members, which frightens other participants.

Opportunities:

Professionals identify the potential for saving human and economic resources. Additionally, they emphasise that the broader dissemination of Multifamily Groups (MFG) could extend the benefits to a larger number of individuals.

Threats:

The identified threats revolve around the lack of awareness regarding the therapeutic potential of this resource among colleagues and mental health administrators. This lack of awareness is attributed to a prevailing influence of other models centred on the individual, particularly within the realm of classical psychiatry.

Focus 2: Presence of a management team.

Strengths:

In terms of the performance of MFG driving, professionals agree that the strength lies in teamwork and co-therapy. This collaborative approach allows the sharing of the 'emotional burden' arising

from challenging situations within the group, particularly when traumatic situations emerge. The mutual support among team members contributes to enhanced 'containment' of anxieties and fosters the creation of an emotional climate characterised by trust and security.

Weaknesses:

Teams may experience a loss of coherence, leading to internal rivalries and struggles. Another identified negative factor is the reliance on a singular leadership approach.

Opportunities:

Concerning the opportunities presented by shared leadership, there is recognition of the diversity of perspectives brought forth by professionals. This diversity can be integrated into a cohesive whole, contributing to the therapeutic process and potentially overcoming controversies associated with different psychotherapeutic orientations.

Threats:

The threat to this mode of work often arises from challenges such as a shortage of personnel, inadequate understanding of this therapeutic resource, and a lack of research in this field. These factors contribute to resistance among professionals and institutions.

Focus 3: Post-Group.

Strengths:

The strength of the post-group exchange is highlighted by professionals who agree on the significance of intervision or internal/external supervision. The post-group session facilitates an immediate and 'hot' reflection on various aspects, including group dynamics, emotional climate, emerging themes, involvement of the leadership team, and the nature of interventions. This exchange also enables the integration of diverse viewpoints from team members and provides a platform to address the emotions felt by the team members.

Weaknesses:

Weaknesses observed in the post-group setting include the presence of differing viewpoints and a potential misunderstanding of the discussed topics. Specifically, the identified weaknesses include a lack of a unified integration model and an absence of constructive criticism.

Opportunities:

Professionals recognise the potential for continuous reflection on the task, emphasising the need for ongoing training. Additionally, the post-group setting provides an opportunity for special work on the driving team.

Threats:

The threats often correspond to the pressure of attendance and the lack of a habitual reflexive practice within institutions.

5.3.2 Focus Group with MFG Users

5.3.2.1 Participants

The face-to-face meeting took place with the Multifamily Group (MFG) of the Day Hospital at the

Uribe Costa Centre for Mental Health, held in the Culture Classroom of the City of Guecho. This MFG was initiated by a team of 5 members (3 psychiatrists, 1 psychologist, and 1 nurse) in November 1984 at the Mental Health Centre and, due to the substantial number of participants, was relocated a few years ago to the Culture Classroom. The group continues to meet on Mondays from

12.30 to 14.00. It is noteworthy that this group holds a significant historical significance, being the first of its kind performed in Spain and Europe, according to some authors, following the model of García Garcia Garcia Badaracco (Multifamily Psychoanalysis).

5.3.2.2 Methodology

It was considered appropriate to conduct this focus group within an operational Multifamily Group (MFG). The session took place on 6th February 2023, in its usual place, on the designated day and time mentioned above. Participants were requested to provide their consent for answering questions. Approximately 60 to 70 individuals regularly attend this group, facilitated by a conductor, a co-conductor, and multiple practising psychologists. All sessions of the group were recorded with the explicit consent of all participants.

Three questions were posed:

- What expectations did you have when you were offered to participate in the MFG and what benefits did you get from attending?
- How do you understand mental illness? How can MFGs contribute to the improvement of mental health?
- Do changes within the family relate to improvements in the family situation?

5.3.2.3 Results

Focus 1: What expectations did you have when you were offered to participate in the MFG and what benefits did you get from attending?

The 10 participants who answered this question expressed that they approached the group with a sense of hopelessness influenced by previous treatments that transmitted the notion of incurability and primarily emphasised medication. These individuals held misconceptions about the illness, lacking awareness of the pivotal role of the family - both in its negative aspects, as a contributor to the miscomprehension of the sick member and a contributor to their apparent impasse, and in the positive aspects, as an active participant in the treatment process by acknowledging challenges and gaining a different perspective on their current situation.

Participants highlighted the benefits they derived, including an enhanced understanding of behaviours deemed 'ill', increased tolerance for diversity, and a heightened awareness of their involvement in relational situations. The prospect of healing was also mentioned as a positive outcome. Conversely, non-participation was attributed to work-related scheduling issues and personal challenges that prevented them from confronting difficult situations.

Focus 2: How do you understand mental illness? How can MFGs contribute to the improvement of mental health?

As for the second question, participants discussed the 'taboo' surrounding mental illness and the social stigma it carries. One participant expressed, ‘The diagnosis is a slab.’. The process of

'universalising' problems and sharing concerns and anxieties enabled them to navigate very challenging situations, providing relief from familial suffering. Some participants noted that the group contributed to their personal growth, making them more compassionate individuals, fostering tolerance for diverse perspectives, and increasing their support for others experiencing distress. They also regarded access to this public resource as a 'privilege'. However, they highlighted negative aspects, including the perceived 'waste' of time in discovering this treatment after prolonged suffering and the limited dissemination of the method, which could benefit a larger number of individuals.

Focus 3: Do changes within the family relate to improvements in the family situation?

The third question probed whether participants perceived changes in family relationships contributing to the improvement of both the family situation and that of the 'designated' patient. Most of the participants who shared their perspectives highlighted that, without this help, it would be impossible for families to undergo transformation. Initially, the designated patient is often attributed as the source of the family's 'misfortune', and no one feels responsible for the prevailing situation. As time progresses, participants come to realise that what unfolds within the family concerns everyone. One participant mentioned that the group prompted him and his family to see things differently, leading to an improved and harmonious life. Several participants expressed that they acquired the skill of listening: 'Listening is learning', said the mother of a patient of the Day Hospital, who added that she came with preconceived ideas that were modified as she paid attention to other parents. Many expressed regrets for not having known about this 'big family' experience earlier, acknowledging its contributions, solidarity, and the hope it transmits.

5.3.3 Focus Group Conclusions

In the focus groups with MFG conductors, most coordinators agreed that working with 2 or more generations generates a rich and different dynamic compared to situations where relatives are absent from treatment. They stated that this setting allows for the observation and exploration of toxic relationships (pathogenic interdependencies) in which family members are 'trapped'. Additionally, they highlighted the cost-effectiveness in terms of both human and economic resources to address the needs of numerous people, including patients and their relatives. Coordinators emphasised teamwork and cross-examination as the most effective approaches to cope. They underscore the importance of the professionals caring for themselves to share experiences of 'high voltage' (containment), thereby creating a climate of security and confidence. Post-group meetings (intervision) are identified as the most effective method for capturing diverse opinions and views from team members regarding the performed task and for sharing the emotional mobilisation produced by the task.

In the focus groups with MFG users, a sense of hopelessness was observed through the questions when relatives attended for the first time. This perspective was supported by previous experiences in the field of mental health, where the idea of incurability and reliance on medication as the sole means for improvement were transmitted. A lack of awareness regarding the importance of the family, both in the genesis of problems and in their resolution, was mentioned. The taboo associated with mental illness and its social stigma was highlighted. The diagnosis was described as 'a difficult slab to bear.' The multifamily group was acknowledged for allowing the participants to be more tolerant towards others, promoting respect for differences, and cultivating solidarity with the suffering of others. Users referred to the privilege of being part of that 'big family', which allowed them to improve their family relations, making coexistence more satisfactory. The

therapeutic resource was regretfully acknowledged by most participants for not having been discovered earlier.

5.4 BIBLIOGRAPHIC RESEARCH

For the bibliographic research in the Castilian language, two platforms were utilised: Google General and Google Scholar, and the bibliographic portal Dialnet was consulted. The keywords were:

- Multifamily Group (MFG);
- Multifamily psychoanalysis (MFP);
- Multifamily Psychoanalysis Group (MFPG);
- Multifamily therapy (MFT);
- Multifamily Therapy Group (MFTG);
- Multifamily Group Treatment (MFGT).

A total of 68 citations were collected from more than a hundred sources. The selection was based on different sections: theory and clinical experience. Dissertations and post-graduate were excluded. Dissertations and post-graduate work were excluded, and no research works or comparative studies with other therapeutic resources were found. The majority of studies are exploratory, given the lack of prior research supporting the work with these groups. Their work aims to analyse these types of groups, forming hypotheses from observations and perceptions of participants, including both families and professionals. Characteristics of the participating population, such as types of families, pathologies, ages, socio-economic levels, etc., are also described. Some works attempted to analyse and explain observed phenomena from a specific theoretical perspective, leading to conclusions and predictions that enhance understanding and practice. The majority of the works were influenced by the ideas of García Garcia Garcia Badaracco (Multifamily Psychoanalysis). This influence has been predominant in both Latin America and Spain since the 1960s in the Castilian language. At present, a significant number of developers of Multifamily Groups (MFGs) continues to build upon and deepen this influential body of work.

The bibliography gathers works covering various themes, including the early days of MFGs and their development, the variety of pathologies treated, the competence of conductors/coordinators, the theoretical aspects supporting the activity, etc. (see Appendix 4).

5.5 CONCLUSIONS

In Spain, based on the data available, multifamily groups consist exclusively of a minimum of 2 generations, incorporating the person receiving treatment. These groups primarily follow the orientation of multifamily psychoanalysis, supplemented by other psychotherapeutic approaches (systemic, group analysis, dynamic, cognitive-behavioural, interfamilial, etc.). Psychoeducational groups were excluded as they did not involve individuals undergoing treatment.

As highlighted in other sections of the report, it is noted that almost all of these groups rely on multifamily psychoanalysis. This situation dates back to the first experience conducted in Spanish territory in Bilbao in 1984, which was subsequently disseminated through courses offered by the Basque Foundation for Research in Mental Health (OMIE) in Bilbao from 1985 onwards. Additionally, the Institute of Multifamily Psychoanalysis in Buenos Aires played a significant role, having received over 600 residents in psychiatry and psychology from Spain since 2000. Many professionals with diverse orientations have adopted the approach of Multifamily Psychoanalysis

and enriched it with their expertise.

Regarding the training of professionals, there is a uniformity in that they derive from multifamily psychoanalysis. However, different operational forms are observed, emphasising the need for comprehensive training that prioritises the individual development of conductors, teamwork, and the socio-cultural context in which MFGs are conducted.

6 PORTUGAL REPORT

6.1 PORTUGUESE SITUATION

In Portugal, the foundations of the national policy and organisation of mental health are defined by Law No. 36/98 of 24 July, subsequently affirmed in the National Mental Health Plan (PNSM). According to Order No. 1605/2018 dated 30 January, the PNSM is tasked with:

- Promoting and facilitating the monitoring of the mental health of the Portuguese population, focusing on key indicators of morbidity and service utilisation.
- Driving the implementation of programs to enhance the well-being and mental health of the population, as well as the prevention, treatment, and rehabilitation of mental illnesses.
- Facilitating the coordination of specialised mental health care with primary health care and other relevant sectors for the effective implementation of the National Mental Health Plan.
- Developing the 'Rede Nacional de Cuidados Continuados Integrados' (RNCCI) (National Network for Integrated Continued Care) for Mental Health in alignment with the National Coordination for the Reform of the National Health Service in RNCCI.
- Encouraging the active involvement of users and caregivers in the rehabilitation and social integration of individuals facing serious mental health challenges.

The practical implications of its application include:

- The promotion of integrated continuous mental health care and the establishment of the initial services and residential programs in this sector.
- The creation of new units and an expanded referral network in the realm of child and adolescent mental health.
- The initiation of innovative programs facilitating the integration of mental health into efforts against domestic violence, providing support for the homeless, and assisting young people facing adaptation and social inclusion challenges in collaboration with the social, justice, education, and employment sectors.

To enhance access to mental health care, intervention in its determinants is crucial, addressing issues such as:

- Stigma and ignorance surrounding mental illness.
- Shortages in human and structural resources.
- Inappropriate organisation of psychiatric services concentrated in large, centralised institutions with poor integration with primary health care.
- Continuous training for mental health professionals.

Portugal has pursued improvements in mental health care through several initiatives, including the decentralisation of services, the establishment of mental health centres in all districts, integration with primary health care, inclusion of mental health in the general health system, shifting specialised care to general and community hospitals, and the development of psychosocial rehabilitation programs and structures. An article published in the International Review of Psychiatry provides a historical-descriptive and critical analysis of the psychiatric assistance situation in Portugal, detailing its emergence and evolution to the present day (Palha & Marques-

Teixeira, 2012). In 2006, rehabilitation programs were formally established, and the National Network of Continued Integrated Care (Rede Nacional de Cuidados Continuados Integrados, RNCCI) was formed, contributing to the modernisation of mental health in Portugal. On 9 October 2019, the National Health Plan 2021-2030 was launched, with the following objectives:

- Foster a positive predisposition to view public health as a social commitment.
- Create collaborative networks and relationships of trust.
- Mobilise internal and external resources.
- Promote participatory and collaborative communication practices.
- Co-create and involve multiple stakeholders.
- Activate and foster a sense of belonging.
- Share knowledge for community resilience.

In April 2001, Portugal hosted its inaugural Multifamily Group (Garcia Garcia Badaracco, 2000) at the Psychiatric Service's Day Hospital of CHULN-HSM (Centro Hospitalar Universitário Lisboa Norte - Hospital de Santa Maria), a public general and university hospital in Lisbon. This event marked a significant therapeutic milestone and has since been an integral component of the Psychiatric Day Hospital's framework. The Day Hospital holds historical significance, being the first Hospitalisation Unit established in the Psychiatric Service at HSM (Hospital de Santa Maria) in 1957. As of May 2023, the current Day Hospital at HSM, distinguished by its psychoanalytic and group analytic model, has celebrated 46 years of operation. Over the years, the Day Hospital has emerged as a prominent therapeutic and training unit in Portugal, particularly known for its application of group analytic and psychoanalytic principles in psychiatric and mental health interventions. The Day Hospital attracts individuals and institutions from across the country for both therapeutic and training purposes.

6.2 SURVEY – MFG CHARACTERISTICS

A list of Portuguese institutions, associations, and therapeutic communities in mental health was compiled, to dispatch the letter introducing the project and providing the questionnaire link. Following a positive opinion from the Ethics Committee for Health at the Lisbon Academic Centre for Medicine, the study commenced. The President of the Ethics Committee of the Administração Regional de Saúde de Lisboa e Vale do Tejo (ARSLVT)[2] (Lisbon and Tagus Valley Regional Health Administration) provided guidance on the prevailing legislation in Portugal. This led to the investigation of new cases and the solicitation of new opinions from the Comissão de Ética para a Saúde (CES) (Ethics Committees for Health). These Ethics Committees span the entirety of Portugal and are associated with the Regional Health Administrations of Portugal.

1. Administração Regional de Saúde de Lisboa e Vale do Tejo, IP
2. Administração Regional de Saúde do Centro IP
3. Administração Regional de Saúde do Alentejo, IP
4. Administração Regional de Saúde do Algarve, IP
5. Administração Regional de Saúde do Norte, IP (has not replied yet)

[2] ARSLVT - a collegial and multidisciplinary body that functions as an advisory committee to the Board of Directors of ARSLVT, IP, particularly in matters related to care and research ethics.

6. Administração Regional de Saúde do Alentejo (has not replied yet)
7. Serviço de Saúde da Região Autónoma da Madeira (this service replied that there were no MFGs in the territory)
8. Direção Regional de Saúde da Região Autónoma dos Açores (replied that there were no MFGs in the territory)
9.

The process was lengthy as each of these committees required various and different documents. Meetings were also necessary to clarify doubts and detail all the project's procedures. Finally, some answers were received, but not all of the Health Ethics Committees have replied. The lack of response from some Ethics Committees impeded the inclusion of these regions in this study. Fortunately, the multifamily groups that were found are part of the regions whose Ethics Committees responded. After the necessary approvals, contacts were made (105), by telephone/e-mail, to public and private institutions all over the country. Five responses were received:

- Three institutions in Lisbon
- One institution in Fátima (central region of Portugal)
- One institution in Estremoz (Alentejo, southeast region of Portugal).

It is presumed that there are several psychoeducational multifamily groups in Portugal within various public and private institutions (IPSSs)[3]. However, it remains unclear whether these groups involve only one or two generations. Notably, there are currently only two active multifamily psychoanalysis groups. Specifically concerning multifamily psychoanalysis groups (MFPGs) in Portugal, there are two groups located in Lisbon, operating within two Day Hospitals affiliated with distinct Psychiatric Services in public hospitals. The remaining three MFGs assemble two generations, incorporating individuals undergoing treatment. However, these groups deviate from the multifamily psychoanalysis group framework. They include 1) a psychiatric ward at a public hospital; 2) a therapeutic community for addictions (IPSS) in Fátima (central region of Portugal); and 3) a private institution (IPSS) in Estremoz (southeast region of Alentejo). The frameworks of these groups consist of, respectively, two cognitive-behavioural psychoeducational groups and one Integrative psychotherapy group with a dialogical and relational basis.

The challenges encountered in disseminating the questionnaire, primarily due to the extended duration of obtaining permissions from various health ethics committees, impeded obtaining more timely and extensive results.

6.2.1 Institutional/Organisational Context

Concerning the administrative structure of the institutions/organisations hosting these groups, two belong to private/IPSS institutions, and three are associated with public institutions (public hospitals). In terms of the types of services and care provided, all institutions offer outpatient care, encompassing Mental Health Centres, Social Centres, Day Hospitals, and Private Consultations. Additionally, two of these institutions admit patients from residential facilities (Hospitals).

[3] 3 IPSS (Instituição Privada de Solidariedade Social) - Private Social Solidarity Institutions are institutions or organisations established exclusively on a private, non-profit basis, which aim to promote equality and social justice. IPSSs operate within the framework of the social economy and their main objective is social solidarity, with a focus on areas such as social security, education and health. These institutions work closely with the population and in cooperation with the state to address emerging social problems within the communities they serve.

Regarding geographical distribution, a notable prevalence of groups is observed in the southern part of the country. Specifically, there is one group located in Fátima (central region), three in Lisbon, and one in Estremoz (Alentejo's region).

6.2.2 Properties

Concerning the theoretical and methodological orientation of the MFGs, most groups reported using more than one framework. Two groups specifically mentioned the utilisation of the Multifamily Psychoanalysis framework developed by J. García Garcia Garcia Badaracco. Additionally, three groups indicated the application of alternative frameworks, such as systemic, psychodynamic, interfamilial, operating group, etc. Moreover, two groups reported employing psychoeducation and cognitive-behavioural frameworks. In terms of academic qualifications, the respondents exhibited diverse backgrounds. Two (40%) were psychiatrists, two were psychologists (40%), and two were nurses (20%).

Regarding the objectives of the interventions, MFGs commonly pursue combined objectives. Three groups mentioned conducting psychotherapeutic interventions, two reported focusing on psychoeducational interventions, two groups highlighted providing support, two mentioned counselling, and one group specified that the primary objective was to promote self-help.

6.2.3 Conduction

Concerning the characteristics of the conductor/co-therapist groups, they consist of multidisciplinary teams. Three of the groups reported having both a conductor and co-therapists, while two groups mentioned designating only co-therapists.

Examining the academic qualifications of professionals involved in MFGs, it is observed that three groups reported having psychiatrists, three reported psychologists, and three reported nurses in the team. Additionally, social workers (2), occupational therapists (1), educators (1), and other professionals with educational and social specialities (1) were mentioned. Regarding the training of the conducting team, there is a wide range of psychotherapeutic experiences, with a prevalence of therapies derived from psychoanalysis, such as group analysis (1), psychodynamic therapies (4), operating groups, etc. Two groups reported following systemic family theory, and one group mentioned cognitive-behavioural therapy. Concerning the qualification of the conductor (when designated), only two groups provided information: one had a psychiatrist, and one had a psychologist.

Regarding supervision, it is noteworthy that most groups reported no supervision (4), with one group mentioning both direct/intern and indirect/extern supervision. Almost all groups engage in intervision (4), with only one group not participating.

6.2.4 Participants

Regarding the age of participants, all groups accept adults, and three groups also included older adults (more than 65 years old).

Concerning the generations participating in these groups, and characterising them, four MFGs reported the presence of two generations, and one group included more than two.

The relationships between individuals under treatment and their relatives revealed that all groups included people with paternal links (5) and other members of the nuclear family living with the patient (5). Four groups included sons, four included other members of the extended family, and

four also accepted other individuals not belonging to the family.

6.2.5 Structure and Functioning

All groups reported heterogeneity regarding the diagnosis of their participants, with all including Affective Disorders, Personality Disorders, Psychotic Disorders, and Anxiety Disorders. Other pathologies were also present, namely Psychosomatic Disorder (2), Eating Disorder (1), Post-traumatic Stress Disorder (2), Addictive Disorder (3), and Obsessive-compulsive Disorder (3).

Concerning the type of group, the majority (3) were open, 1 was closed, and 1 was slow-open. The duration of the groups ranged from a minimum of 60 minutes to a maximum of 120 minutes.

Regarding the use of development phases, all groups stated that they did not follow this method.

Considering the size of the groups, 1 had a small dimension (less than 10 participants), 3 had a medium size (up to 30 participants), and 2 reported more than 30 participants. The frequency of the groups ranged from fortnightly (2) to monthly (3). Most sessions took place during working hours (4), with only one conducted outside working hours. The majority of MFGs functioned in a group room, while only one used a multipurpose room. Four participants responded that the conditions of the room were considered appropriate. Privacy and confidentiality were considered appropriate by 4 of the respondents, and no answer was provided by one of the groups. In most groups, the seats are arranged in a circle (3), while only one group sits around a table. Other provisions were deemed irrelevant.

Regarding the existence and continuity of the groups in years, it ranged from 1.5 to 22, with a medium time of 8.5 years. All groups reported some interruption, with 4 groups interrupted due to the pandemic and 1 group due to human resources constraints. Three groups reported a change in the modality of the groups, transitioning from in-person to online mode. Two groups reported no change after the interruption, although one group mentioned the addition of the option to participate online to the in-person mode. The interruption time varied from 3 months to 18 months, mainly during the most critical stage of the pandemic.

6.2.6 Referral

Concerning the referral of participants to MFGs, all groups accepted participants from within the organisation, with 3 also accepting participants from external institutions, and 2 receiving individuals who self-proposed.

6.3 FOCUS GROUPS

Two focus groups were conducted, following the program's recommendations and utilising the shared methodology with partners. The first target group comprised conductors and co-therapists experienced in MFPG. The second target group included family members of former patients from the Day Hospital, along with therapists familiar with MFG but lacking experience in MFPG. A SWOT analysis was applied, and the same set of four questions were addressed to participants in both groups.

6.3.1 Focus Group with MFG Conductors

6.3.1.1 <u>Participants</u>

Invitations were extended via e-mail and telephone to twelve (12) conductors and co-therapists experienced in MFPG. However, only six (6) were able to attend the group, consisting of four

psychiatrists, one psychologist, and one university professor trained in psychotherapy with a two-year traineeship in the Day Hospital's MFPG. The group was carried out by one moderator and two observers.

6.3.1.2 Methodology

Modality: Session conducted (and recorded) through the Zoom platform. Session Time: 90 minutes – from 9.00 to 10.30.

The session commenced with a brief welcome, expressing gratitude to those present, followed by a concise presentation of the FA.M.HE project and its overarching objectives. Subsequently, the group received information about the methodology and goals of the focus group session, along with an explanation of the roles of the moderator and observers. It was clarified that four questions would be posed about MFPGs, grounded in the SWOT methodology. The moderator sought agreement from the participants and obtained their consent for the session to be recorded. With unanimous consent, the session began, and participants introduced themselves to the group. The subsequent questions were then posed.

6.3.1.3 Results

Question 1: Strengths (Advantages): What characteristics of a MFG make it an advantageous psychotherapeutic device compared to other psychotherapeutic interventions (internal - families/team/service; and external - institution/community)?

1. Extension of the patient's problems to the whole family - presence of more than one generation.
2. Speed of diagnosis.
3. Direct observation of relational psychopathology – intergenerationality and transgenerationality.
4. Rapid improvement of the patient in treatment.
5. Peer learning.
6. Change in the concept of becoming ill: the individual does not become disorganised alone, he/she becomes disorganised in the family environment.
7. Possibility to observe the relationship and communication patterns of the various family members.
8. Patient Protection: The therapist as an auxiliary ego of the patient; the possibility to test oneself in a protected environment - MFPGs are like an antechamber of social reality.
9. Facilitation of open communication between family, patient, and the team, avoiding the family talking behind the patient's back.
10. Education and training of health professionals.
11. Cost/benefit to the health system - reduces re-hospitalisation and emergency room visits.
12. Long-term effectiveness - improvements for a longer duration.
13. Decreased chronicity - treats the problem at its source rather than camouflaging it.

Question 2: Weaknesses (Disadvantages): What characteristics put MFPG at a disadvantage compared to other psychotherapeutic devices (internal - families/team/service; and external - institution/community)?

1. It is not sufficient as a therapeutic device – needs other devices to complement it (individual psychotherapy in some cases).

2. The difficulty that sometimes arises when it is necessary to share speaking time more or less equally.
3. Logistics: need for more than one therapist; need for a room with enough space and privacy conditions.
4. Need for adequate therapists' training – MFPG is a group that implies specific technical knowledge/experience.
5. Need for availability, constancy and continuity of therapists in the sessions - in institutions, it can be difficult to maintain this continuity.

Question 3: Opportunities: What aspects should be emphasised in MFPG, as a psychotherapeutic approach to mental health, to make it easier to adhere to it? Or, to what extent can working with MFPG contribute to the transformation of: families/team/service; and institution/community?

1. The relevance of the positive effects of MFGs on public health care and other social institutions should be emphasised.
2. Numerous opportunities to develop new and more structuring/healthy identifications, enabling personal growth for patients, families, and therapists.
3. Training opportunities for professionals: new professional experiences and a new look at psychiatry.
4. The possibility of using distance media - reaching more people (distance and time).
5. The possibility of broadening the understanding of the patient's problems: covering various stages of the patient's and family's life cycle (transgenerationality) - through the narratives of the various family members.
6. The opportunity to improve cost-effectiveness in the long term: longer-lasting improvements, fewer crises, and less absenteeism from work.

Question 4: Threats: In what ways can MFPG be a threat (internal/external)?

1. Cultural and psychological resistances - for many, what is unknown or unusual is threatening.
2. Difficulties posed by institutions that consider the number of professionals involved a waste of resources.
3. Lack of specialised professionals.
4. Exhaustion of health professionals in dealing with the obstructions posed by the institutions.
5. Difficulty in ensuring that content expressed in the group remains private.

6.3.2 Focus Group with MFG Users

6.3.2.1 <u>Participants</u>

Sixteen (16) invitations by telephone and e-mail were sent to healthcare psychotherapists and health professionals with MFPG knowledge but without MFPG experience, as well as to family members of former patients of the MFPGs. Only seven (7) people could attend the group: two psychologists who are also psychotherapists, three psychiatric interns without psychotherapy experience (all without MFPG experience), and two former patients' mothers. The group was moderated by one person, and two observers were present.

6.3.2.2 Methodology

Modality: The session was conducted (and recorded) through the Zoom platform. Session Time: 90 minutes – from 09.00 to 10.30.

Similar to Focus Group 1, the moderator welcomed and thanked those present. A brief presentation of the FA.M.HE project and its general objectives, along with the session objectives and information about the methodology for the meeting, was provided. The role of the moderator and observers was explained. Secondly, it was clarified that the SWOT analysis methodology would be applied, involving four questions on the Strengths, Weaknesses, Opportunities, and Threats of the MFPGs. Like in Focus Group 1, the moderator asked the participants if they agreed and gave their consent for the session to be recorded. With everyone's consent, the session began, with participants introducing themselves to the group. Then, the following questions were posed.

6.3.2.3 Results

Question 1: Strengths (Advantages): What are the characteristics of MFPG that make it an advantageous psychotherapeutic device compared to other psychotherapeutic interventions (internal - families/team/service; and external - institution/community)?

1. The role of the therapist as a stabilising factor: overcoming communication difficulties, conflicts, and language variations.
2. Possibility of overcoming fears, inhibitions, and taboos after adapting to the group.
3. Transgenerationality – The presence of more than one generation allows the identification of transgenerational patterns, addressing conflict actors and resolving misunderstandings.
4. Possibility of rectifying/transforming communication - clarification of communication, resolution of misunderstandings, and understanding of behaviours.
5. Development of thinking and feeling – learning to think about oneself through others.
6. Broadening of the mind: Many individuals can only begin to reflect on themselves when they hear descriptions from other participants, fostering creativity and new perspectives.
7. The universality of psychological and relational problems and the possibility of identifying solutions: listening to others breaks down family isolation, facilitating the overcoming of problems.
8. Development of empathy, initially with others and then with members of one's own family.
9. Possibility to understand problems from a new perspective, seek innovative solutions, and actively contribute to the recovery of family members.
10. Hierarchy of problem severity: the ability to identify which situations should be prioritised, determining their importance.

Question 2: Weaknesses (Disadvantages): What characteristics put MFPG at a disadvantage compared to other psychotherapeutic devices (internal - families/team/service; and external - institution/community)?

1. Generational differences: varied problems across different generations can hinder communication and empathy.
2. Need for well-trained therapists.
3. Difficulty in addressing traumatic situations in a large group.
4. Group duration and time management in a large group.
5. Initial adherence to group therapy is not always easy.
6. Group Cohesion – e.g., therapeutic alliance: Irregular participation of members in a

therapeutic group is not conducive to the development of a therapeutic alliance/group cohesion. If there are therapeutic objectives, it is crucial to commit to attendance, as the bonds and intimacy formed among participants must be based on continuity.

Question 3: Opportunities: What aspects should be emphasised in MFPG, as a psychotherapeutic approach to mental health, to make it easier to adhere to it? On the other hand, to what extent can working with MFPG contribute to the transformation of: families/team/service; and institution/community?

1. Awareness of impact on others: opportunities to improve communication and empathy.
2. MFPG heals relationships and mismatches between parents and children; and fosters peace and understanding. People in treatment feel their family members' presence in the MFPG as a demonstration of care and love.
3. Adherence to medication and improvement of the disease
4. Hope: The progress of others shows how recovery is possible.
5. Self-knowledge: It is an opportunity for family members to get to know themselves through what they experience in the group.

Question 4: Threats: In what ways can MFPG be a threat (internal/external)?

1. Mistrust and resistance to treatment in a large group.
2. Given the size of the group, insufficient time for everyone to talk.
3. Conflicts arising in the group may not be fully resolved within the available time.
4. Absences from the group might be perceived as a weakness, leading to a feeling of not being integrated by those who are absent. It might encourage others to be absent, and the absence of family members can be perceived as a threat to treatment.
5. Fear of leaks/confidentiality breaches.

6.3.3 Focus Group Conclusions

Analysing the content of the answers received to the four questions posed in Focus Groups 1 and 2, some were similar, while others were different. The goal was to compare the responses of therapists with experience in MFG with the responses of therapists without experience in MFG and relatives of former patients. To facilitate summarisation and draw conclusions from this SWOT analysis, several categories were created based on the type of answers received (See below, in Table 1).

The following categories were created for question 1:

- Transgenerationality/presence of more than one generation;
- Benefits for families and therapists;
- Possibilities of transformation;
- Clinical and institutional advantages.

The following categories were created for question 2:

- Possible difficulties generated by generation differences;

- Problems of space and training;
- Difficulties presented for being a (large) group;
- Group Cohesion / Therapeutic Alliance.

The following categories were created for question 3:

- Opportunities for patients and families;
- Opportunities for health caregivers and institutions.

The following categories were created for question 4:

- Resistances of the families;
- Difficulties of the institutions;
- Problems with being a (large) group.

The answers to the first question were very similar in the two focus groups: both highlighted the importance of the presence of more than one generation in resolving current problems, as well as the relevance of transgenerationality. Both groups highlighted the multiple benefits of MFGs for families, health professionals, and institutions.

The second question pointed out the need for specific training of the therapists and the importance of other therapeutic devices to complement the MFGs; some difficulties related to the size of the group and the gap of generations; and the importance of constancy in the presences, both therapists and families, was also highlighted.

Regarding the third question, Focus Group 1 highlights the opportunities for professionals and institutions to reduce treatment times with cost-benefit advantages, while Focus Group 2 highlights opportunities for family growth and development.

Finally, in question 4, as threats to MFPGs, both groups highlight the resistances and difficulties posed by participants and institutions, and the urgent necessity of a group culture to combat the psychological resistance to what is unknown or unusual.

Below is a table summarising the results obtained from the two focus groups.

Table 1. SWOT Analysis: Questions/Categories.

Question 1: Strengths (Advantages): What characteristics of MFPG make it an advantageous psychotherapeutic device over other psychotherapeutic interventions (internal - families/team/service; and external - institution/community)?		
CATEGORIES	**FOCUS GROUP** 1	**FOCUS GROUP 2**
Transgenerationality/presence of more than one generation	1) Extension of the patient's problems to the whole family - presence of more than one generation. 3) Direct observation of relational psychopathology - intergenerationality and transgenerationality.	3) Transgenerationality – The presence of more than one generation allows the identification of transgenerational patterns, addressing conflict actors and resolving misunderstandings.
Benefits for families and therapists	5) Peer learning. 6) Change in the concept of becoming ill: the individual does not become disorganised alone, he/she becomes disorganised in the family environment. 10) Education and training of health professionals.	5) Development of thinking and feeling - learning to think about oneself through others. 6) Broadening of the mind: many individuals can only begin to reflect on themselves when they hear descriptions from other participants, fostering creativity and new perspectives. 8) Development of empathy, initially with others and then with the members of one's own family.
Possibilities of transformation	7) Possibility to observe the relationship and communication patterns of the various family members. 8) Patient Protection: The therapist as an auxiliary ego of the patient; the possibility to test oneself in a protected environment - MFPGs are like an antechamber of social reality. 9) Facilitation of open communication between the family, patient, and the team, avoiding the family talking behind the patient's back.	1) The role of the therapist as a stabilising factor: overcoming communication difficulties, conflicts, and language variations. 2) Possibility of overcoming fears, inhibitions, and taboos after adapting to the group. 4) Possibility of rectifying/ transforming the communication - clarification of communication, resolution of misunderstandings, and understanding of behaviours. 7) The universality of psychological and relational problems and the possibility of identifying solutions: listening to others breaks down family isolation, facilitating the overcoming of problems. 9) Possibility to understand problems from a new

		perspective, seek innovative solutions, and actively contribute to the recovery of family members. 10) Hierarchy of problem severity: the ability to identify which situations should be prioritised, determining their importance.
Clinicand institutional advantages	2) Speed of diagnosis. 4) Rapid improvement of the patient in treatment. Cost/benefit to the health system - reduces re-hospitalisation and emergency room visits. 12) Long-term effectiveness - improvements for a longer duration. 13) Decreased chronicity - treats the problem at its source rather than camouflaging it.	
Question 2: Weaknesses (Disadvantages): What characteristics put MFPG at a disadvantage compared to other psychotherapeutic devices (internal - families/team/service; and external - institution/community)?		
Possible difficulties generated by generation differences		1) Generational differences: Varied problems across different generations can hinder communication and empathy.
Problems of space and training	3) Logistics: need for more than one therapist; need for a room with enough space and privacy conditions. 4) Need for adequate therapists' training – MFPG is a group that implies specific technical knowledge/experience.	2) Need for well-trained therapists.
Difficulties presented for being a (large) group	1) It is not sufficient as a therapeutic device – needs other devices to complement it (individual psychotherapy in some cases). 2) Sometimes, it can be difficult to divide speaking time equally.	3) Difficulty in addressing traumatic situations in a large group.

Group Cohesion / Therapeutic Alliance	5) Need for availability, constancy and continuity of the therapists in the sessions - in institutions, it can be difficult to maintain this continuity.	6) Group Cohesion – e.g., therapeutic alliance: Irregular participation of members in a therapeutic group is not conducive to the development of a therapeutic alliance/group cohesion. If there are therapeutic objectives, it is crucial to commit to attendance, as the bonds and intimacy formed among participants must be based on continuity.
Question 3: Opportunities: What aspects should be emphasised in MFPG, as a psychotherapeutic approach to mental health, to make it easier to adhere to it? Or, to what extent can working with MFPG contribute to the transformation of: families/team/service; and institution/community?		
Opportunities for patients and families	2) Numerous opportunities to develop new and more structuring/healthy identifications, enabling personal growth for patients, families, and therapists. 4) The possibility of using distance media - reaching more people (distance and time).	1) Awareness of impact on others: Opportunities to improve communication and empathy. 2) MFPG heals relationships and mismatches between parents and children; and fosters peace and understanding. People in treatment feel their family members' presence in the MFPG as a demonstration of care and love. 3) Adherence to medication and improvement of the disease. 4) Hope: The progress of others shows how recovery is possible. 5) Self-knowledge: It is an opportunity for family members to get to know themselves through what they experience in the group.
Opportunities for health caregivers and institutions	1) The relevance of the positive effects of MFGs on public health care and other social institutions should be emphasised. 3) Training opportunities for professionals: new professional experiences and a new look at psychiatry.	

	5) The possibility of broadening the understanding of the patient's problems: covering various stages of the patient's and family's life cycle (transgenerationality) - through the narratives of the various family members. 6) The opportunity to improve cost-effectiveness in the long term: longer-lasting improvements, fewer crises, and less absenteeism from work.	
Question 4: Threats: In what ways can MFPG be a threat (internal/external)?		
Resistances of the families	1) Cultural and psychological resistances - for many, what is unknown or unusual is threatening.	1) Mistrust and resistance to treatment in a large group. 4) Absences from the group might be perceived as a weakness, leading to a feeling of not being integrated by those who are absent. It might encourage others to be absent, and the absence of family members can be perceived as a threat to treatment.
Difficulties of the institutions	2) Difficulties posed by institutions that consider the number of professionals involved a waste of resources. 3) Lack of specialised professionals. 4) Exhaustion of the health professionals in dealing with the obstructions posed by the institutions.	
Problems with being a (large) group	5) Difficulty in ensuring that content expressed in the group remains private.	2) Given the size of the group, no time for everyone to talk. 3) Conflicts arising in the group and being resolved within the time available to the group. 5) Fear of leaks/confidentiality breaches.

6.4 BIBLIOGRAPHIC RESEARCH

In tandem with the development of the questionnaire, a comprehensive literature review on multifamily intervention in mental health was initiated. This review enabled the project partners to refine and focus their web-based research in line with the research objectives and the Intellectual Output I of the project. Multiple search engines, including Google, Google Scholar, PubMed, Hall, and Cairn, were utilised, with results organised using the Zotero management software. The APA 6th edition citation style was applied.

The agreed-upon keywords, established during transnational meetings, include:

- Multifamily Psychoanalysis
- Multifamily Therapy
- Multifamily Group
- Multifamily Psychoanalysis Group
- Multifamily Group Therapy
- Multifamily Group Treatment

These search terms were translated into relevant country languages and supplemented with country-specific terms. Consensus among partners led to searches in various national languages, extending beyond national borders for each language and encompassing additional countries.

The bibliographic search conducted in Portugal revealed that keywords such as Multifamily Group, Multifamily Psychoanalysis, and Multifamily Therapy yielded a more comprehensive and qualitative content index. The Portuguese language bibliography notably featured articles, monographs, books, and book chapters (Refer to Appendix 5 for details.).

6.5 CONCLUSIONS

The primary objective of the 'Multifamily Groups in Mental Health' Project, which involves characterising the models and mapping existing multifamily groups in mental health in Portugal, was not fully reached due to constraints outlined in the previous chapter (6.2), leading to delays in delivering the results of the questionnaires and focus groups.

Only five questionnaires were received, representing five institutions. These results encompass both types of MFG outlined in the project's objectives: 1) Psychoeducational Multifamily Groups, which address mental health problems and provide information on managing them; and 2) Psychotherapeutic Multifamily Groups, which include Multifamily Psychoanalysis Groups. This latter type includes the CHULN-HSM's Psychiatric Service's Day Hospital, established in 2001 and serving as the pioneer in Portugal (Lisbon), and the Psychiatric Service's Day Hospital of CHLO, in existence since 2016.

As previously explained, the Day Hospital, being part of a University Hospital affiliated with the Lisbon University's Faculty of Medicine (FMUL), has consistently included a training component. This has facilitated the training of numerous health professionals through institutional internship programs. Besides institutional trainees, the Day Hospital has also accommodated other health professionals - psychiatrists, child psychiatrists, psychologists, and nurses - who, while not official trainees, expressed interest in learning the psychoanalytic and group analytic model of the Day Hospital. This interest grew significantly after the initiation of MFGs in 2001. Until a few years ago, upon learning about the existence of the MFG, many colleagues requested authorisation from the

CHULN-HSM administration to undertake voluntary, unpaid observation/training internships lasting several months. Some of these health psychotherapists subsequently replicated the model of the Day Hospital's MFG in the institutions where they were employed[4] However, in recent years, new rules implemented by the CHULN-HSM administration have prevented health professionals who are not part of the internship system from training at the CHULN-HSM's Day Hospital.

Several factors contribute to the limited dissemination of Multifamily Psychoanalysis Groups in Portugal. Institutional resistance and the pragmatic need for suitable conditions, such as physical space and trained psychotherapists, are significant challenges. Institutional resistances stem from cultural and psychological biases, misinformation, and prejudices regarding certain psychotherapeutic approaches, especially dynamic-based group psychotherapies. This resistance may be attributed to doubts, insecurities, preferences for classical/pharmacological approaches, false beliefs about cost-effectiveness, and concerns about resource utilisation. Economic and resource-related claims, such as the perceived waste of human resources due to the number of professionals involved in group psychotherapies, were identified as threats to Multifamily Groups by the MFG conductors in focus groups.

Addressing these challenges requires the development of a 'group culture' to counter psychological resistance to the unknown or unconventional. Additionally, the bureaucratic nature of Portuguese institutions poses additional obstacles, hindering the implementation of new and different approaches due to various procedures and constraints.

While some focus group participants acknowledged the potential of Multifamily Groups as a valuable setting for training health professionals, they also emphasised the need for specific training for MFG therapists. Regarding the added value of MFGs, participants highlighted the importance of having more than one generation present as an advantage in resolving current conflicts. Both focus groups emphasised the numerous benefits of MFGs for families, health professionals, and institutions.

[4] 1) Day Hospital of the Psychiatric Service of the Hospital Fernando da Fonseca in Amadora, Lisbon district; 2) Day Hospital of the Psychiatric Service of the CHLO; 3) Day Centre of the Institute of Drugs and Drug Addiction (IDT), currently the Service for Intervention in Addictive Behaviours and Dependencies (SICAD); the first and the latter group ended some years ago.

7 RESULTS

7.1 SURVEY: ANALYSIS

AIDFM (Associação para Investigação e Desenvolvimento da Faculdade de Medicina, Portugal) took on the responsibility of presenting the results of the Intellectual Output I project for the four involved countries. After compiling its report and receiving reports from partners in Italy, Belgium, and Spain, it produced the Final Report for the four countries, as presented below.

Group psychotherapies, especially Multifamily Groups (MFGs), are regarded as one of the most significant innovations in mental health services. While 'group psychotherapy' has a long history[5], the practice of multifamily psychotherapy emerged in the 1970s, primarily following the psychoanalytic approach introduced by the Argentinean psychiatrist García Garcia Garcia Badaracco. He first adopted it in the 1960s at the Psychiatric Hospital of Buenos Aires, where collaborative work with in- patients and family members demonstrated the possibility of discharging individuals from the asylum structure. MFG began to gain traction in the new century, evolving alongside the joint development of family therapy and the systemic approach. Today, it encompasses various theoretical models and serves as a well-established psychotherapeutic practice supported by evidence confirming its effectiveness in terms of outcomes[6].

MFG facilitates the creation of a therapeutic climate, often characterised by strong emotional intensity, involving individuals with mental suffering, their family members/relatives or close associates, and practitioners from diverse backgrounds. Typically, it engages a large number of people (30 to 90) representing at least two generations. With its psychodynamic approach, the group is marked as a transformative experience for all involved, 'both for the richness of the human experience and for the quality of the mutual learning that is experienced[7]'.

MFG heralds a new phase in the treatment of psychiatric disorders by fostering an interactive dynamic that makes 'users', especially those suffering from psychosis, and their family members aware of the pathological interdependence links in which they are involved. This allows them to reflect and compare their situations with those of other participants.

This process unfolds through collective meetings based on a few rules: all individuals are 'listened to, understood, and respected to the extent that they feel they can begin to count on each other's help and, therefore, on each other's opinion, even if different from their own', all of equal value. Within the group, 'a situation is built in which everyone can get to look from the outside at the role they play and the way they do it: children, parents, and caregivers, themselves children and/or parents in their own lives'. In addition to the intrinsic value of the inner dimension, there exists the relational dimension of an encounter between people: 'one is no longer a child, parent, or psychiatrist. One feels on an equal footing with the other,' while the dialogue between users and family members cannot do without 'looking into each other's eyes' and fostering emotional contact

[5] This designation originated in the 1930s, credited to J. L. Moreno.

[6] Literature and testimonials in this research highlight various benefits, including improved family relationships, and reductions in TSO admissions and drug therapy. As noted, 'To the extent that the competence of the family and between families increases, drug therapy can be reduced by 3 or 4 times in a gradual and consistent manner and the improvement of family relationships'). Cf. Canevaro A., Bonifazi S. (2011), Il gruppo multifamiliare. An experiential approach, Armando Editore, Rome, p. 49.

7 Cf. by G. Villa (2016), Il Gruppo Multifamiliare tra funzione migrante e apprendimento, 'In Gruppo: omogeneità e differenze, rivista online Argo6.

in the ‘dramatic space’ of the encounter. Key themes of participation in the MFG include ‘sharing’, ‘confrontation’, ‘exchange’, ‘support’, or ‘help’[8], establishing a therapeutic climate based on confidence, empathy, respect, self- and other-acceptance, and spontaneity of human contact. This atmosphere is influenced by the relational qualities, especially empathy, of the caregivers, starting with the conductor/coordinator. This figure stimulates and regulates dialogues by giving the floor to all who request it, facilitating the rapid circulation of ideas and encouraging a succession of interventions based on 'free associations' so that everyone can learn, by analogy or imitation, from the experiences of others. Additionally, participants can mirror each other.

The conductor, assisted by other co-therapists, should refrain from any judgment of the suffering persons and family members. They should also relinquish their ‘cognitive certainties to immerse themselves in the world of affections and emotions; accepting to float freely together with all the others,[9]’ and they can then discuss as a team what happens in the groups. This continuous learning experience in the group brings together caregivers and family members.

MFGs reinforce the acknowledgement of the family as the ‘designated patient’ sphere, removing it from isolation and elevating it in therapeutic cooperation as an active participant in recovery projects. Simultaneously, they encourage the exploration of ‘self-help’ among family members. Notably, most MFG family members are also engaged in self-help groups[10], which can, in turn, evolve from multifamily groups that gradually become autonomous. As expressed, ‘the art of the MFG is to help families help themselves’ so ‘when this happens, the group can function on its own.[11]’

7.1.1 The Research: Purpose, Cognitive Objectives, and Methodology

The primary objective of this initial exploratory research was to enhance comprehension of the experiences and functioning of MFGs in four European countries, each with distinct histories and trajectories in the shift from psychiatry to mental health. Although these experiences are relatively recent, not yet widespread or uniform, and still evolving, they represent a compelling avenue for addressing distress from a systemic, family, and community perspective, extending beyond specialist services and individual therapies. The research unfolded in two sequential phases:

1) An initial survey that aimed at collecting information on general, organisational, and operational characteristics of the MFGs, through the completion of a questionnaire by the participants. The specific cognitive objectives encompass the following sets of indicators:

- General aspects: time of creation, promoting body and activating service, theoretical-methodological orientation.
- Logistical and organisational elements: meeting room suitability and organisation of spaces, meeting methods, frequency, duration and timetable.
- Human resources involved: entity, qualifications, specific training background and team composition.
- Operating aspects of the group: size, opening-closing, phases and sessions, supervision and intervision, interruptions, changes over time, and impacts of the COVID-19 pandemic.

8 See (ed.) R. Frisanco (2016), Reti di cura e disagio psichico. Utenti, famiglie e servizi di salute mentale a Roma, Palombi Editori, Roma.

9 Cf. Narraci A. (2015), Psicanalisi Multifamiliare come Esperanto, Antigone Edizioni, Torino.

10 See (ed.) Frisanco R., op. cit.

11 Op. cit., Canevaro A and Bonifazi S. (2011), p. 31.

- Characteristics of participants: sending channel, age group and prevalent disorders.

2) A subsequent in-depth qualitative study on the MGFs conducted in each country, with two focus group interviews: The first focus group involved a representation of group conductors while the second involved a small sample of users. Together, they facilitated an initial subjective evaluation of the observed phenomenon, identifying strengths, weaknesses, opportunities and obstacles.

The 'added value' of this survey resided in comparing experiences across the four countries, highlighting disparities and original aspects, supplemented by reflections from those directly involved.

From a methodological perspective, the study predominantly exhibited the characteristics (and limitations) of an exploratory survey: The initial first phase utilised a structured questionnaire of 36 closed questions and alternative answers, administered online through Google Forms. The subsequent qualitative phase involved interviews with small groups of conductors and users (focus groups), guided by specific questions to facilitate collective in-depth discussions on the key aspects of MFGs (‘focuses’).

7.1.2 Examination of the Research Data in the Four EU Countries

In the four countries, 92 Multifamily Groups were examined, which is fewer than expected. This situation is noteworthy, especially considering that, except for Portugal, the widespread adoption of MFGs could have allowed for the exploration of a larger sample of cases. These experiences are not yet well-established and stable, given their relatively recent integration into the mental health service system. It is noteworthy that, even in places with a mental health information system, such as Italy, data on this therapeutic approach are not collected, reflecting a lack of recognition as an innovative aspect.

7.1.3 The Profile of Multifamily Groups (MFGs)

The Multifamily Groups (MFGs) examined in the four national areas have varying lengths of activity. Their average ‘seniority’ is 8.5 years overall, but the more accurate median time value is just over 6 years. The most established MFGs are in Spain, with an average of 10.6 years of activity, followed by Italy and Portugal (8.6 years). The appearance of MFGs in mental health services in Belgium is relatively recent, with an average of 6.1 years. Italy has the longest experience, with MFGs active for 45 years, while in Spain, 9 groups have been active for at least 15 years, with the oldest established 38 years ago. In Belgium, the oldest group has a track record of 23 years. It is evident that the MFGs that have been active the longest have adopted G. Garcia Garcia Badaracco's model of multifamily psychoanalysis, mainly present in Spain and Italy. These groups have been active for 9 years, especially in Spain, where the average seniority of MFGs with a psychoanalytic imprint is almost 11 years.

Regarding whom filled in the questionnaire, psychologists (53.3%) predominantly took on this responsibility, especially in Italy and Belgium (more in Flanders), while in Spain, psychiatrists played a more prominent role. The prevalence of psychologists over other roles indicates both their different numerical presence in the groups and their unequal involvement in the therapeutic conduct of MFGs. Nurses and social workers, auxiliary figures in mental health services, had a marginal role in filling out the questionnaire (Table 2).

Table 2. Occupational roles of the questionnaire's respondents.

DESCRIPTION	Total a.v.	%	I	S	B	P
Psychologist	49	53.3	18	11	18	2
Psychiatrist	37	40.2	15	15	5	2
Nurse	1	1.1	0	0	0	1
Social security worker	2	2.2	0	2	0	0
Other	3	3.2	2	0	1	0
Total	***92***	***100***	***35***	***28***	***24***	***5***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

The structures that initiate the MFG are predominantly public (57.6%), with varying distributions in different countries. In Italy and Portugal, there is a more pronounced involvement of health institutions, whereas in Spain, initiatives from private administrative bodies (or the third sector) slightly predominate, similar to the situation in Belgium (Table 3).

Table 3. Type of administrative structure. *Private structures of both the associative and private profit world; **10 are from the private profit sector and 5 are third sector entities affiliated with the public; ***Non-profit organisations.

DESCRIPTION	Total a.v.	(%)	I	S	B	P
Public	53	57.6	26	13	11	3
Private	38	41.3	9*	15**	13***	1
Public-private partnership	1	1.1	0	0	0	1
Total	***92***	***100***	***35***	***28***	***24***	***5***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

The type of service where most MFGs are advocated and utilised is the territorial mental health service (34.8%). This model prevails in Italy and Spain, where the network of such services is more extensive. In Belgium, the traditional psychiatric hospital still plays a significant role, even though it has the capacity to embrace innovative approaches such as MFGs. The notable aspect of the Belgian experience lies in the ability to gauge the effectiveness of the group in the process of moving beyond these more traditional structures. However, in both Flanders and Wallonia, Mental Health Centres are entirely disconnected from the management of MFGs, highlighting a situation characterised by fragmented responsibilities for mental health services between federal and local governments. The Portuguese experience is somewhat similar, with the few analysed groups exclusively present in psychiatric in-patient facilities of the General Hospital and residential facilities (Therapeutic Community, Table 4).

Table 4. Type setting/environment where the sessions were conducted.

DESCRIPTION	Total a.v.	(%)	I	S	B	P
Community Health Centre	32	34.8	19	13	0	0
Psychiatric Hospital	23	25.0	0	1	22	0
General Hospital/Psychiatric Ward	7	7.6	2	1	1	3
Communitary organisation	12	13.0	7	5	0	0
Therapeutic community	6	6.5	2	2	0	2
Day hospital	5	5.4	0	5	0	0
Other	7	7.6	5	1	1	0
Total respondents	***92***	***100***	***35***	***28***	***24***	***5***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

However, MFGs with a territorial focus, of a type not exclusively medical, constitute the majority of the cases examined (53.3%). This proportion rises to 74.3% among those examined in Italy, indicating a growing emphasis on the 'relational' conception and practice in the therapeutic approach to mental health. The systemic-familial approach introduced by MFGs, wherever they operate, signifies a shift away from the traditional psychiatric approach centred on drugs and beds. Instead, it affirms a new operational paradigm in mental health services.

In summary, it is observed that MFGs are considered an indispensable resource for therapeutic activity in any type of service, whether territorial, in-patient, residential, or daytime, each with its unique settings and objectives. In other words, in any type of therapeutic organisation, the MFG has a distinct mission, especially when it is open and invested in its continuity over time.

Concerning the predominant type of care in facilities with a multifamily group, outpatient-territorial care is the most common (57.6%). However, this prevalence is concentrated in Italy and Spain, where almost 8 out of 10 cases fall under this category. In contrast, in the two regions of Belgium and in Portugal, MFGs primarily serve in-patients in the psychiatric wards of the General Hospital or in the Day Hospital (constituting 69% of the types of care) (Table 5).

Table 5. Type of service assistance.

DESCRIPTION	Total a.v.	(%)	I	S	B	P
Outpatient	53	57.6	22	20	10	1
Daycare hospital	25	27.2	2	8	13	2
Inpatient ward	21	22.8	1	1	18	1
Residential care	8	8.7	4	1	2	1
Other	14	15.2	9	3	2	0
Total responses	121	131.5	38	33	45	5
Total respondents	***92***	***100***	***35***	***28***	***24***	***5***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

Among the objectives of the intervention within the MFG, the primary one aligns with the psychotherapeutic goal, constituting nearly 9 out of 10 units. On average, this psychotherapeutic objective is accompanied by another, most commonly either providing support to participants or having a psychoeducational focus. 'Support' is closely linked with psychotherapeutic or psychoeducational interventions, facilitating these objectives by creating an environment of acceptance, understanding of experiences, and the sharing of suffering. The few groups that do not prioritise the psychotherapeutic aim are those oriented towards self-help, counselling, and/or simple support, or a psychoeducational action that likely operates on the periphery of a therapeutic intervention. On average, Belgian MFGs implement more intervention goals (2.9), with some variations between Flanders and Wallonia (where there is more emphasis on self-help and counselling), in contrast to Italian MFGs (1.8) (Table 6).

Table 6. Objectives of MFG intervention, based on respondents and responses.

DESCRIPTION	Total a.v.	(%)1	(%)2	I	S	B	P
Psychotherapeutic	79	39.9	85.9	27	28	20	4
Support	42	21.2	45.6	12	14	16	0
Psychoeducational	36	18.2	39.1	13	6	15	2
Self-help	20	10.1	21.7	8	3	9	0
Counselling	15	7.6	16.3	2	6	7	0
Other	6	3.0	6.5	1	2	2	1
Total respondents	92	100	-	63	59	69	7
Total responses	***198***	***-***	***215.1***	***35***	***28***	***24***	***5***

Source: research FA.M.HE 2023. a.v. = absolute value; %1 = relative value considering the total respondents; %2 = relative value considering the total number of responses.

The distribution of MFGs relatively to their theoretical frame of reference reveals a predominant preference for one of the four main theories: psychoanalytic, psychoeducational, psychodynamic, and systemic. However, these approaches are not strictly exclusive, often featuring points of contact, hybridisations, and a shared technical-operational procedurality. In the sample from the four European countries, the most prevalent theoretical approach is multifamily psychoanalysis (52%), introduced by G. Garcia Garcia Badaracco. This approach is nearly exclusive to group experiences in Italy and Spain, constituting 92% of the total. Following in order of frequency are the systemic family theory and the psychoeducational approach, both notably present in the Belgian experience. Finally, only 15% of the groups, limited to Italy and Belgium, adopt the psychodynamic approach.

It is essential to note the 'other' responses, indicating local experiences (such as therapy groups) or a blend of different theories and techniques. An illustrative example is that of Javier Sempere in Spain, who initiated the Multifamily Psychoanalysis Group and developed his own model of Family Therapy, incorporating attachment theory (Bowlby) and the open dialogue approach (Seikkula). Other instances of experimentation can be found in Belgium (Maudsley's model based on cognitive principles and McFarlane's psychoeducational model) and in Italy with the Multifamily Group of Integrative Psychoanalysis (Mandelbaum). This diverse panorama reflects the vibrancy in shaping therapeutic techniques applied to families (Table 7).

Table 7. Theoretical background of MFGs.

DESCRIPTION	Total a.v.	(%)	I	S	B	P
Multifamily Psychoanalysis	48	52.2	21	23	2	2
Psychoeducation	18	19.6	7	0	9	2
Systemic theory	24	26.1	4	4	16	0
Dynamic Theory	14	15.2	4	6	4	0
Other theoretical background	17	18.5	3	8	5	1
Total responses	121	131.5	37	41	36	5
More than one background	27	29.4	2	13	12	0
Total respondents	***92***	***100***	***35***	***28***	***24***	***5***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

In total, there are 261 team members across the 92 MFGs, averaging 2.8 practitioners per unit, with no significant difference observed among the four countries. Examining their educational qualifications, the data underscore a predominant presence of psychology graduates, found in 9 out of 10 MFGs, with a consistent representation across all four countries. Individuals with a degree in psychiatry are also well-represented in the majority of groups, trailing slightly behind psychologists, except in Spain where they are present in 8 out of 10 cases. Nurses emerge as the

third most prevalent professional group, particularly in Belgium, where groups are more active in psychiatric hospital[12] contexts. Social workers follow, with educators having a lesser presence. The latter two figures are relatively more common in Italian MFGs, often complementing the expertise of psychologists or psychiatrists, occasionally with the inclusion of rehabilitation therapists. Similar figures, including 17 'other' caregivers, are also observed in Belgium (Table 8).

Table 8. Educational qualifications of MFG members. *Rehabilitation therapists ** Other therapists (11), Professional by experience (2), Other (4).

DESCRIPTION	Total a.v.	(%)	I	S	B	P
Psychologists	82	89.1	33	24	22	3
Psychiatrists	52	56.5	17	22	10	3
Nurses	41	44.6	13	10	15	3
Social services workers	29	31.5	12	8	7	2
Educators	12	13.0	6	1	4	1
Occupational therapists	10	10.9	2	7	0	1
Other	35	38.0	13*	4	17**	1
Total responses	261	283.7	96	76	75	14
Mean value	2.8	-	2.7	2.7	2.8	2.8
Total respondents	***92***	***100***	***35***	***28***	***24***	***5***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

A pertinent inquiry concerns the psychotherapeutic training background of team members, complementary both to university training, where special emphasis is placed on the individual, and to specialist training, which, at most, includes nuclear family treatment. Working with a large group can induce a caregiver to 'habitually experience the sensation of loss of therapeutic control with the consequent emergence of anxiety and avoidance behaviour[13].. Consequently, it is deemed essential that the training of those involved in MFGs, particularly those leading them, encompasses individual, group, and systemic-family psychotherapy, along with familiarity with psychodrama and gestalt groups, irrespective of the group's theoretical orientation.

Regarding the training techniques and skills imparted to the groups in the study, six main areas were identified: cognitive-behavioural psychotherapy, systemic family therapy, psychoanalysis, group analysis, other group therapies, and psychodynamic therapy. There is a noticeable emphasis on training in 'systemic family therapy' (cited by 57.5% of caregivers) and, secondarily, on 'psychodynamic therapy' (46.7%). Four out of ten MFG facilitators acknowledge the importance of training in psychoanalysis, aligning with the theoretical approach of a significant number of groups.

[12] A distinction can be made in Belgium, between Flanders, where more psychologists and social workers work, and Wallonia, which has a higher proportion of psychiatrists and nurses. These situations seem to characterise two models of therapeutic approach in mental health.

[13] See Canevaro A. and Bonifazi S. (2011), Il gruppo multifamiliare. Un approccio esperienziale, Roma, Armando Editore.

On average, 2.5 specific training topics are mentioned, with Spain reporting a higher average of 3.1, where additional training fields are also acknowledged. Belgium, on the other hand, records a lower average of 1.8, with a specific focus on in-depth studies in the systemic and cognitive-behavioural domains (see below, Table 9).

Table 9. Type of psychotherapeutic background of team members of MFGs.

DESCRIPTION	Total a.v.	(%)	I	S	B	P
Systemic therapy	53	57.5	20	12	19	2
Psychodynamic therapy	43	46.7	18	16	5	4
Psychoanalysis	36	39.1	16	16	2	2
Group Analysis	29	31.5	8	20	0	1
Cognitive-behavioural psychotherapy	27	29.3	12	4	10	1
Other group therapies	22	23.9	7	12	3	0
Other	22	23.9	7	8	5	2
Total responses	232	252.2	88	88	44	12
Mean value	2.5		2.5	3.1	1.8	2.4
Total respondents	***92***	***100***	***35***	***28***	***24***	***5***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

Another distinctive aspect of the group's operational profile is its conduction - the assumption of therapeutic coordination with the responsibility for maintaining the functionality of the MFG. Authors studying MFGs confirm that a group should have at least one pair of therapists, one leading the group, and the other (or others) acting as co-therapist(s), playing a complementary role, and engaging in participant observation of group dynamics. Particularly in larger groups, it is advisable to have more than one conductor and several co-therapists. The roles of conductors and therapists hold strategic significance, particularly during initial meetings and transitional phases within the group, aiming to encourage interaction among all members, establish a conducive atmosphere, and contain the emotional and psychological manifestations of familial anxieties. They also consistently intervene with a cohesive approach to interlink narratives and occurrences, thereby ascribing meaning and perspective to participants' experiences. In the majority of the 92 surveyed groups (54.3%), there is a structured conduction involving joint coordination at a more therapeutic level, which can be carried out by various professional figures (in 42 MFGs). Some variations are noticeable across the four countries: the prevalence of conductors is highest among Italian MFGs (63 out of 100) and the few Portuguese MFGs, decreasing in Spain (57 out of 100), and significantly reduced in Belgium (37.5%), where MFGs are led by the psychologist-nurse pair (in Flanders) or the psychiatrist-nurse pair (in Wallonia) (Table 10).

Table 10. Composition of the MFG team.

DESCRIPTION	Total a.v.	(%)	I	S	B	P
1 conductor and co-therapists	42	45.6	21	10	8	3
Only co-therapists (no conductor)	42	45.6	13	12	15	2
2 or 3 conductors or more co-therapists	8	8.7	1	6	1	0
Total	92	100	35	28	24	5

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

Practitioners and teams involved in all psychotherapeutic activities need to monitor the conduct and progress of the group through a specific control methodology. Initially, supervision is employed, which, in the case of the MFG, can occur at different times and in various ways: with continuous monitoring conducted by the same team after each session; through periodic meetings of the service team, including discussions on the treatment of individual cases; and through an external evaluation of the group's progress. External supervision may complement internal supervision.

In total, just under half of the groups (49%) incorporate internal and/or external supervision. Italians show the highest inclination towards this practice (57.1%), followed by the Spanish and Belgians (50%), while one in five groups in Portugal engages in supervision. In some instances, as indicated in the national reports, 'peer supervision' appears to be conducted, involving a comparison between therapists leading or participating in the group.

Conversely, intervision is widely practiced almost universally, with negligible variations. This approach facilitates the monitoring of individual service users who are also group participants; cases are collaboratively discussed, and ideas and suggestions are exchanged. In essence, it operates as a ‘learning-by-doing’ method, enabling the establishment of effective approaches for working on individual cases and informing practices for handling similar situations (Table 11).

Table 11. Supervision and intervision on MFG.

SUPERVISION	Total a.v.	(%)	I	S	B	P
Internal	23	25.0	12	9	2	0
External	12	13.0	3	4	5	0
Internal and external	9	9.8	5	3	0	1
No supervision	47	51.1	15	12	16	4
Omitted	1	1.1	0	0	1	0
Total responses	92	100	35	28	24	5
INTERVISION						
Yes	88	95.7	33	27	24	4
No	4	4.3	2	1	0	1
Total respondents	***92***	***100***	***35***	***28***	***24***	***5***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

7.1.4 Characteristics of Individuals Participating in MFGs

A set of inquiries pertained to the profile of participants, encompassing their origin, age group, generational data, relationships, and diagnosis. In 70% of cases, participants in the groups are drawn from two generations, a condition mandated by the research definition, while in the remaining 30%, there are instances of three generations (see Table 12).

Table 12. Number of generations involved in MFGs.

DESCRIPTION	Total a.v.	(%)	I	S	B	P
2 generations	64	69.6	25	19	16	4
more than 2 generations	28	30.4	10	9	8	1
Total respondents	***92***	***100***	***35***	***28***	***24***	***5***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

Each participating family, therefore, comprises two or more members representing at least two generations and typically involves additional relatives such as siblings, aunts, uncles, or grandparents of the users or individuals under care.

Regarding the origin of users participating in MFGs, it is observed that, in 7 out of 10 cases, they exclusively consist of individuals in charge of the same institution or service that established the MFG. Conversely, in only 1 out of 10 cases are individuals sent by other services, bodies, or organisations, or come from external sources. The remaining 20% of the groups exhibit a hybrid composition, including users from both the service managing the MFG and those originating from external sources. It can be inferred that these groups are relatively well-recognised and valued within their context, primarily addressing the therapeutic coverage needs of the services that

initiate them, thereby fostering continuity of care for their users (see Table 13).

Table 13. Source of referral for the patients.

DESCRIPTION	Total a.v.	(%)	I	S	B	P
Internal references	64	69.6	22	22	15	5
External references	9	9.8	7	1	1	0
Both internal/external	19	20.6	6	5	8	0
Total respondents	***92***	***100***	***35***	***28***	***24***	***5***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

The analysed groups predominantly exhibit homogeneity concerning the age group of the individuals under their care. Sixty-three per cent of these groups are specifically tailored to a particular age category, with a primary focus on the 'adult' demographic in the majority of cases (53.4%). Notably, this demographic constitutes one-third of the MFGs, with a higher prevalence in Italy (40%) compared to Belgium (25%). There is a considerable percentage of groups dedicated to the child-adolescent to early youth age groups (20.7% in the four countries, especially 25% in Belgium), while the representation of elderly individuals is minimal, and those few in this age group are accommodated within adult groups (refer to Table 14).

Table 14. Age spectrum of patients engaged in the MFG sessions. *There are 2 groups of 0- 18 years old.

DESCRIPTION	Total a.v.	(%)	I	S	B	P
Up to 12 years old	3	3.3	2	1	0	0
13-18 years old (adolescents)	16	17.4	5	5	6*	0
Adults	31	33.7	14	9	6	2
Old adults (more than 65 years old)	3	3.3	1	2	0	0
Others (e.g. under 25 or 15-25)	5	5.4	1	1	3	0
Total responses	58	63.0	23	18	15	2
Different age groups	34	37.0	12	10	9	3
Total respondents	***92***	***100***	***35***	***28***	***24***	***5***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

It is intriguing to scrutinise participants in the groups concerning their family role or proximity to the patient's family. The presence of the patient's parents is predominant in the vast majority of the groups (93.5%). Additionally, the involvement of other relatives, such as siblings or cohabiting grandparents, and extended family members is noteworthy, accounting for 49 out of 100 cases.

Notably, over a third of participants consist of individuals who are not related to the family.

Significantly, in 65.2% of the groups, both close relatives residing with the person with a mental disorder and non-cohabiting relatives and individuals external to the family are concurrently present. On average, each MFG represents 3.4 different components from the aforementioned categories, rising to 4.4 in the five groups surveyed in Portugal (Table 15).

Table 15. Type of family relationships in MFGs.

DESCRIPTION	Total a.v.	(%)	I	S	B	P
Parents	91	98.9	34	28	24	5
Children	86	93.5	32	26	24	4
Other members who live with the patient	64	69.6	23	16	20	5
Other members of the extended family	45	48.9	11	18	12	4
People that do not belong to the family	32	34.8	7	10	11	4
Total responses	318	345.6	107	98	91	22
Members from both inside and outside the family	60	65.2	33	10	12	5
Mean value	3.4	-	3.1	3.5	3.8	4.4
Total respondents	***92***	***100***	***35***	***28***	***24***	***5***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

Examining the participants' diagnoses, there is a prevalence of groups with a diverse type of psychiatric disorders, numbering 73, in contrast to 19 MFGs that are tailored exclusively for a single disorder. Groups encompassing a broader spectrum of diagnoses are prominently featured across all countries, with a minimum of 9 out of 10 groups exhibiting this characteristic, except in Belgium, particularly Flanders. In this region of Belgium, there is a predominance of MFGs catering to a homogeneous clientele, specifically focusing on diagnoses related to drug addiction and eating disorders, which often involve a younger population, particularly adolescents (10 groups in Flanders). Wallonia, on the other hand, stands out for having more heterogeneous groups concerning diagnoses.

The prevalent diagnoses characterising MFG users at large are the more severe ones[14], including psychosis, severe affective disorders, and personality disorders, all with comparable frequencies[15].

[14] Wallonia exhibits the highest coefficient among the categories of group participants, standing at 4.7. Additionally, it demonstrates a heightened presence of both internal and external family members.

[15] According to McFarlane W.R. (2002) in 'Multifamily groups in the treatment of severe psychiatric disorders', The Guilford, New York-London, MFG is deemed the most effective long-term psychotherapeutic intervention for schizophrenia. McFarlane argues that the restoration of family ties is a challenging yet essential task, particularly with

Following closely in the ranking of quantitative values are anxiety disorders, obsessive-compulsive disorders, and post-traumatic stress disorder, occupying a middle position (see Table 16).

Table 16. Composition of MFGs regarding patients' diagnosis: Heterogeneity (Ht) and Homogeneity (Hm) in diagnoses.

DESCRIPTION	Total		I		S		B		P	
	Ht	Hm	Ht	Hm	Ht	Hm	Ht	Hm	Ht	Hm
Non-psychiatric	21	2	11	2	7	0	3	0	0	0
Psychotic	54	13	26	9	19	1	4	3	5	0
Affective disorders	57	11	23	9	22	0	7	2	5	0
Anxiety disorders	46	3	15	3	19	0	7	0	5	0
Trauma and stress- related disorders	33	4	11	4	13	0	7	0	2	0
Personality disorders	55	6	22	6	21	0	7	0	5	0
Obsessive-compulsive disorder	38	3	11	3	18	0	6	0	3	0
Substance use disorders	28	9	12	5	10	0	3	4	3	0
Eating disorders	28	9	8	3	15	0	4	6	1	0
Psychosomatic Disorder	28	2	6	2	16	0	4	0	2	0
Other	10	0	1	0	7	1	2	0	0	0
Total responses	398	62	146	46	167	2	54	15	31	0
More than one type of psychiatric disorder	73		33		26		9		5	
One type of psychiatric disorder		19		2		2		15		0
Total respondents	***92***		***35***		***28***		***24***		***5***	

Source: research FA.M.HE 2023.

7.1.5 Characteristics of the Multifamily Group

A primary characteristic of the MFG lies in its open-closure dynamic concerning the possibility of entry and/or departure at any point during the group's existence. The MFG can be open, allowing users and families to enter freely throughout its duration. In this scenario, it is also considered permanent, facilitating the evolution of users and the team over time and across various sessions, while remaining a stable component of a therapeutic organisation. Alternatively, a group may adopt a closed status, restricting entries to those agreed upon at the beginning of the experience.

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chronic psychotics.

In this case, it tends to be temporary, concluding at the end of a particular phase. Examples include MFGs with the pre-established goal of transforming into a self-help group or those operating within a short time frame (15-20 sessions) with a homogeneous group in terms of diagnosis, such as an anorexia nervosa or borderline group.

Some groups exhibit diverse characteristics, as observed in this survey, drawing from various models and orientations related to specific therapeutic schools, operational contexts, or the diverse characteristics of participants within this therapeutic framework. These groups may operate on the fringes or outside the mental health services system (e.g., addressing substance dependence or pathological gambling under appropriate services) while still contributing to the pursuit of mental health as an integral part of overall health and well-being, as defined by the World Health Organization (WHO).

In the majority of cases examined, the MFG adopts an 'open' model, a pattern more prevalent in the Italian (80%) and Portuguese (4 out of 5) experiences compared to the Spanish (50%) and notably the Belgian (29%) experience, primarily observed in Flanders. Spain distinguishes itself for the prevalence of many 'slow-open' entities (62%) (Table 17).

Table 17. Configurations of MFGs regarding open or closed dynamics.

DESCRIPTION	Total		I	S	B	P
	a.v.	(%)				
Open	53	57.6	28	14	7	4
Closed	18	19.6	5	1	12	0
Semi-open	21	22.8	2	13	5	1
Total respondents	***92***	***100***	***35***	***28***	***24***	***5***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

Conversely, no more than a third of all MFGs incorporate phases where alterations in participation, operational methods, or other aspects take place. Among these cases, half (15) outline a predetermined number of sessions for each phase. Notably, in the majority of these instances (67%), users actively participated in every stage (Table 18, Table 18.1, and Table 18.2).

Table 18. Existence of group phases.

DESCRIPTION	Total		I	S	B	P
	a.v.	(%)				
Yes	30	32.6	8	7	15	0
No	50	54.3	19	17	9	5
Omitted	12	13.0	8	4	0	0
Total	***92***	***100***	***35***	***28***	***24***	***5***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

Table 18. 1. (If yes) Is there a fixed number of sessions?

DESCRIPTION	Total		I	S	B	P
	a.v.	(%)				
Yes	15	50.0	3	0	12	0
No	15	50.0	5	7	3	0
Total	***30***	***100***	***8***	***7***	***15***	***0***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

Table 18. 2. (If yes) Are the patients present in every phase?

DESCRIPTION	Total		I	S	B	P
	a.v.	(%)				
Yes	20	66.7	8	0	12	0
No	10	33.3	0	7	3	0
Total	***30***	***100***	***8***	***7***	***15***	***0***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

Regarding the current operational mode of the group following the COVID-19 emergency, there is a notable preference for in-person, in-person meetings (74%), indicating a slight deviation from the pre-COVID-19 period (76%), with no significant variations observed among different countries. Undoubtedly, the experimentation with new meeting methods facilitated by digital technology has brought about some changes compared to the pre-pandemic era. Presently, 19 MFGs utilise online tools or alternate between online and in-person modes. While the online mode proves valuable in emergencies, it may not be the optimal choice for this type of meeting, where individuals' non-verbal expressions and emotional reactions are likely compromised (refer to Table 19).

Table 19. Modality of MFG meetings, pre- and post-COVID-19.

	Total		I		S		B		P	
DESCRIPTION	Pre-Covid	Post-Covid	Pre-Covid	Post-Covid	Pre-Covid	Post-Covid	Pre-Covid	Post-Covid	Pre-Covid	Post-Covid
In-person	70	68	26	25	24	20	17	23	3*	0
Online	5	9	4	4	0	5	1	0	0	0
Mixed	1	10	1	6	0	3	0	1	0	0
Omitted	16	5	4	0	4	0	6	0	2	5
Total respondents	***92***		***35***		***28***		***24****		***5***	

Source: research FA.M.HE 2023

Concerning the group size in terms of the number of participants, MFGs with fewer than 10 people are infrequent, and those with over 30 users are even scarcer (constituting less than 20%). The predominant average size, ranging between 10 and 30 participants, is evident across groups in each country (65%). This size strikes a balance, being small enough to foster a positive atmosphere of spontaneity and confidentiality among those present, yet large enough to withstand the potential, even momentary, absence of some participants. The largest groups are found in the Spanish experience, which also boasts a longer history. The Italian situation occupies a middle position, while Belgium (with a significant contribution from Walloon Groups) is in a medium-low position. The 5 Portuguese MFGs fall within a medium-high range (Table 20).

Table 20. Number of participants per MFG.

DESCRIPTION	Total a.v.	(%)	I	S	B	P
Less than 10	17	18.5	8	0	8	1
Between 10 and 30	60	65.2	25	18	15	2
More than 30	15	16.3	2	10	1	2
Total respondents	***92***	***100***	***35***	***28***	***24***	***5***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

The frequency and duration of meetings represent another aspect of significant variability among different multifamily groups. A short periodicity predominates, with meetings occurring weekly or, at most, fortnightly in 7 out of 10 groups. Two out of ten MFGs follow relatively less frequent meeting schedules, particularly every month. Distinct differences between countries are evident in this regard: Italy encompasses groups that meet most frequently, either weekly (54%) or fortnightly (34%), followed by Spain. In contrast, Belgium (especially Wallonia) and Portugal show less frequent encounters (see Table 21).

Table 21. Frequency of sessions and average duration (in minutes). *Excluding 5 groups who organise meetings with the duration of one day.

DESCRIPTION	Total a.v.	(%)	I	S	B	P
Weekly	30	32.6	19	9	2	0
Fortnightly	34	37.0	12	11	9	2
Every 3 weeks	3	3.3	0	1	2	0
Monthly	19	20.6	3	7	6	3
Other	5	5.4	0	0	5	0
Omitted	1	1.1	1	0	0	0
Total respondents	92	100	35	28	24	5
Duration session (average in minutes)	***100***	***-***	***98***	***91***	***106****	***90***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

Diverse meeting frequencies can be attributed to the theoretical-operational models of reference. Those adopting a systemic-relational perspective generally meet monthly, while those employing a psychoeducational approach opt for biweekly meetings, and multifamily psychoanalysis groups convene weekly.

Equally intriguing are the findings concerning the duration of MFG meetings. Existing literature suggests that meetings typically last from one and a half to two hours, aligning with the average times recorded in this research - around 100 minutes with minor variations across the four countries. Portugal's MFGs exhibit the shortest duration, while Belgium's groups have the lengthiest meetings.

Regarding meeting times, a significant majority (68.5%) schedule meetings during working hours, with Spain leading in this aspect (82%). This contrasts with holding meetings at various post-work hours, which might attract a broader range of participants. Belgium, particularly the Wallonia region, aligns closely with this approach (see Table 22).

Table 22. Meeting times of the MFGs.

DESCRIPTION	Total a.v.	(%)	I	S	B	P
Working hours	63	68.5	25	23	11	4
Post-work hours	28	30.4	10	5	12	1
Omitted	1	1.1	0	0	1	0
Total	***92***	***100***	***35***	***28***	***24***	***5***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

An essential aspect for MFGs is to have a meeting place that is spacious, comfortable, and adaptable to the dynamics emerging in the 'emotional' space of collective sessions. Queries directed at MFG representatives revolve around the characteristics of their meeting space: Is it sufficiently sized and equipped to ensure the comfort and participation of everyone? Can it guarantee confidentiality? The responses generally indicate a favourable situation: the meeting room is multipurpose for 6 out of 10 MFGs - an environment typically free from health-related issues, adequately sized and comfortable, with ample seating and conducive to providing conditions of privacy and confidentiality. Belgium, especially the Flanders region, stands out in this regard, with many cases featuring a dedicated psychotherapeutic room for these meetings (refer to Table 23).

Table 23. Meeting space properties: place, adequacy, capacity, and privacy conditions.

ROOM DESCRIPTION	Total a.v.	(%)	I	S	B	P
Group room/psychotherapeutic room	19	20.7	1	4	12	2
Medical office	2	2.2	0	0	0	2
Activity room	12	13.0	9	2	0	1
Multipurpose room	54	58.7	23	21	10	0
Other	5	5.4	2	1	2	0
Total respondents	92	100	35	28	24	5
ADEQUACY						
Yes	88	95.6	33	26	24	5
No	4	4.4	2	2	0	0
CAPACITY						
Yes	91	98.9	35	27	24	5
No	1	1.1	0	1	0	0
CONDITIONS OF APPROPRIATE PRIVACY						
Yes	89	96.7	33	27	24	5
No	3	3.3	2	1	0	0

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

Equally important is a seating arrangement that facilitates communication among all participants. Regardless of the group's size, there is a close collaboration with one or two families at a time, harnessing the collective 'emotional power' of participants who, even when not actively participating, convey emotions non-verbally. Moreover, they can internalise the situations and experiences of others, fostering a reflective process. In 78% of cases, chairs are arranged in a circle, and sometimes in two or more concentric circles (15%). Less frequently, individuals are seated around a table, and rows of chairs are rarely utilised (Table 24).

Table 24. How are the chairs placed?

DESCRIPTION	Total a.v.	(%)	I	S	B	P
One circle	72	78.3	28	23	17	4
Two or more concentric circles	14	15.2	7	5	2	0
Around a table	11	12.0	4	1	5	1
Other	3	3.3	2	1	0	0
Total responses	100	108.7	41	30	24	5
Total respondents	***92***	***100***	***35***	***28***	***24***	***5***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

The MFGs exhibit an average age slightly surpassing 8 years, but the median data in the distribution of seniority suggests a history not exceeding 6 years. Hence, this experience is still in the process of consolidation. On the other hand, 65% of these groups report having experienced an interruption at some point in their history (see Table 25).

Table 25. Was there any interruption since the beginning?

DESCRIPTION	Total a.v.	(%)	I	S	B	P
Yes	60	65.2	23	18	14	5
No	32	34.8	12	10	10	0
Total respondents	***92***	***100***	***35***	***28***	***24***	***5***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

While the prevailing reason for these forced interruptions is attributed to the COVID-19 emergency period (80%), a third of the responses point to other causes, with limited human resources being the most significant among them. These interruptions have also impacted the context or characteristics of the groups in 63% of cases. Out of 34 representatives explaining the changes caused by interruptions, 16 cite the COVID-19 effect. This effect resulted in alterations in interaction methods, shifting from face-to-face to remote interactions, which also had an impact on decreased participation. In some instances, two or more groups were unified, and in one case, the group transitioned to a permanent online format. Other minor reasons for interruptions include a reduction in participants, leading to their departure from the group (7 responses), indicative of precarious stability. Changes in meeting rooms for more spacious and comfortable ones, conductor rotations, transitions from closed to semi-open groups, or the evolution from an old group effectively closing its activity to make way for a rejuvenated youth group are additional factors contributing to interruptions (refer to Table 25.1, Table 25.2).

Table 25. 1. If yes, what were the reasons?

DESCRIPTION	Total a.v.	(%)	I	S	B	P
Physical space constraints	0	0	0	0	0	0
Human resources constraints	12	20.0	7	0	4	1
Pandemic	48	80.0	17	16	11	4
Other	7	11.7	4	2	1	0
Total responses	67	111.7	28	18	16	5
Total respondents	***60***	***100***	***23***	***18***	***14***	***5***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

Table 25. 2. Have these interruptions changed the context/characteristics of the group?

DESCRIPTION	Total a.v.	(%)	I	S	B	P
Yes	38	63.3	12	15	8	3
No	22	36.7	11	3	6	2
Total respondents	***60***	***100***	***23***	***18***	***14***	***5***

Source: research FA.M.HE 2023. a.v. = absolute value; % = relative value.

7.1.6 Comparative Reading Between the MFGs of Different Countries

A final comprehensive table outlines the MFG profile for each of the four countries, summarising the prevailing responses for comparison (Table 26).

Table 26. Comparison between the MFGs of different countries.

DESCRIPTION	ITALY	SPAIN	BELGIUM	PORTUGAL
Years of activity (average)	8.6	10.6	6.1	8.6
Administrative structure	Public	Private	Private	3 Public (2 Private)
Type of structure	Community Health Centre	Community Health Centre	Psychiatric Hospital	3 General Hospital- Psychiatric Service
Type of service assistance	Outpatient	Outpatient	Inpatient ward; Daycare hospital	Inpatient ward; Daycare hospital
Objectives of MFG	Psychotherapeutic	Psychotherapeutic	Support;	Psychotherapeutic

			Psychoeducational	
Educational qualifications	Psychologist Social services workers	Psychiatrist	Nurses	Psychologist, Psychiatrist, Nurses
Average number of therapists/ figures present in MFGs	2.7	2.7	3.1	2.8
Theoretical background of MFG	Multifamily Psychoanalysis	Multifamily Psychoanalysis	Systemic theory Psychoeducation	Multifamily Psychoanalysis and others
Type of psychotherapeutic background of team members	Systemic therapy, Psychodynamic Therapy, and Psychoanalysis	Group Analysis, Psychoanalysis, and other group therapies	Systemic therapy and cognitive behavioural psychotherapy	Psychodynamic therapy
Composition of the MFG team	1 conductor and co-therapists	2-3 conductors or more co-therapists	Only co-therapists	Conductors and co-therapists
Supervision	Internal and/or external	Internal and/or external	No supervision	Supervision (1)
Age class of patients	Adults	Adults	Adults and adolescents	Adults
Type of family relationship	Parents, children and members that live with the patient.	Members from the extended family	Members who live with the patient People that do not belong to the family	Members who live with the patient
Number of family members, relatives and non-family members	3.1	3.5	3.8	4.4
Type of group	Open	Slow-open	Closed	Closed, open, and

				slow-open
Does the group have stages?	No	No	Yes	No
Number of patients per group	10 to 30	More than 30	10 to 30	30 or more
Session frequency	Weekly	Fortnightly	Every 3 weeks or monthly	Monthly (3)
Session duration (average, in minutes)	98	91	106	60-120
Period of the day	During working hours	During working hours	After work	During working hours
Place or room of the group	Multipurpose room	Multipurpose room	Psychotherapeutic room	Psychotherapeutic room or multipurpose room
How are the chairs placed?	Circle	Circle	Circle	Circle
Was there any interruption since the beginning?	Yes	Yes	Yes	Yes
Source of referral for participants	Internal references	Internal references	Internal references (only Vallonia)	Internal and external references

Source: research FA.M.HE 2023

Italy

The MFG operates as an extension of the Mental Health Centre within the public institution, providing territorial outpatient assistance with a strong emphasis on psychotherapeutic intervention. The inclusion of psychologists is pivotal, and their presence is more pronounced, particularly with support from social service workers. On average, the Italian MFG involves 2.7 professional figures, more than in the other countries, and is led by at least one facilitator/conductor in addition to co- therapists, subject to internal and/or external supervision.

While the theoretical approach of the MFG is primarily psychoanalytic, therapists also incorporate systemic and psychodynamic therapeutic elements into their practice. The user base primarily consists of adults with severe mental disorders, reflecting the demographic of the local mental health service. The Italian MFG exhibits heterogeneity in user diagnosis composition, adopting an open and generally permanent structure without specific phases. It holds close, weekly meetings - a higher frequency compared to other countries - with an average duration of 98 minutes.

Family member participation in these groups is predominantly from cohabiting members. In terms of the number of participants, the Italian group falls within a distinctly 'medium' size range, accommodating 10 to 30 units. Meetings occur during working hours in a spacious and comfortable room, with a seating arrangement that encourages circular communication. The group has experienced inevitable interruptions due to pandemic constraints, and, slightly more than in other

contexts, has been affected by a reduction in human resources.

Spain

On average, Spain stands out as the country where the MFG has established itself the longest, with an average duration of nearly 11 years. Managed by private legal entities, often for-profit, these entities are actively engaged in outpatient facilities within the region, prioritising psychotherapeutic responses. The pivotal figure in the MFG is the psychiatrist, collaborating with two other practitioners. The guiding theoretical approach aligns with multifamily psychoanalysis, sharing common ground with the Italian experience. The training background encompasses group analysis, psychoanalysis, and various other theoretical approaches.

The Spanish MFGs are facilitated by multiple conductors and/or co-therapists, employing internal and/or external supervision. Users within the groups are internal to the service, comprising adults grappling with severe pathologies, participating alongside extended family members. The Spanish MFGs adopt a semi-open structure, devoid of distinct cycles, and are notably the largest in terms of average participants, with no group having fewer than 10.

Meetings occur at a relatively close frequency, generally bi-weekly, with durations slightly below the general average of 91 minutes. Sessions are scheduled during working hours, taking place in a comfortable meeting room with circular seating arrangements.

Belgium

In this country, the data encompasses two distinct geographical areas, Flanders and Wallonia, each governed by different mental health policies, resulting in notable differentiations in the organisation and management of MFGs. These variations are elaborated upon in the comments associated with each indicator. Belgium, overall, represents the most recent establishment of group units, potentially reflecting the historical prevalence of inpatient or day hospital structures in psychiatry. The MFG, integrated into traditional psychiatric structures, provides assistance similar to a hospital ward, with a primary intervention objective of psychoeducation, more pronounced than in other regions. The nurse plays a crucial role in the group, collaborating with two other figures, with the psychologist featuring more prominently than the psychiatrist.

Belgium's groups operate with a systemic therapeutic vision, a significant component of staff training alongside cognitive-behavioural psychotherapy. Notably, these groups are led by pairs of co-therapists without a designated conductor, and they do not undergo any form of supervision, except for occasional peer supervision.

The Belgian groups are particularly characterised by the homogeneity of their users, often dealing with addictions, eating disorders (following a psychoeducational model), or mood problems. Unlike other regions, their users are not exclusively adults. Operating as 'closed' groups, they maintain a stable user base, participating in cycles and affiliated with the body managing the group. While these groups have faced interruptions, they were fundamentally linked to the pandemic emergency. The temporal frequency of meetings tends to be extended (every three weeks or a month), with durations averaging over 100 minutes. Meetings are scheduled after working hours to facilitate the participation of family members and other close relatives of the users. Taking place in dedicated psychotherapy rooms, these sessions adopt a more professional atmosphere, fostering face-to-face dialogue among all participants.

Portugal

In Portugal, only five MFGs were identified, leading to challenges in comparability with others and limited visibility of peculiarities. Active for just under 9 years on average, these groups are situated in public facilities, primarily within the psychiatric department of general hospitals, and exclusively pursue psychotherapeutic objectives. In alignment with the Belgian context, these MFGs involve nearly three professional figures and do not incorporate supervision. They operate as slow-open groups without distinct cycles, comprising users from the services in which they are based, all coping with serious disorders.

These groups extend beyond cohabiting family members, encompassing the entire parental circle, with an average of 4.4 different participants. Meetings occur on a monthly and fortnightly basis, lasting an average of 90 minutes, and are scheduled during working hours. Sessions take place in a conducive environment where participants can engage in direct communication and make eye contact.

7.1.7 Final Considerations

After reviewing the data pertaining to the experiences of the 92 Multifamily Groups, an initial assessment of this recent phenomenon can be attempted, since it has not been thoroughly explored through comprehensive and representative research across various geographical areas and models. Undoubtedly, a more in-depth understanding of this phenomenon is necessary to subsequently formulate guidelines that delineate boundaries and internal rules for the groups, aiding them in moving beyond a phase of experimentation. Furthermore, the foundations for such an investigation exist today, given the diverse array of experiences emerging from this initial survey.

The examined data portrays Multifamily Groups (MFGs) as a dynamic and expanding phenomenon in recent years. This growth is attributed to the multitude of services adopting it, the diverse theoretical reference models, organisational typologies, and specialisations in specific disorders. These therapeutic entities are present in various mental health facilities, encompassing local, daytime, residential, and inpatient services, deriving from both public and private, for-profit, and non-profit organisations. The MFG serves as an integrative and innovative device, transforming traditional treatments based on individual or dual (child and parent) care, by considering the suffering individual within the context of their life and relationships. This approach aims to address family dynamics, emotional tensions, and developmental blocks, and foster 'mutual self-help' resources among all participants, guided by a therapeutic framework and rooted in circular communication.

The theoretical models supporting these groups are diverse and often hybrid, permeable to one another. Therapists' training backgrounds also encompass an eclectic array of techniques and therapeutic models. Despite the varied operational methods of the groups, some commonalities exist: psychotherapy as a central intervention, the pervasive role of psychologists (present in 9 out of 10 MFGs), collective management by at least two professional figures, a manageable average group size (up to 30 people, therapists excluded), and the use of spacious meeting rooms to facilitate communication. Additionally, the aggregation of three family figures (user, cohabiting, and non-cohabiting family members), the regularity of meetings (mostly weekly or fortnightly), and the openness or semi-openness of the groups characterise them as permanent groups. Closed groups typically address users with specific problems, exhibiting homogeneity in diagnosis and/or age group, often focusing on young people. Some groups experienced interruptions, notably due to the pandemic. Internal or external supervision remains less widespread, primarily occurring informally

among the therapists.

The age group of the users aligns with the services they predominantly seek, primarily comprising adults with severe diagnoses. The satisfaction of internal users' therapeutic demand indicates that the Group is viewed as an integrative rather than an alternative therapeutic element in treatment.

The research reveals variations between groups in different countries and within the same country (as in Belgium, between Flanders and Wallonia), emphasising the impact of local experiences on the composition, intervention strategies, and user profiles, reflecting the contextual needs. These differences represent nuances or variations within a generally shared MFG model across diverse experiences.

In summary, this first survey on MFGs, combined with an in-depth qualitative study of focus groups, not only provides preliminary insights into the phenomenon but also lays the groundwork for subsequent research. This future research, based on a statistically representative sample and guided by a methodologically rigorous design with predefined objectives and indicators, would utilise previously tested instruments and be conducted by a reputable research organisation. Such a research effort should examine thoroughly the choices and evaluations of MFG promoters and organisers and promote reflection on the results and their impact indicators, in terms of responses to needs and the influence on the mental health services system.

7.2 FOCUS GROUPS

After disseminating and compiling the questionnaire results, the four partners conducted two types of focus groups (FGs): one involving therapists and the other involving MFG users (patients and families).

7.2.1 Focus Group Framework

The focus group is an interview conducted by a moderator, sometimes accompanied by an observer, typically lasting an average of two hours. The number of participants may vary; the larger the group (e.g., around ten to twelve participants), the more diverse opinions emerge, resulting in a greater wealth of ideas. Conversely, in smaller groups, there is a higher potential for in-depth analysis and openness, particularly when addressing delicate issues. A focus group presents both advantages and disadvantages:

Advantages:

- Speed and cost-effectiveness;
- Mutual stimulation among participants;
- Interaction between participants.

Disadvantages:

- Potential creation of inhibitions among participants;
- Collection of more numerous but less detailed insights compared to individual interviews;
- The need to ensure that everyone can speak.

The group must be homogeneous in terms of social and cultural stratification, and the participants should not work together. Specific stimulus questions guide the conversation, allowing for a deep

dive into specific topics and keeping the discussion within the research themes. A focus group is led by a moderator and involves the participation of two observers, each with specific roles:

Role of the moderator:

- Leading the conversation;
- Encouraging discussion among all participants;
- Facilitating the participation of all;
- Preventing the discussion from being dominated by a conductor;
- Maintaining a position of neutrality;
- Refraining from expressing personal opinions and evaluations.

- Role of the observer:
- Managing the reception of participants;
- Recording the meeting;
- Writing notes on relevant issues that arise;
- Supporting the moderator as needed.

Each partner planned and prepared the focus groups in their respective countries, determining dates, hours, locations/modalities, and establishing objectives and methodology. Invitations were extended to a greater number than necessary to account for potential absences.

7.2.2 Focus Group Planning and Methodologies

The four partners unanimously decided to adopt a common methodology, namely the SWOT Analysis. This approach enabled each participant to articulate their perspectives, analysing the strengths and weaknesses of MFGs, both internally and externally to the context. Within the SWOT framework and drawing from the primary findings of the questionnaire, each partner formulated statements/topics to serve as a guide throughout the conversation.

The sessions of the various focus groups (FGs) were conducted in three modalities: in person, online (via the Zoom platform), and in hybrid mode (solely by the Belgium partner). The Zoom sessions were recorded with the awareness and consent of all participants.

The FGs in Italy and Portugal each had one moderator and two observers. The Belgium FGs were led by external moderators and included two observers. The Spanish FG1 had one conductor and one observer, while the Spanish FG2 had a conductor and a co-conductor as moderators, with several practising psychologists serving as observers. Italy and Portugal each organised two focus groups, one for therapists and another for users. The Portuguese FG2, targeting MFG users, did not include patients but involved therapists and family members of former patients. In both Flanders and Wallonia, two focus group sessions were organised with an interval of about a month, totalling four focus group sessions, conducted in two national languages (Dutch and French). During the initial meeting, a SWOT analysis was conducted based on the results of the questionnaire. In the second meeting, a more in-depth examination of the findings from the first focus group took place. An anonymised transcript was created from the recorded sessions.

Below are two tables, presenting respectively: Focus Groups planning (Table 27), and Focus Groups Methodologies and Topics followed by the four countries (Table 28).

Table 27. Focus Group Planning. *The Spanish FG2 was moderated by a conductor and a co- conductor, and the observers were several practising psychologists.

Country	FG	Modality	Length (min)	Participants /Invitations	Invited	Present	Moderator /Observers
Italy	FG1	Online (Zoom platform)	180	MFG conductors who had completed the questionnaire.	34	9	1 Moderator; 2 Observers.
	FG2	In-person (LIPsiM headquarters)	180	MFPG users (patients, parents, family members and caregivers from public and private social sectors).	18	12	1External Moderator; 2 Observers.
Belgium	FG1	Online (Zoom platform)	90	Experts (those who have published) and questionnaire respondents. FG1 was subdivided into 4 groups: FG1.1 – Flanders; FG1.2 – Wallonia; FG1.3 - Wallonia (in-depth analysis); FG1.4 - Flanders (in-depth analysis).	FG1.1 - 11 FG1.2 - 13 FG1.3 - 9 FG1.4 - 12	FG1.1 - 11 FG1.2 - 13 FG1.3 - 9 FG1.4 - 10	1 Moderator; 2 Observers.
Spain	FG1	Online (Zoom platform)	180	Professionals working in MFPG, relying on the ideas and experiences provided by Multifamily Psychoanalysis (J. García Garcia Garcia Badaracco) and other theoretical contributions (Group Analysis, General Theory of Systems, Theory of Attachment, Open Dialogue, etc.).	23	14	1 Moderator; 1 Observer.
	FG2	In-person (Day Hospital of the Uribe Costa Centre for Mental Health)	-	FGs with MFG users - a conductor, a co-conductor, several psychologists in practice and families.	-	60 - 70	2 Moderators; Several observers*.
Portugal	FG1	Online (Zoom platform)	90	MFPG conductors with MFPG experience.	12	6	1 Moderator; 2 Observers.
	FG2	Online (Zoom platform)	90	MFPG family members and therapists with MFPG knowledge, but without MFPG experience.	16	7	1 Moderator; 2 Observers.

Source: research FA.M.HE 2023

Table 28. Focus group methodology and addressed topics.

Country	FG	Methodology	Topics
Italy	FG1	SWOT analysis – Three topics emerged as significant and defining elements of the majority of MFPG experiences represented in the questionnaires.	Involvement of at least two generations, including individuals currently being treated for mental health problems; Presence of a management team; Activation of an exchange space between conductors immediately following the meeting of the MFG (Post-Group).
	FG2	SWOT analysis - The examination was conducted using two of the topics, which were considered more assessable by users. The third topic proposed to the sample of conductor/facilitator (activation of a post-group) appeared difficult to evaluate by the users as it concerns a moment of the multifamily meeting usually reserved for the management team.	Involvement of at least 2 generations, including individuals currently being treated for mental health problems; Presence of a management team.
Belgium	FG1	Two focus groups were conducted, with an interval of about one month, in Flanders and Wallonia regions. In total, four meetings were held with MFPG therapists (2 in Dutch and 2 in French). During the first two meetings, corresponding to the FG1.1 and FG 1.2, a SWOT analysis was done, based on the results of the questionnaire. In the second meetings (FG 1.3 and FG 1.4), a thorough examination of the findings from the first meeting took place. An anonymised transcript was generated from the recorded session.	Dealing with different requests for help within a single system; Resistances to work with an MFPG; Need for supervision/Intervision; Current needs around MFPG.
Spain	FG1	SWOT analysis based on the extensive experience of conductors/coordinators. The discussion centred around 3 key topics, which correspond to the qualitative responses from the questionnaire. Preliminary note: The participants refer to the importance of the emotional climate, a factor not explicitly addressed in the questionnaire, and the type of interventions, emphasising the 'conversation' over interpretations aimed at revealing the unconscious.	Involvement of at least 2 generations, including individuals currently being treated for mental health problems; Regarding the presence of a management team; The exchange between conductors after the meeting (post-group).
	FG2	In their usual space (MFPG) and at the prearranged day and time, participants were asked to make decisions	What were your expectations when invited to participate in the MFG, and what benefits have you derived from

		regarding three topics.	attending? How do you conceptualise mental illness, and what contributions can MFG make towards improvement? Do alterations in family dynamics correlate with improvements in the family situation?
Portugal	FG1	Four questions were addressed to the participants, following the SWOT analysis.	Strengths (Advantages): What characteristics of MFPG make it an advantageous psychotherapeutic device over other psychotherapeutic interventions (internal - families/team/service; and external - institution/community)? Weaknesses (Disadvantages): What characteristics put MFPG at a disadvantage compared to other psychotherapeutic devices? (Internal - families/team/service; and External - institution/community). Opportunities: What aspects should be emphasised in MFPG, as a psychotherapeutic approach in mental health, to make it easier to adhere to it? Or, to what extent can working with MFPG contribute to the transformation of: families/team/service; and institution/community? Threats: In what ways can MFPG be a threat (internal/external)?
	FG2	Four questions were addressed to the participants, following the SWOT analysis.	The participants in FG2 were asked the same questions as the participants in FG1.

Source: research FA.M.HE 2023

7.2.3 Focus Group Results and Conclusions

Across all countries, the focus groups (FGs) yielded a consensus that Multifamily Groups (MFGs) offer benefits but also present challenges that require resolution. These findings apply to all participants in MFGs, including caregivers, families, and individuals undergoing treatment. A common finding was the perceived significance of having more than one generation involved in MFGs, identified as the primary advantage of these groups due to its fundamental role in easing access to transgenerational knots.

Furthermore, unanimous agreement exists on the various benefits experienced by participants, including families (patients included), therapists, and institutions. Spain underscores MFGs' contribution to enhancing tolerance, respect for diversity, and solidarity with those who suffer. Italy highlights the development of empathy, the ability to establish and maintain healthy boundaries, and to express emotions. Belgium and Portugal emphasise the transformative potential of MFGs, particularly in developing new and healthier identifications, in particular, developing and

transforming pathological patterns in intra-family relationships and communication. All four countries

affirm that MFGs offer clear clinical advantages, both diagnostically and in terms of recovery time, making them more cost-effective for institutions.

Regarding the challenges encountered, Belgium and Portugal mention potential difficulties such as the lack of suitable space for group sessions and insufficient training for therapists. Italy adds concerns about inadequate information on MFGs, limited specific training for operators (health professionals/therapists/caregivers), and potential impediments or resistances from institutions. Participants from Belgium and Portugal also mentioned that being large groups, MFGs could lead to difficulties for some individuals, especially those who struggle with self-expression or deal with issues that trigger shame, guilt, and stigma. Addressing family secrets and taboos can pose challenges, due to the fear of exposing oneself to one's family, as evidenced by Italy's observations. Various forms of resistance may emerge from both participants and institutions, reflecting an ongoing scepticism towards group psychotherapies. Concerning open, closed, or slow-open groups, Belgium and Portugal underscore that an open group might lead to the formation of large and diverse subgroups, making it challenging to ensure the consistent presence of participants.

The consistency of participants' presence influences group cohesion. Given that group cohesion is analogous to the therapeutic alliance in individual psychotherapy, establishing strong cohesion is desirable to create a climate of trust that facilitates participant adherence, attachment, and effective communication.

In summary, participants in focus groups in all countries agree that Multifamily Groups offer more benefits, advantages, and strengths than drawbacks or perceived threats.

7.3 BIBLIOGRAPHIC RESEARCH

7.3.1 National and International Methodology

A critical literature review pertaining to multifamily intervention in mental health was conducted, to guide partners in defining and delimiting web research, aligning with the research objectives and the project's Intellectual Output I. Common keywords, applicable across all partners, were identified and utilised, including Multifamily Groups, Multifamily Psychoanalysis Group, Multifamily Psychoanalysis, Multifamily Therapy, Multifamily Group Therapy, and Multifamily Group Treatment. These search terms were translated into each country's respective languages and supplemented with country-specific, relevant terms. Partners collectively decided to conduct searches in their national languages, extending the search beyond national borders for each language. The international bibliographic research encompassed multiple countries, employing English keywords for the search. An excerpt from the bibliographic search is provided in Appendix 6.

Search engines such as Google, Google Scholar, PubMed, Hall and Cairn were utilised for the research. In Spain, the bibliographic portal Dialnet was also consulted (Table 29). In Italy, associations dedicated to the development, study, clinical practice, and training in the Multifamily sector were identified according to various models represented in the research.

The recurring bibliographic items common to all partners comprise articles, books, and book chapters. Bibliography from Spain excludes dissertations and post-graduate work. Conversely, bibliographies from Belgium, France, Canada, Switzerland, and Portugal encompass monographs and Ph.D. thesis.

Table 29. Methodology.

Country	Common keywords	Specific keywords	Search engines
Belgium	Multifamily Groups (MFGs); Multifamily psychoanalysis (MFP); Multifamily Therapy (TMF).	Consultation Multi-Familiale (CMF); Thérapie Social e Multi- Familiale (TSM).	Google; Google Scholar; PubMed; Hall and Cairn.
Italy	Multifamily Groups (MFGs); Multifamily Psychoanalysis (MFP); Multifamily Therapy (TMF).		Google; Google Scholar; PubMed; Hall and Cairn.
Portugal	Multifamily Groups (MFGs); Multifamily Psychoanalysis (MFP); Multifamily Therapy (TMF).	Multifamily Psychoanalysis Group (MPG); Multifamily Therapy Group (MFTG); Multifamily Group Treatment (MFGT).	Google; Google Scholar; PubMed; Hall and Cairn.
Spain	Multifamily Groups (MFG); Multifamily Psychoanalysis (MFP); Multifamily Therapy (TMF).	Multifamily Psychoanalysis Group (MFPG); Multifamily Therapy Group (MFTG); Multifamily Group Treatment (MFGT).	Google; Google Scholar; PubMed; Hall Cairn; Dialnet.
International	Multifamily Groups (MFG); Multifamily Psychoanalysis (MFP); Multifamily Therapy (MFT).	Multifamily Psychoanalysis Group (MFPG); Multifamily Therapy Group (MFTG); Multifamily Group Treatment (MFGT).	Google; Google Scholar; PubMed; Hall and Cairn.

7.3.2 Quantitative Analysis of the Results in the Partners Language

Following the bibliographical survey conducted by each country, a comprehensive examination of the contents of each entry was carried out, to categorise the information based on theoretical orientation and practical application. The combined bibliography from the four partners yielded 177 entries for the selected keywords. Around 70% of these entries consist of published articles in magazines, bulletins, newspapers, periodicals and online publications, while the remaining entries are comprised of books, book chapters and monographs. The topics covered in the bibliography are diverse and were categorised into Theoretical Guidance (Table 30) and Practical Application (Table 30.1).

Table 30. Topics covered in the bibliography - Theoretical Guidance.

Multifamily Psychoanalysis.
Multifamily Therapy, theoretical and technical aspects influenced by García Garcia Garcia Badaracco's ideas.
A comprehensive explanation of the observed phenomena within the theoretical framework of the García Garcia Garcia Badaracco model and Multifamily Psychoanalysis.
Multifamily Group Therapy, theoretical and technical aspects.
The group as a therapeutic agent.
Intergenerationality.
Perspectives of patients, family, partners, therapists and observers who participated in multifamily groups.

Source: research FA.M.HE 2023

Table 30. 1. Topics covered in the bibliography – Practical Application.

Representative experiences in implementing the intervention model with multifamily groups.
Family psychoeducational approach.
Psychosocial rehabilitation.
Systemically oriented rehabilitation and Multifamily Groups.
Clinical applications of multifamily therapies and approaches.
Evidence base for Multifamily Therapy.
Therapeutic function and training.
Multifamily psychotherapy session led online.

Source: research FA.M.HE 2023

The interventions concern Justice, Educational, Community, and Health contexts (Table 31). These encompass diverse populations including adults, adolescents, and children (Table 32); individuals without psychiatric conditions or problems, and psychiatric patients in treatment (patients admitted to wards and day hospitals, as well as outpatients) (Table 32.1). Several groups were the target of therapeutic interventions (Table 33). The corresponding bibliography is presented in Appendix 6.

Table 31. Intervention Context.

Justice context	
Educational context	
Community context	
Health context	General hospitals, mental health services and psychiatric hospitals.

Source: research FA.M.HE 2023

Table 32. Population in the interventions – I.

Adults
Adolescents
Children

Source: research FA.M.HE 2023 Table 32. 1. Population in the interventions - II.

Table 32. 1. Population in the interventions - II.

General population, non-psychiatric conditions, and problems
Population in treatment of psychiatric disorders: hospitalised and day hospital, consultations.

Source: research FA.M.HE 2023

Table 33. Groups targeted by therapeutic interventions.

Children with psychological difficulties
Eating-disordered adolescents
Anxious school refusal in adolescents
Transgender teenagers
Teenage sex offenders
Major depression
Anorexia nervosa
Chronic disease
Chronic pain
Maternity
Chronic psychosis
Schizophrenia
Bipolar disorder
Alcohol dependence and family
Substance abuse patients and their children
Families and sexual abuse

Source: research FA.M.HE 2023

In conclusion, the bibliographical research in each partner's country revealed an evolving interest in multifamily groups. This evolution is attributed to the translation of Jorge García Garcia Garcia Badaracco's work, leading to the study and development of his theoretical and practical models based on the collective experience of working with families in each respective country. Simultaneously, the model's applicability expanded to diverse population groups, various social and community contexts, and different environments in health and illness. This inclusivity encompasses interventions related to psychiatric illness, organic pathology, and relational psychopathology, fostering further advancements in its implementation.

7.3.3 International Bibliographic Research

7.3.3.1 Historical Framework

In providing an international overview of the bibliography related to Multifamily Groups, three

broad categories can be distinguished:

- MFGs with a psychoeducational and cognitive-behavioural nature;
- MFGs of systemic and dynamic origin;
- Psychoanalytic MFGs.

Regarding psychoeducational groups, these present a widespread global dissemination, with the majority of published scientific works available in English.

Eia Asen, a professor at the Anna Freud National Centre, is considered the creator of systemic and dynamic groups. His contributions include the development of 'Mentalisation-Based Treatment with Families,' an approach empirically based on effectiveness studies conducted in collaboration with Peter Fonagy.

The cultural contexts where psychoanalytic MFGs, following the Argentine model, have developed the most are in Europe (Italy, Spain, Portugal and, more recently, Belgium) and South America, particularly in Argentina and Uruguay.

Regarding the fields of application, predominantly homogeneous groups can be identified, oriented towards specific diagnoses, and according to the course of the pathology, age groups, and the context of treatment. This category is mainly associated with psychoeducational MFGs. Concerning the systemic, dynamic, and psychoanalytic groups, there are diagnosis-oriented approaches and less selective approaches, which are accessed to patients with predominantly serious disorders.

Systemic and dynamic MFGs and psychoanalytic MFGs for serious disorders

Systemic and dynamic MFGs, as well as psychoanalytic MFGs, trace their origins to two distinct branches. The initial developments for both branches can be traced back to the 1960s. They originated from experiences conducted in psychiatric institutions for individuals with severe psychotic conditions.

Buenos Aires

Jorge García Garcia Garcia Badaracco's work commenced at the Borda Hospital in 1960, with its origins traced to the department he directed upon returning from his training period in Paris in 1958. Some biographies of García Garcia Garcia Badaracco place the foundation in 1962 of the aforementioned department, marking the inception of the first group he defined as multifamily psychoanalysis. However, he detailed the changes brought about by the groups in the ward climate starting from 1964: ‘the common room of my ward became the noisiest, unlike those of the other departments of the psychiatric hospital, which were characterised by autism and isolation’ (García Garcia Garcia Badaracco, 1989). García Garcia Garcia Badaracco identified a phase of significant resistance among the patients. Then, he observed that ‘typically infantile situations began to appear as soon as a climate of basic trust and emotional security was created, that is to say, when the community became an adequate psychological container for the patients who leave defensive attitudes, renouncing pathological omnipotence and accepting to take part, in some way, in the new experience’ (García Garcia Garcia Badaracco, 1989). During this phase, the so-called inclusion of the family into the treatment context occurred, also integrating work and experiences that had given rise to family and systemic therapy since the 1950s. ‘We discovered that the patients' families, even if they had sufficient adaptive abilities, which made them appear suitable for social life, were immature beings, who in group situations presented important psychological difficulties

on an emotional level, particularly in interpersonal relationships'. All subsequent observations and theoretical developments led to García Garcia Garcia Badaracco's first monograph in 1989, later translated into Italian in 1997 by the Franco Angeli publishing company. The multifamily psychoanalysis groups described by García Garcia Garcia Badaracco are distinguished by their specific focus on treating severe disorders, including psychosis and personality disorders, covering various diagnoses and human suffering, along with the diversity of patients and family members involved. The numerous clinical cases detailed by García Garcia Garcia Badaracco stand as evidence of the effectiveness of his groups and the therapeutic process initiated during multifamily psychoanalysis sessions.

New York

Peter Laqueur, in his works published between 1964 and 1980, references his first multifamily therapy group. His description of the origins is the following: 'In 1951, when I was the director of a department for the clinical treatment of schizophrenic patients, between the ages of 12 and 52, in a large hospital in the New York area, every Sunday the parents, and sometimes the brothers and sisters, uncles, aunts, etc., of these patients visited the hospital, and during visiting hours they saw me, each in turn, for a few minutes so that I could reassure them, give them hope, and try to explain the techniques and medications used to change the psychotic state of the patients.'. 'When we discovered these feelings in the group, we decided to do something which was altogether taboo in the period: We had all the patients and all their visitors join us for two to two-and-a-half hours in an open discussion of all questions related to schizophrenia, to treatment methods, to problems during the patients' stay in the hospital, and those of the future when the patients would go home again, their employment, their possibilities for marriage and for having children, etc. We perceived that sometimes the so-called "healthy" members of the families were almost as sick as the patients themselves, the main difference being that the patients had been the first ones to be sent to the hospital. To prevent the frequent return of our patients to the hospital after having gone home, it became necessary to treat their families as well as them. We formed groups of four of five hospitalized patients and their families and met with them weekly in therapeutic sessions throughout the patient's stay in the hospital. During 17 years of this work with hospitalized patients and their families, we were able to reduce the number of readmissions to the hospital by 80%. Sometimes discharged patients and their families continued to participate in these multiple family therapy sessions and gradually, as our method became better known, multiple family therapy groups were formed in clinics and offices with ambulatory patients and their families' (Lewis, 2021). It is from Laqueur's efforts that MFGs evolved, by integrating his observations with those of the familiarists, on the one hand, and the psychoeducational approach of McFarlane, on the other. The intensive model of multifamily therapy merged into various experiences, including the one developed by Alain Cooklin in 1982 in the Marlborough Family Service in London. Subsequent developments led to specialisations of the method in the field of eating disorders (Scholz and Asen 2002; Dare and Eisler 2000; Scholz and Asen 2001; Slagerman and Yager 1989; Wooley and Lewis 1987), alcohol and substances (Schaefer 2008), chronic systemic diseases (Steinglass, 1998), Huntington's disease (Murburg et al. 1988) and abused children (Asen et al., 1989).

7.3.3.2 Results

From this comprehensive international research, a clear pattern emerges: the multifamily approach has generated significant interest among researchers and professionals. These individuals have incorporated their personal experiences and training into this method of addressing mental disorders and psychological distress.

Over time, group therapy has steadily gained prominence in terms of therapeutic effectiveness, evolving into a dynamic and progressive working method. The concept of 'groupality,' centred around the family as a constitutive member rather than focusing solely on the individual, holds innovative significance. It introduces the idea that suffering, mental distress, and disorder are not confined to an individual but exist within a system of relationships, often encapsulated by the family, which, in turn, is interconnected with its environment and history.

Despite the 70 years of existence, resulting in diverse working methodologies that are challenging to systematise and integrate, this approach is still considered innovative. The analysis of scientific literature and published books led to the categorisation of results into three main sections:

a) Annotated Bibliography on Multifamily Psychoanalysis.

b) Annotated bibliography on systemic and dynamic Multifamily Groups: This section incorporates a diverse range of scientific works and monographs due to the lack of differences between works based on a purely psychoanalytic model, those rooted in a psychodynamic model and those aligned with a systemic approach.

c) Studies on Psychoeducational Multifamily Groups 2020-2022:

The decision to focus on the last two years is attributed to the vast and diverse nature of the international bibliography. When searching on the web for surveys regarding MFGs, seven results were found.

7.4 Final Conclusions – Conclusion of the Intellectual Output I

This study marks the conclusion of the first phase of the FA.M.HE project (IO1), conducted by the four partners. The document primarily focused on enhancing understanding regarding existing Multifamily Groups (MFGs) in the field of mental health. The research involved a meticulous examination of various models operating in distinct regions and at the international level, to disseminate the gathered information.

For the current project, two types of Multifamily Groups (MFGs) were considered, both encompassing at least two generations, irrespective of the methodologies employed: Multifamily Psychoeducation groups and Multifamily Psychoanalysis groups, the latter, rooted in J.G. Garcia Garcia Badaracco's theories. These groups are designed to address mental health issues by concentrating on the family context rather than solely focusing on the individual who more clearly manifests mental health problems.

Based on the reports from the partners, it can be concluded that the main objectives for the Intellectual Output I were achieved. All the countries conducted a survey, involving the development, distribution, and analysis of a questionnaire designed to explore the characteristics of MFGs. Additionally, two types of focus groups were organised, one with conductors and the other with users of MGFs. The four countries executed national-level bibliographic research, and Italy was responsible specifically for leading international bibliographic research. The details of this research can be found in the reports above.

In the subsequent discussion, the most relevant findings from the four countries are highlighted. With regards to the group’s typology existing in each country:

- Italy confirmed the presence of two types of MFGs (Psychoeducational and Psychoanalysis

MFGs), with a prevailing percentage attributed to Multifamily Psychoanalysis Groups (approximately 60 MFPGs active across various regions). The widespread adoption of this methodology nationwide can be attributed to the continuous efforts in comparison, research and training carried out by the Italian Laboratory of Multifamily Psychoanalysis (LIPsiM). As an associative structure, the LIPsiM serves as a network for support, encouragement, and in-depth analysis of the application of MFGs in the treatment of psychological distress.

- According to the report from Belgium, there are 24 MFGs distributed across all provinces of the country, primarily associated with psychiatric hospitals. These groups typically operate within a systemic framework, complemented by a cognitive or psychoeducational approach, with less emphasis on a psychoanalytic perspective.

- Spain reported the existence of 28 MFGs in the country. However, there was an uneven eographical distribution, indicating a concentration of MFGs in certain provinces while being absent in others. It is noteworthy that MFGs were identified in only 8 out of Spain's 50 provinces and 2 autonomous cities, despite evidence suggesting the existence of MFGs in additional provinces. One potential explanation for this territorial imbalance could be the lack of interest from some institutions, where a predominant focus on pharmacological and cognitive-behavioural perspectives may exclude a more dynamic approach. The MFGs mentioned in the questionnaire involved a minimum of 2 generations, including the person undergoing treatment. For these MFGs, the framework was essentially based on multifamily psychoanalysis, enriched by other psychotherapeutic approaches (systemic, group analysis, dynamic, cognitive-behavioural, interfamilial, etc.). Psychoeducational groups were excluded from this survey as they did not include individuals undergoing treatment.

- Portugal reported a limited number of MFGs, with a total of 5 identified. Among these, 3 were Psychoeducation groups associated with other frameworks, and only 2 were Multifamily Psychoanalysis groups. This figure is notably small considering the country's territorial dimension and compared with the other participating countries. The reasons for this low number, as outlined in the Portuguese report, are primarily attributed to challenges in disseminating the questionnaire. Additionally, institutional resistance to therapeutic approaches that deviate from the conventional psychiatric/orthodox perspective, often closely linked to pharmacology, may contribute to the lack of responses to the questionnaires. While acknowledging the existence of psychoeducational MFGs in various Portuguese institutions, it remains unclear whether these groups include more than one generation.

In terms of institutional resistance, Italy reported having encountered external obstacles, noting a series of challenges within the institutional context. Also, Belgium highlights that external difficulties in implementing MFGs are primarily at the organisational level. It is therefore essential to take these cultural and ideological institutional challenges into account. Investing in appropriate training, that addresses the culture and operation of mental health care and support contexts, may help overcome ‘closed minds’ (Garcia Garcia Badaracco 2009). Such efforts have the potential to broaden perspectives and facilitate the acceptance of the innovative approach of multifamily psychoanalysis groups.

Concerning the characteristics of the groups, Belgium presents significant variations between the regions of Flanders and Wallonia. These differences encompass therapeutic frameworks,

methodologies, target populations, settings, and forms of referral. Despite these regional distinctions, all the participants in the MFG, both the technical team and family members, agree that the MFG represents a paradigm shift in mental health care, where the family assumes a prominent role and psychopathology is managed within a relational/family context.

The training of conductors emerged as a highly significant aspect unanimously acknowledged by all partners. While a common ground exists in the multifamily psychoanalysis groups across the four countries, distinct operational approaches were observed. This divergence underscores the need for a comprehensive training that prioritises individual conductor training, fosters teamwork and considers the socio-cultural context within which MFGs operate.

There was a consensus regarding the urgent need to establish specific and robust training programs for MFG conductors. This aligns with another key objective of the project: fortifying the role and figure of MFG facilitators within the labour and mental health sectors. The aim is to design a European training curriculum grounded in essential skills and competencies, drawing from the collective experiences of the partners. A training course for MFG conductors should encompass not only the essential skills but also the adaptation of courses to the diverse academic backgrounds and clinical experiences of the health professionals constituting the team. When developing training programs, it is crucial to consider not only the desirable profile of a conductor but also the different skills of the candidates. All partners agreed on the importance of training MFG conductors, highlighting that the development of their competencies should be rooted in solid theoretical and technical training, incorporating an experiential clinical component. Further exploration of this theme will be developed in the subsequent phases of the project.

The practice of debriefing between therapists participating in MFGs after group sessions was identified as a common practice in all countries. This debriefing serves as a tool for analysis and reflection, contributing to the continuous refinement of techniques and methodologies. Moreover, it is recognised as a valuable learning complement for therapists in training. In terms of the added value of MFGs, there is a clear emphasis on the significance of the presence of more than one generation. This is considered an advantage of these groups and an effective strategy for resolving family conflicts. The inclusion of multiple generations brings the involved elements face to face in the presence of the group, which serves as a secure, empathetic, and supportive entity.

In a Multifamily Group, everyone stands to benefit, including families, healthcare professionals, and institutions. The MFG serves as the bridge connecting the institution with the community, establishing a community place where individuals can gather, share mutual support, and experience solidarity. All participants and family members agreed that MFGs align with a paradigm shift in the field of mental health care, in which the family assumes a prominent position, alongside the patient and caregivers. This shift contributes to minimising stigma and expanding each person’s healthy potential. The information collected thus far indicates widespread implementation of MFGs in the four countries. This provides an opportunity to advance the methodology and expand the reach of this intervention in family health to an even larger population. To achieve this, it is necessary to disseminate information about the existence of Multifamily Groups and to train specialised professionals in the field.

APPENDICES

APPENDIX 1 - Italian Bibliography and International Bibliography Translated into Italian

Italian Bibliography

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APPENDIX 7 – Questionnaire

QUESTIONNAIRE - MULTIFAMILY GROUPS IN MENTAL HEALTH I -
FIRST PART - GENERAL DATA

1. INTERVIEW DETAILS

1.1. Interview code_____
1.2. Partner/Country_____
1.3. Interview Date _____
1.4. Interviewer identification___
1.4.1 Name (acronym) _____
1.4.2. Professional training
1.4.2.1. Psychiatrist ☐
1.4.2.2. Psychologist ☐
1.4.2.3. Nurse ☐
1.4.2.4. Social Worker ☐
1.4.2.5. Other ☐
1.5. Identification of data provider
1.5.1. Name (acronym)_____
1.5.2. Professional training
1.5.2.1. Psychiatrist ☐
1.5.2.2. Psychologist ☐
1.5.2.3. Nurse ☐
1.5.2.4. Social Worker ☐
1.5.2.5. Other ☐

1.6. Data collected via
1.6.1. Face-to-face ☐
1.6.2. Telephone ☐
1.6.3. Videoconference ☐
1.6.4. E-mail ☐
1.6.5. Other ☐

2. INSTITUTION/ORGANISATION IDENTIFICATION

2.1. Location of the Institution/Organisation
2.1.1. Country: _____
2.1.2. City: _____

2.2. Institution/Organisation Name
_____
_____

2.3. Institution/Organisation Contacts
2.3.1. Phone(s) _____
2.3.2. E-mail(s) _____

2.4. Administrative Structure of the Institution/Organisation
2.4.1. Public ☐
2.4.2. Private ☐

2.5. Institution/Organisation Type

2.5.1. General Hospital (Psychiatric Service):

2.5.1.1. Ambulatory ☐

2.5.1.2. Ward ☐

2.5.2.3. Day Hospital ☐

2.5.2. General Hospital (Other Service) ☐

2.5.3. Psychiatric Hospital:

2.5.3.1. Ambulatory ☐

2.5.3.2. Ward ☐

2.5.3.3. Day Hospital ☐

2.5.4. Mental Health Centre ☐

2.5.5. Educational Institution/ Organisation ☐

2.5.6. Social / Community Institution/Organisation ☐

2.5.7. Other ☐

Which one? _____

II - SECOND PART - MULTIFAMILY GROUPS

3. MULTIFAMILY GROUP IDENTIFICATION AND FRAMEWORK

3.1. Name/Designation of the Multifamily Group (if pertinent)

_____

_____

3.2. Theoretical Framework of the Multifamily Group

3.2.1. Psychoeducational ☐

Which one? _____

3.2.2. Psychodynamic ☐

Which one? _____

3.2.4. Multifamily Psychoanalysis (J.G.Garcia Garcia Badaracco) ■

3.2.5. Other ☐

Which one? _____

3.3. Multifamily Group Intervention:

3.3.1. Psychotherapeutic ☐

3.3.2. Psychoeducational ☐

3.3.3. Self-help ☐

3.3.4. Support ☐

3.3.5. Counselling ☐

3.3.6. Other ☐

4. MULTIFAMILY GROUP COMPOSITION

4.1. Is the group designed for any particular age group?

4.1.1. No ☐
4.1.2. Yes ☐

4.2. If you answered 'Yes' which one?

4.2.1. Children (under 12) ☐
4.2.2. Adolescents (12 to18) ☐
4.2.3. Adults ☐
4.2.4. Older Adults (up to 65) ☐
4.2.5. Other ☐

If you answered 'Other' please clarify_____

_____

_____

4.3. Number of generations present in the group

4.3.1. Two ☐
4.3.2. More than two ☐

4.4. Relationship between those in treatment and their relatives (Please check all that apply)

4.4.1. Parents ☐
4.4.2. Children (sons/daughters) ☐
4.4.3. Other relatives ☐
4.4.4. Close figures (non-family) ☐
4.4.5. Others ☐

4.5. What are the Therapist's Academic Degrees?

4.5.1. Psychologists ☐ How many?_____
4.5.2. Doctors (Psychiatrist / others) ☐ How many?_____
4.5.3. Occupational Therapists ☐ How many?_____
4.5.4. Nurses ☐ How many?_____
4.5.5. Social Workers ☐ How many?_____
4.5.6. Educators ☐ How many?_____
4.5.7. Others ☐ How many?_____
Whom? _____

4.5.8. Non-mental health professional participants: family elements /other persons with experience with mental illness ☐ How many? _____
Whom? _____

_____

4.6. What is the Therapist's Psychotherapeutic Training?

4.6.1. Psychoanalysis How many?_____
4.6.2. Group analysis How many?_____
4.6.3. Other Dynamic psychotherapies How many?_____
Which one? _____
4.6.4. Systemic Therapy ☐ How many?_____
4.6.5. Cognitive-behavioural psychotherapy ■ How many?_____
4.6.6. Other ☐ How many?_____
Which one?_____

_____

4.7. Conductor /Co-therapists:

4.7.1. One Group Conductor + Co-therapists ☐
4.7.2. Only Co-therapists (without Group Conductor) ☐
4.7.3. (Usually) How many Co-therapists are present? _____

5. MULTIFAMILY GROUP CHARACTERISTICS

5.1. Heterogeneous group (members have different diagnostics/ pathologies):

5.1.1. Psychiatric Pathologies ☐
5.1.2. Non-Psychiatric Pathologies ☐

5.2. Homogeneous group (members have the same diagnostic/ pathology)
Please indicate the main diagnostic/ pathology

5.2.1. Psychotic Disorders ☐
5.2.2. Affective Disorders ☐
5.2.3. Anxiety Disorders ☐
5.2.4. Trauma + stress disorders ☐
5.2.5. Personality Disorders ☐
5.2.6. Obsessive-Compulsive Disorders ☐
5.2.7. Addictive Disorders ☐
5.2.8. Eating Disorders ☐
5.2.9. Somatic Disorders ☐
5.2.10. Others ☐
5.2.11. Non-Psychiatric Pathologies ☐

5.3. Group type

5.3.1. Open group ☐
(Members can join or leave the group at any time; the group composition usually varies over time and may vary throughout sessions)

5.3.2. Closed group ☐
(New members are not admitted to the group after it has started)

5.3.3. Slow open group ☐
(Absence of firm starting or ending dates; new members replace those who have left the group; the group members' number may remain unchanged for some time).

5.4. Group Size
5.4.1. Small (less than 10 participants) ☐
5.4.2. Medium (up to 30 participants) ☐
5.4.3. Large (more than 30 participants) ☐

5.5. Group Modality
5.5.1. Face-to-face ☐
5.5.2. Online ☐
5.5.3. Face-to-face + Online (some sessions are face-to-face and others online) ■

5.6. Group Frequency
5.6.1. Weekly ☐
5.6.2. Fortnightly ☐
5.6.3. Monthly ☐
5.6.4. Other ☐
Which one?_____

5.7. Group Time /Duration
5.7.1. Time of session (in minutes) _____
5.7.2. Group duration (if it is a closed group, how many years/months /sessions are planned?
_____

5.8. Time of day
5.8.1. During the work time ☐
5.8.2. After-work time ☐

5.9. Group Place/Room
5.9.1. Activities room ☐
5.9.2. Medical/Psychotherapy room ☐
5.9.3. Polyvalent room ☐
5.9.4. Other ☐

5.10. Are the necessary conditions of privacy and confidentiality guaranteed?
5.10.1. Yes ☐
5.10.2. No ☐
Observations_____

5.11. Group Suitability of the room (satisfactory room dimensions/soundproofing/comfort)

5.11.1. Yes ☐

3.11.2. No ☐

Observations _____

_____

5.12. Room capacity (are there seats for everyone?)

5.12.1 Yes ☐

If you answered 'yes' how many sitting places? _____

5.12.2 No ☐

5.13. Seating arrangements

5.13.1. One circle ☐

5.13.2. Concentric circles ☐

5.13.3. Other (please explain) _____

_____

5.14. Group Phases

5.14.1. Is the multifamily group organised in phases (in which there are changes e.g. the presence or absence of certain participants)?

5.14.1.1. Yes ☐

5.14.1.2. No ☐

5.14.2. If you answered 'Yes', is there a fixed/planned number of sessions for each phase?

5.14.2.1. Yes ☐

5.14.2.2. No ☐

If so, how many? _____

Observations _____

_____

5.14.3. Will the patients be present in all phases?

5.14.3.1. Yes ☐

5.14.3.2. No ☐

5.14.4. If you answered 'No', in which phases are patients expected to be present?

_____

_____

6. EXISTENCE/CONTINUITY/DISCONTINUITY OF THE MULTIFAMILY GROUP

6.1. Group existence (since when? / how long?) _____

6.2. Throughout the group's history did it have any interruptions? _____

_____

6.3. If so, what were the reasons for those interruptions?

6.3.1. Physical space constraints? ☐
6.3.2. Human resources constraints? ☐
6.3.3. Pandemic constraints? ☐
6.3.4. Others? ☐
Which ones? _____

6.4. For how long? _____

6.5. Did these interruption(s) change the group setting/ characteristics/etc. (e.g., change from a Face-to-face group to a group online)? Please explain _____

_____

_____

6.6. Pre-Covid group setting modality:

6.6.1. Face-to-face ■
6.6.2. Online ☐
6.6.3. Face-to-face + Online ■

6.7. Current (post-Covid) group setting modality:

6.7.1. Face-to-face ■
6.7.2. Online ☐
6.7.3. Face-to-face + Online ■
Observations _____

_____

7. GROUP'S REFERRALS

7.1. Internal (from the inside the institution/organisation) ☐
7.2. External (from other entities, both public and private) ☐

8. SUPERVISION/INTERVISION

8.1. Supervision

8.1.1. Direct/Internal: (meeting with an external supervisor who was present in the group ■

8.1.2. Indirect / External: ('classical' supervision - meeting with an external supervisor who was absent from the group ☐

8.2 Intervision: (post-group meeting among the conductors and co-therapists who were present in the group ☐

Final Remarks

_____

_____

_____

APPENDIX 8 - Bibliographic Research Classification Tables

BIBLIOGRAPHIC RESEARCH CLASSIFICATION TABLES

Topics Covered - Theoretical Guidance. Main Theoretical Orientation.

Topics Covered – Practical Application of the Multifamily Groups.

Intervention Context.
Types of contexts: educational, justice, health, etc.

Population-I. Age Group.

Population–II.
Psychiatric or non-psychiatric conditions population.

Groups of Pathologies.

APPENDIX 9 - Focus Groups Classification Tables

FOCUS GROUP CLASSIFICATION TABLES

Focus Group Planning.

Countries	FGs	Modality	Duration	Participants /Invitations	Invitations	Present	Moderator /Observers

Focus Group Methodology and Topics.

Countries	FGs (1, 2, 3, 4)	Methodology – SWOT Analysis	Topics/Focus Points (Questions)