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MULTI-FAMILY THERAPY — A NEW METHOD OF WORKING WITH FAMILIES

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Summary

The aim of this article is to familiarize the reader with the method of therapeutic work called multi-family therapy (MFT), in which several families participate simultaneously. The authors are presenting the process of development of multi-family therapy around the world, which has been continuing since the 40s of the previous century. The text describes the possibilities of using the multi-family therapy in treatment of different mental disorders, in diverse institutional settings, as well as in different forms tailored to families' needs. This form of therapy can be used, among others, with multi problem families, is employed in treatment of eating-disordered patients, teenagers and their families, and becomes useful when it comes to cooperation with schools. The authors recommend this form of psychotherapy in our country and they indicate that it deserves organizing proper courses on teaching of its rules and including it in therapeutic care offered in our country.

Introduction

Multi-family therapy (MFT) is a form of therapy in which a few families participate at the same time. It could be described as a combination of family and group therapy. It is a hybrid based on the experience of family and group therapists that is developing against a background of the changing work reality and which is dictated by practical aspects. Put simply — it is a meeting of a few families (usually three or more) during which issues that are common for all of them are discussed. Generally, one of the family members suffers from a problem concerning mental health (e.g. psychotic disorders or anorexia nervosa), functioning at school (e.g. poor performance at school) or internal family relations (e.g. hostility or violence). This may be defined from a psychiatric, educational, legal or social perspective. The size of the group is dependent on the number of families and their particular sizes. The therapeutic work may be

conducted with dyads of mother and child (as in multi-family therapy for mothers with toddlers), parents with the child (in this case an identified patient) or with all the siblings. If the circumstances as well as therapeutic and practical reasons call for it, the therapy is also attended by other family members (e.g. grandparents), people living together with the participants or others involved in the life of the family. It is also possible for the therapy to involve former spouses, current partners, adopted children, and in some cases – teachers, educational workers or tutors.

Before MFT appeared

Defining exactly who the pioneer of multi-family therapy was and the moment it was applied for the first time causes certain difficulties. The reason for this is the process of its "evolution", which it was possible to observe in the period before its establishment in the form that we know today. Before descriptions of multi-family therapy appeared, articles were published describing work with groups of relatives of the sick as well as with groups of married couples with similar problems.

In the 1940s and 50s, publications appeared in the United States containing descriptions of therapeutic work with parents of children experiencing behavioral problems at school [1] or with relatives of people with schizophrenia [2, 3, 4]. A particularly interesting work was that of W. D. Ross, who described how the concept of therapeutic interaction between mothers of hospitalized patients was established. This idea was purely practical – the meetings organized for them were to be a solution to the problem of troublesome carers who were constantly hindering medical personnel with questions and requests. In order to save a little time, the doctors decided to meet many mothers at the same time. The form of such meetings allowed them to discuss issues freely between themselves and to ask any common questions to the doctors in charge of treatment. As Ross describes — these meetings helped carers to deal with grief after the loss of a child's health, to reduce the feeling of stigmatization, and also to come to terms with the necessity of long-term hospitalization. Another benefit was the psycho-educational aspect of the group. Hospitalized patients participated in separate group sessions. They joined the meetings for mothers only when the therapists decided to use drama therapy techniques.

Another form of therapeutic work which can be considered as a predecessor of MFT was group therapy for married couples. The first reports of this type of conducted therapy began to appear in the 1960s. Gottlieb [5] wrote in detail about this form of work, giving clinical examples in his article as well as the dynamics of the group processes, the change process in individual participants, and the role of co-therapists. It should be mentioned here that similar work was conducted by Polish therapists. Attempts at conducting group therapy for pairs were made by the Department of Family Therapy, Chair of Psychiatry, Collegium Medicum Jagiellonian University in Krakow [6].

In 1953, Abrahams and Varon [7] issued the book *Maternal dependency and schizophrenia: mothers and daughters in a therapeutic group*. The book included a description of therapeutic meetings for girls suffering from schizophrenia and their

mothers. The subject of interest for the researchers-therapists was, however, connected more with the mother-daughter relationship and an assessment of their level of dependence (which represented a reflection of the then popular concept of maternal dependency and schizophrenia) than a description of the meetings as a new form of therapy.

The first MFT experiments

The first reports concerning therapeutic work with a group of patients and their families appeared at the Third World Congress of Psychiatry in Canada in 1961 [see: 8]. In the same year, the *Archives of General Psychiatry* journal published an article by Hes and Handler [9]. The article presented a description of a new therapeutic method consisting of three simultaneous forms of treatment in the psychiatry ward – group therapy for patients, group therapy for their families and group therapy for both patients and family members (the authors used the term *multidimensional group psychotherapy*). While the meetings with patients or families took place in a peaceful atmosphere, the meetings with the mixed group caused many emotions, to the extent that the observers of the sessions said it was hard to distinguish the patients from the non-patients. The authors of the article summarized that, despite the rather unconventional way of organizing the groups and conducting the meetings, and also despite the fact that the stay of the patients in hospital was rather short, spectacular changes in the patients and their families were observed [9].

The official beginning of MFT in the USA

The father and creator of MFT is considered to be Peter Laqueur — a psychiatrist practicing in New York in the 1960s [10]. In an article published in 1969, he described the course of psychotherapy for five young patients hospitalized due to schizophrenia as well as their nearest family members. During the hospitalization of the patients (and also often afterwards), the team consisting of therapists and an observer conducted weekly sessions lasting 75 minutes. Laqueur quickly noticed that the most important factors during the meetings of families with other families experiencing similar difficulties turned out to be: the sharing of common experiences, mutual support, constructive criticism and modeling.

Laqueur's valuable experience became an inspiration for other clinical workers and led to the formation of multidisciplinary teams consisting of psychologists, psychiatrists and psychotherapists, who began to use MFT by focusing mainly on help for the families of mental health patients. McFarlane [11] adapted this type of work to help the families of patients treated by psychiatrists. He paid attention to the possibilities of using this method in the processes of resocialization, countering stigmatization, improving communication and coping in crisis situations. He also observed that the acquisition by the family or its individual members of an “insight into the problem” is not necessary to accomplish therapeutic change. Instead of this, he believed that families may

learn by seeing part of themselves in others – in this way also becoming aware of their own dysfunctionalities.

Anderson [11] applied the idea of psychoeducation in multi-family therapy for patients with schizophrenia. Here, an important role is played by the significance and understanding of language, which enables closeness with others to be obtained and which is used to share descriptions of reality. The main theory of the work says that, by correcting communication deficiencies, conditions for more functional patterns can be created. Such an approach to family therapy should improve the way families refer to the patient, and through work on criticality, hostility and excessive engagement – reduce the level of expressed emotions (EE). In other aspects, this model resembles the work of McFarlane, with common factors being, among others, help for families in developing social networks, reducing the appearance of stigmatization and the willingness to lessen the load of carers by offering families the support of medical personnel.

MFT in the world

Work in the area of MFT was also conducted outside North America, taking place not only in Europe but also in South America. In addition to the intensive development of the methods in England (which will be presented in detail later), there were also experiments described by teams from France, Belgium and Switzerland [11].

Benoit et al. [12], in a publication in 1980, described experiments that took place in a hospital in Villejuif near Paris for psychotic patients at the end of the 1970s. They conducted meetings for the families of hospitalized patients, with the aim being to shorten the time of hospitalization. They paid attention to making each family more autonomic through interaction with members of other families, and also with other patients and members of the medical personnel.

In the middle of the 1980s, in the Swiss town of Cery, Dr Salem [13], together with a team of doctors, social workers and ward nurses, began the process of countering social and mental isolation among psychiatric patients. MFT, which Salem described in a publication from 1985, took place once a month over a ten-month period. Thirteen families took part in the therapy, with five attending each meeting. The majority experienced life with a person suffering from schizophrenia on a daily basis, and almost half of the patients had chronic illnesses. The team of therapists and the families defined the beneficial effects of the applied method as: openness to internal family relations and social relations, clearer inter-generation borders, easier expression of emotions, easing of meta-communication (through discussions concerning emotions, relations or verbal and non-verbal communication), as well as the learning of new internal family behavior through the observation of other families.

Jorge García Badaracco is an Argentinian psychiatrist who, from the beginning of the 1960s, contributed to the development of MFT in Buenos Aires [14]. While using this method, he referred to the idea of the family in a wide context, which meant that the therapeutic meetings could be attended by everyone who felt affected by the patient's illness through its influence on their life in any form. It turned out that around 100 people

appeared for the therapy, including Badaracco and other therapists. During the MFT meetings, he placed particular attention on his accessibility, believing it to be a fundamental feature of multi-family therapy. This type of therapy was proposed for the families of patients with schizophrenia, as well as those with mood disorders. The multi-family therapy was organized once a week, but the patients were also able to take part in additional individual or family therapy. In total, Badaracco conducted MFT sessions for over 3000 of his patients. In the publications describing his experience, he emphasized the significance of various fields for patients with schizophrenia, i.e. in individual, family and also multi-family therapy. In his opinion, all of the mentioned types of therapy are complementary and provide the opportunity to observe the functioning of the patient from various perspectives, which he believed to be essential for understanding the patient's problems and the organization of care as a whole. Badaracco emphasized the significance of the health potential found not only in each patient, but also in each family, as well as the necessity to work on a basis of similarities.

The first center in the world based on the idea of MFT

Marlborough Family Service was a London institution established out of Marlborough Day Hospital – a day ward for children [15]. The person responsible for the name change, and then for the constant transformation of the center, was the British psychiatrist Alan Cooklin, who became the director of Marlborough in 1976. One of the first decisions he took was to change the name of the center, which was intended to more clearly reflect the new approach to work with families. The center was not a “hospital”, in which “patients” were “treated”, but an institution which “serves” all members of the family. The change of name was also accompanied by a paradigm shift in the work. In the center that had previously functioned mainly based on psycho-analytical theory, Cooklin gradually began to introduce the idea of systematic understanding of the family, meaning that Marlborough quickly became a center of family therapy. His work as director was continued by Eia Asen, the greatest supporter of MFT in the world.

The therapists working in Marlborough quickly focused on families where their previous interventions had been ineffective. These families, in accordance with Minuchin's theory, were characterized by a chaotic structure, blurred or non-existent borders between sub-systems, a high level of enmeshment, family hierarchy disorder, and also the simultaneous experience of many problems. Surprisingly — in regard to the external world, and in particular to control institutions, such as social care — they presented high levels of unanimity and unity. However, they lacked the ability to maintain internal structure and organization (concerning work, finances and care for children). These families were also often affected by the problems of violence, addiction to psychoactive substances or alcohol, mental disorders of parents or children, and social isolation. Due to this, various institutions (e.g. schools, social care and family courts) and many specialists (psychotherapists, doctors and psychiatrists) were involved in the support given to the mentioned families. This created a feeling of helplessness and it was not difficult to come to the conclusion that help for these families was impossible. It

seemed a good idea, therefore, to use family therapy, but one meeting per week was, in their case, like a drop in the ocean of needs.

It is exactly with such, so-called multi-problem, families in mind that the Family Day Unit (FDU) was established at Marlborough, which was based wholly on the idea of multi-family therapy. It was a place for very intensive therapeutic work: even up to ten families met in one building five days per week, eight hours per day. The constantly developing institution was staffed by an inter-disciplinary team of specialists consisting of, among others, psychiatrists, social workers, psychologists, teachers, therapists and nurses. The therapeutic work followed a set program (as a response to the lack of internal organization in the families), which assumed the appearance of "controlled crises". The aim of the therapists was to create situations in which the families had to cope with the crises in an institutionally created therapeutic context. Thanks to the newly-found ways of coping, it was not necessary to involve more specialists or institutions in the support of the families, in this way limiting the "fragmentation" of the support system. Within the framework of the therapy used in the *Family Day Unit* there were daily social meetings, family therapy sessions, group therapy sessions for parents, group therapy for children and, of course, multi-family therapy sessions. In addition, the daily plan also included time for parents to spend with their children, prepare meals or do the shopping.

The daily program was constructed so that families could experience constant changes in context through the movement from one activity to another. The family could meet the therapist during family sessions or take part in meetings with the therapist together with others; household members could receive tasks to do with other families in a structured form or could spend time on informal, non-structured, free activities consisting mainly of fun together with other families and personnel; carers could meet together while their children had school or therapeutic activities; they could be asked to take care of their children, and also children from other families. These constant changes in context forced the families to change their way of behavior and expectations towards others, challenging their set schemes of behavior and encouraging them to constantly experiment.

The Family Day Unit underwent many modifications over the years. The time of families being under the care of the institution and the daily program changed. The proportion of multi-family work compared to other work was also modified, with MFT being increasingly used. In the applied therapeutic approach, the experience and supervision of leading family therapists, such as Salvador Minuchin, Luigi Boscolo and Gianfranco Cecchin, was used. The FDU therapists, inspired by the work of Tom Andersen, also introduced therapeutic work based on reflecting teams. In turn, in recent years, multi-family therapists in England have begun to pay great attention to therapeutic intervention based on mentalization theory.

Varied applications of MFT

The first experiments with multi-family therapy, as mentioned earlier, mainly concerned patients with mental disorders [2-4, 8, 10, 16, 17] and MFT initially found the

greatest application in such a context. However, over the years, attempts were made to apply this method in various institutional conditions (stationary wards, day wards, advisory centers and schools), in various groups of the population (children, adolescents and adults), as well as with people suffering from various mental or somatic disorders. Gathering all the previous work concerning MFT in one place is difficult, however, below is an attempt at presenting the most interesting reports from the last twenty years.

Therapeutic intervention based on cooperation with the family has turned out to be effective in the treatment of depressive disorders, and attention has been paid to this by, among others, Keitner [18] and Lemmens [19]. The latter, in research conducted with his team, showed better results while treating people with deep depression when family or multi-family therapy is added to the standard therapy program. Among the group of people participating in MFT, a greater number of patients responding to treatment was noted, as was a reduced need for anti-depressant medicine, and a greater level of positive changes in the health of psychiatric patients was noted by partners. Hellemans [20], in turn, dedicated his research to understanding the circumstances of those being treated by MFT for depressive disorders. He discovered the existence of a few therapeutic factors, which were mentioned both by the patients and their partners. These were, among others, the presence of other people (experiencing similar problems), coherence and a feeling of understanding by them, the opportunity to open up and discuss, as well as the experience of observation and the feeling of being led by the therapist. These factors allow the treatment process to be better understood and, according to the authors, should be highlighted in the therapy process and better explored in future. MFT in the treatment of mood disorders has also been implemented in work with children [21–24]. The significance of this type of therapeutic work is highlighted by Fristad [21] who noted that, thanks to MFT meetings, the knowledge of parents concerning the symptoms of childhood mood disorders significantly increased, as did the number of positive internal family interactions announced by parents. Children, however, noticed changes in the way their parents supported them.

The strength and effectiveness of multi-family interaction in the treatment of schizophrenia very quickly became obvious, and interest in the development of this method in various models and conditions has increased. In bipolar disorder, which shares important features with schizophrenia (biological basis, psycho-social context) and is also a great challenge for families, the application of MFT turns out to be based on good reason. Moltz et al. [25] in the book *Multi-family groups in the treatment of severe psychiatric disorders* describe the application of MFT in psycho-educational forms, directed both to patients dealing with the symptoms of bipolar disorder and their families. It was noticed that patients participating in MFT had fewer outbursts of rage and coped significantly better with the symptoms and episodes of the illness. Participation in the group was connected with a less frequent need for patient hospitalization or the appearance only of episodes, thus destabilizing their lives to a lesser extent. This is probably because the other participants of the MFT groups noticed disturbing signs much earlier and began to help. Members of the family considered the greatest benefit they

received from the group through listening to their experiences to be the significant growth in their confidence to cope with the illness.

The same publication includes interesting reports on the role of MFT in treating borderline personality disorders [26]. As in other therapies for mental disorders, the strength of MFT is the ability to create a transformation in the family system. The work methods directly concerned the problems that the families of patients with borderline personality disorder, or the patients themselves, faced on a daily basis. Group members could obtain an insight into their attitudes and styles of expressing emotions, and those who coped better with sympathy for and understanding of others were able to demonstrate their skills. Reports from the work of Berkowitz [26] indicate that their patients claimed there was an improvement in internal-family communication and a reduction in unwillingness towards family members.

In the literature, there are also numerous reports on the subject of work with the families of people with eating disorders, both for adult patients [27], and adolescents [28–33]. Multi-family therapy with the participation of carers of adults suffering from anorexia differs from work with teenagers. The differences described by therapists [27] concern law and responsibility, both in terms of the person with the disorder and their families. Therapy in the case of adult patients often concerned chronic illness. The main therapeutic aim was not to make the patient healthy, but to improve the quality of life. The spectrum of social and emotional development for adults with eating disorders is considerably wider, and the degree of involvement and independence from the family is often inadequate for the age. MFT interactions focused mainly around the sharing of information, support for the carers, training of the family in coping with the symptoms of eating disorders, countering stigmatization and coping with stress. Attempts to adapt MFT for the families of teenagers with eating disorders were undertaken, among others, in the Czech Republic. Mehl [28] and her team described the experiments with MFT in the Eating Disorder Center in the Psychiatric Clinic in Prague. The results of the research conducted there showed varying evidence in regard to the role of MFT and the influence of the method on patients with eating disorders. The researchers noted a significant increase in the patients' quality of life, however, an increase in body mass index (BMI) was accompanied by a decrease in the teenager's self-esteem.

Catherine Stewart [34] described, however, the effectiveness of multi-family interaction in the case of bulimia in teenagers. The program was targeted at families of adolescents and mainly focused on coping with attacks of bulimia as well as reducing its symptoms, the capability of controlling factors affecting the recurrence of the illness (including psychosocial stressors), styles of communication and interaction inside families (affected by eating disorders), as well as the burdens and stress that the families have to struggle with. Feedback from those participating in the multi-family meetings concerned the acquisition of new ways to cope with the illness, as well as forms of internal family communication. Analysis of the gathered clinical results enabled the authors to state that this type of interaction helps to reduce the symptoms of bulimia and depression, together with a noticeable increase in the ability to cope.

MFT in Poland

Multi-family therapy is not yet sufficiently widely used in Poland. As an element of treatment, it was proposed to patients of the Family Mental Health Day Wardof Krakow University Hospital [35]. In 2008, the above-mentioned Department of Family Therapy helped to increase interest in the method by applying it in therapy for couples [6]. Since 2011, the [1]Laboratory of Psychology and Systemic Psychotherapy in the Jagiellonian University Medical College Department of Psychiatry has been trying to create a team of multi-family psychotherapists and to undertake research projects in this area.

In 2016, thanks to funding from the National Scientific Leadership Centre at the Faculty of Medicine of the Jagiellonian University Medical College, the first training course for psychotherapists interested in working with MFT took place in Poland. The year-long training course was conducted by Professor Eia Asen and his team from the Anna Freud Centre in London. It was attended by 35 therapists working on a daily basis in psychodynamic and systematic fields, with experience of cooperating with families, children and adolescents. The result of the training was a widening of information concerning multi-family therapy, as well as the implementation of the method in Poland. Until now, a few editions of MFT have been conducted in Krakow, Warsaw, Stalowa Wola and Wieliczka.

Reports from the world concerning the effectiveness of multi-family therapy encourage the inclusion of this type of activity in the permanent offer of the Psychiatry Clinic of Adults, Children and Adolescents of Krakow University Hospital. The projects conducted so far in the form of support for the families of patients between 6 and 14 years of age treated as outpatients and in day wards has been considered by families to be a good complement to the treatment process. Publications are currently under preparation in which experience gathered from previously conducted meetings will be described.

References

1. Buchmuller AD, Gildea MCL. Group therapy for parents of behaviour problem children in public schools. Int. J. Soc. Psychiatry 1955; 1(3): 51–56.
2. Ross WD. Group psychotherapy with patients' relatives. Am. J. Psychiat. 1948; 104(10): 623–626.
3. Ross WD. Group psychotherapy with psychotic patients and their relatives. Am. J. Psychiat. 1948; 105(5): 383–386.
4. Kahn SW, Prestwood AR. Group therapy of parents as an adjunct to the treatment of schizophrenic patients. Psychiatry 1954; 17(2): 177–185.
5. Gottlieb A, Mansell Pattison E. Married couples group psychotherapy. Arch. Gen. Psychiatry 1966; 14(2): 143–152.
6. de Barbaro B, Drożdżowicz L, Janusz B, Gdowska K, Dembińska E, Kołbik I, Furgał M. Multi-Couple Reflecting Team: Preliminary Report. J. Marital Fam. Ther. 2008; 34(3): 287–297.
7. Abrahams J, Varon EJ. Maternal dependency and schizophrenia: mothers and daughters in a

therapeutic group, a group-analytic study. New York: International Universities Press; 1953.
8. Levin EC. Therapeutic multiple family groups. Int. J. Group Psychother. 1966; 16(2): 203–208.
9. Hes JP, Handler SL. Multidimensional group psychotherapy. Arch. Gen. Psychiatry. 1961; 5(1): 70–75.
10. Laqueur HP, Wells CF, Agresti M. Multiple-family therapy in a State hospital. Psychiatr. Serv. 1969; 20(1): 13–20.
11. Asen E. Multiple family therapy: an overview. J. Fam. Ther. 2002; 24(1): 3–16.
12. Benoit JC, Daigremont A, Kossmann L, Pruss P, Roume D. Groupe de rencontre multi-familial dans un pavillon de malades chroniques. Annales médico-psychologiques 1980; 10: 1253–1259.
13. Salem G, Von Niederhaüsern O, Aubry M, Di Giampetro L. L'approche multifamiliale à l'hôpital psychiatrique. Archives Suisses de Neurologie et Psychiatrie. 1985; 136(6): 67–71.
14. Frankhauser A. Thérapies multifamiliales et schizophrénie: comment complexifier les représentations. Université de Lyon – Faculté de médecine. Doctoral thesis. 2015.
15. Asen KE, Dawson N, McHugh B. Multiple family therapy: The Marlborough Model and its wider applications. London: Karnac; 2001.
16. Kessler, DR, Curry AE. A Preliminary report on multiple conjoint family therapy. Family Process. 1965; 4(2): 311–313.
17. Barcai A. An adventure in multiple family therapy. Fam. Process. 1967; 6(2): 185–192.
18. Keitner GI, Drury LM, Ryan CE, Miller IW, Norman WH, Solomon DA. Multi-family group treatment for major depressive disorder. W: McFarlane WR. Multi-family groups in the treatment of severe psychiatric disorders. New York: Guilford Press; 2002, pp. 244–267.
19. Lemmens GM, Eisler I, Buysse A, Heene E, Demyttenaere K. The effects on mood of adjunctive single-family and multi-family group therapy in the treatment of hospitalized patients with major depression. Psychotherapy and psychosomatics. 2009; 78(2): 98–105.
20. Hellemans S, De Mol J, Buysse A, Eisler I, Demyttenaere K, Lemmens G. Therapeutic processes in multi-family groups for major depression: Results of an interpretative phenomenological study. J. Affect. Disord. 2011; 134(1): 226–234.
21. Fristad MA, Goldberg□Arnold JS, Gavazzi SM. Multi-family psychoeducation groups in the treatment of children with mood disorders. J. Marital Fam. Ther. 2003; 29(4): 491-504.
22. Fristad MA, Verducci JS, Walters K, Young ME. Impact of multi-family psychoeducational psychotherapy in treating children aged 8 to 12 years with mood disorders. Arch. Gen. Psychiatry 2009; 66(9): 1013-1021.
23. Mendenhall AN, Fristad MA, Early TJ. Factors influencing service utilization and mood symptom severity in children with mood disorders: effects of multi-family psychoeducation groups (MFPGs). J. Consult. Clin. Psychol. 2009; 77(3): 463–473.
24. MacPherson HA, Leffler JM, Fristad MA. Implementation of multi□family psychoeducational psychotherapy for childhood mood disorders in an outpatient community setting. J. Marital Fam. Ther. 2014; 40(2): 193–211.
25. Moltz DA, Newmark M. Multi-family groups for bipolar illness. In: McFarlane WR. Multi-family groups in the treatment of severe psychiatric disorders. New York: Guilford Press; 2002, pp. 220–243.
26. Berkowitz CB, Gunderson JG. Multi-family psychoeducational treatment of borderline personality disorder. W: McFarlane WR. Multi-family groups in the treatment of severe psychiatric disorders. New York: Guilford Press; 2002, pp. 268–290.

27. Treasure J, Whitaker W, Whitney J, Schmidt U. Working with families of adults with anorexia nervosa. J. Fam. Ther. 2005; 27(2): 158–170.
28. Mehl A, Tomanová J, Kuběna A, Papežová H. Adapting multi-family therapy to families who care for a loved one with an eating disorder in the Czech Republic combined with a follow-up pilot study of efficacy. J. Fam. Ther. 2013; 35(S1): 82–101.
29. Hollesen A, Clausen L, Rokkedal K. Multiple family therapy for adolescents with anorexia nervosa: A pilot study of eating disorder symptoms and interpersonal functioning. J. Fam. Ther. 2013; 35(S1): 53–67.
30. Voriadaki T, Simic M, Espie J, Eisler I. Intensive multi-family therapy for adolescent anorexia nervosa: adolescents' and parents' day-to-day experiences. J. Fam. Ther. 2015; 37(1): 5–23.
31. Salaminiou E, Campbell M, Simic M, Kuipers E, Eisler I. Intensive multi family therapy for adolescent anorexia nervosa: an open study of 30 families. J. Fam. Ther. 2015 (pending publication). DOI: 10.1111/1467-6427.12075
32. Engman-Bredvik S, Carballeira Suarez N, Levi R, Nilsson K. Multi-family therapy in anorexia nervosa – a qualitative study of parental experiences. Eat. Disord. 2015; 24(2): 186–197.
33. Depestele L, Claes L, Lemmens G. Promotion of an autonomy – supportive parental style in a multi-family group for eating-disordered adolescents. J. Fam. Ther. 2015; 37(1): 24–40.
34. Stewart C, Voulgari S, Eisler I, Hunt K, Simic M. Multi-family therapy for bulimia nervosa in adolescence. Eat. Disord. 2015; 23(4): 345–355.
35. Bogacz J, Wojnar M. Terapia systemowa w grupie wielorodzinnej. Psychoter. 1995; 3: 27–36.

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