9

Multi-family Group Therapy

Elizabeth Mensah and Heleni-Georgia Andreadi

Introduction

"Many Families Grow Together"

It is interaction in the presence of others with similar difficulties that encourages people to help each other, share familiar dilemmas and develop their respective ways of responding and finding solutions. This chapter draws on that premise, in describing and promoting the relevance of Multi-family Group Therapy (MFGT)as used with children and families at the edge of care. A brief theoretical introduction to the model is given, followed by principles, skills and techniques that are adaptable to edge-of-care contexts, in order to achieve positive outcomes.

E. Mensah
London, UK

H.-G. Andreadi (✉)
London, UK

L. Smith (ed.), *Clinical Practice at the Edge of Care*,
DOI 10.1007/978-3-319-43570-1_9

As we value users' involvement and voices to ensure successful outcomes from therapeutic interventions, this chapter includes stories and excerpts from the perspective of parents, children and professionals who have participated in multi-family groups (Andreadi and Mensah 2015).

Some of the challenges and opportunities of this approach will also be highlighted. We hope that, in turn, this will encourage and challenge others in their use of multi-family group practices.

MFGT and its Applications to Practice

Multi-family Group Therapy (MFGT) involves working therapeutically with a collection of families in a group setting. It combines the power of group process with the systems focus of family therapy. MFGT is ideally suited to working with families facing similar difficulties. This model of working was developed in the early 1960s by Laqueur and his co-workers (Laqueur et al. 1964) and originally implemented in inpatient units for adolescents and adults with severe mental health difficulties (Laqueur 1973; Wattie 1994).

Since these first groups, the approach has developed and been used successfully in other areas, including the following: outpatient contexts for children and adults presenting with significant mental health disorders (McFarlene 1982; Anderson & Gehart 2007), drug and alcohol abuse (Kaufman and Kaufman 1979), chronic medical illness (Gonsalez et al. 1989), eating disorders (Slagerman and Yager 1989) and non-medical settings such as schools and community projects (Asen et al. 1982; Cooklin et al. 1983). Significantly, MFGT has been usefully applied with families at the edge of care, including its use as a family assessment and intervention tool during care proceedings (Barratt 2012) and with families referred to the Marlborough Family Centre by the courts and social care services due to significant safeguarding concerns (Asen 2002).

As an intervention, MFGT has proven effective for families struggling with multiple difficulties. Sayger (1996) noted that using MFGT with at-risk families increased the opportunity to build a sense of community

and social support. In an empirical study, Meezan and O'Keefe (1998) reported that using MFGT was effective in increasing social competence amongst children whose families had been abusive or neglectful, also suggesting that MFGT with these families was more effective than traditional family therapy in fostering changes in parent-child interactions.

Organising Principles

The MFGT model creates a space where important aspects of the family life cycle and structure can be observed and explored. The bringing of many families together and the multiple interactions that occur provide a rich sampling of subsystems and boundary issues, as well as the opportunity for analysing and hypothesising about both intra- and inter-family interactional patterns and communication styles.

Key enduring qualities of MFGT are its versatility and the opportunities it allows to combine or draw from various evidence-based modalities, concepts, skills and techniques (Laqueur et al. 1964; McFarlene 1982; Anderson & Gehart 2007). This provides facilitators with immense scope for creativity in planning and delivery of the model with those who may be described as multi-problem, high-risk or complex families.

In MFGT with families where there are significant safeguarding concerns, theoretical relevance and practice-based experience suggests the usefulness of incorporating principles from systemic and collaborative narrative practices, such as the Tree of Life (Anderson and Goolishian 1992; Epston and White 1995; Denborough 2008; Ncube 2006); resilience-building and positive parenting approaches, including behaviour management skills development; and mentalisation-based therapy (MBT) concepts (Midgley and Vrouva 2012). These will be discussed further below. Whilst acknowledging the need to be versatile and inclusive, the core organising principles of MFGT remain highly relevant (Asen 2002; Asen and Scholz 2010; Asen et al. 1982):

- In a group, the family learns that they are not alone, as other families have similar problems and concerns

- The group gives families hope, as they see other families learn, change and grow and as they receive support and encouragement from each other
- As families find themselves able to care for and help other families, they increase their own sense of competence and agency
- The group becomes a support network, where families can feel accepted just as they are and friendships develop between families that continue outside of and beyond the group
- Families learn through identification with other families and through modelling behaviours observed in other families. This is most possible when families come together who have very similar experiences/difficulties and similarly aged children (or children negotiating similar developmental tasks). It is suggested that the more similarities families can identify, the more influential the group becomes
- The group becomes a safe place to experiment with, practice and get feedback on new skills and ways of relating
- By attending and involving themselves in the group, families are publicly committing themselves to change and exposing themselves to subtle peer pressures.

Each family and each group represents unique perceptions and experiences. MFGT facilitators need to remain open to deconstructing their preconceived assumptions of what is "best for all", so as to create a therapeutic space that is uniquely co-constructed by the participating families in each group. This diversity of backgrounds and experiences allows practitioners and families to explore and enhance their strengths and move away from interactions that are no longer helpful or meaningful.

Establishing a Safe Therapeutic Context

The importance of context, and its recursive influence with all aspects of living and meaning-making, is highlighted within systemic epistemology (Bateson 1972). The need for a positive and safe therapeutic context as a prerequisite for successful outcomes in therapy has been repeatedly

highlighted in family therapy literature and elsewhere (Minuchin et al. 2006; Flaskas 1997; Wilson 1993; Mason 2010; Carr 2005).

To this end, an important aspect of systemic practice remains how we prepare ourselves for meeting with the "other" (McAdam and Lang 2009; Andersen 1987; Fredman 2004; Rober 1998). Practices like team hypothesising, inner dialogue, emotional posturing, team reflections and even the use of initial telephone call conversations as the start of our formulation are only a few of the methods that may be used in day-to-day practice.

Organisational contexts may also influence how families are engaged in multi-family group work. For example, within statutory edge-of-care contexts, there may be opportunities to set the tone for how families are invited to attend the groups and how they might be supported to do so, and for this to inform clinical assessment and elimination processes. There may also be opportunities for collaborative working within or across agencies or multidisciplinary teams, comprised of practitioners whose varied experience, knowledge and roles in the families' lives can contribute to creating a therapeutic frame for the work. Through an initial referral, consultation and commissioning process, it is possible to begin reframing linear views of children or family's presentations, extend the systemic paradigm and sow seeds for the possibility of change. It is useful to encourage professionals to maintain the possibility of small shifts that could produce a rippling effect on the family's understandings or behaviours.

The process of "warming the context" (Burnham 2005) via preparing and having the first meetings with families is a significant aspect of the whole MFGT intervention—and usually a predictor of its success. Families at the edge of care often arrive to groups with problem-focused and complaint-saturated narratives, stories of hopelessness, anger and frustration attributed to them by professionals and/or trans-generationally created and held by the families over their lengthy involvement with professional systems (that they may or may not have found helpful). This may position certain family members or whole families in ways that impede their participation and use of the group, unless addressed early on in the process. Likewise, where statutory or legal processes are involved, practitioners need to remain mindful of each family's particular situation and their perceptions and understandings of the remit of the group, which may serve both an assessment and intervention function to inform wider decision-making.

A useful strategy is to organise introductory meetings with each family separately prior to the first group meeting. This space may be used by parents to present some of the problem/complaint-saturated narratives but also to explore their hopes, expectations and past experiences of being part of a group. As well as a beginning to establish the positive alliance required, these meetings provide opportunities to dispel misconceptions and fears. In some cases, preparing for the group also means managing engagement difficulties such as non-attendance, inaccurate referral information or anxieties common to families engaging with statutory child protection services—such as the fear that engaging with professionals will involve being judged or increase the likelihood that children might be removed. Introducing the idea of a preferred future (White 2006) and the use of interventive interviewing (Tomm 1987) offer means of exploring the family's willingness and commitment to making appropriate changes.

Whilst MFGT may involve open or closed group work, the latter is arguably more appropriate when working with families at the edge of care, as it can provide a sense of predictability and familiarity. For families and children who may have experienced multiple changes, movements and uncertainty, environments that provide structure and consistency can be conducive to their experiencing and constructing trustful relationships with others. There is consensus amongst practitioners that such groups are more effective when run with five to eight families (Asen and Scholz 2010), whilst a small-scale evaluation to date suggests that it might be easier for multi-troubled families to sustain their engagement for shorter—around 7–8 weeks—rather than longer periods of time (Andreadi and Mensah 2015).

Although many families at the edge of care will be affected by mental health difficulties, abuse and domestic violence, the nature of the work and context means that MFGT is not suitable for participants with active psychotic presentations or perpetrators of child sexual abuse. Within these restrictions, families may be invited to make decisions about whom they would like to bring along to the group. Engaging fathers can present particular challenges but can add different and useful dimensions to the work if prioritised clinically (Walters 2010). Groups may be carried out in community-based settings, in order to de-stigmatise attendance. Accessibility and continued participation can be supported by the provision of creche facilities and transport to and from sessions.

Group facilitators and families are collectively responsible for planning and ensuring the safety of all participants, children and adults. Encouraging the families to set the "ground rules" in the first meeting, and take responsibility for their implementation throughout the process, is informed by a shared hypothesis that edge-of-care families still have knowledge and ideas about what constitutes safety, which they can meaningfully access if instilled with a sense of agency. The process of co-creation enhances the group's relationships and develops inclusiveness and a sense of group culture. Families repeatedly come up with exhaustive and meaningful lists of what will help everyone remain safe and feel respected when set with this task, which has the potential to be transferred to use in the family home. Children can be especially creative when given the opportunity to contribute to thinking around their and their family's safety. They may have expertise over and above those of the adults in some areas, for example, in creating a set of rules for remaining safe whilst using social media. Parents and children may also work together to create joint "rules", as shown in Fig. 9.1.

Fig. 9.1 An example of a co-created "pizza for a safer family life"

Establishing an Effective Therapeutic Context

Within systemic thinking, there are multiple views on what constitutes change for a system and how change can be sustained. An important distinction is made between first and second order change (Watzlawick et al. 1974). First order change refers to that which an individual or family can make at the level of behaviour and interaction. This could be suggested and/or imposed by external agents or be the outcome of the individual or family's wish to try something different. For example, a parent may minimise their use of physical chastisement, following professionals' recommendations or fearing the potential consequences if they do not comply. Second order change refers to a substantial shift in an individual's or a system's thinking, beliefs and understandings. For example, a parent may refrain from using physical punishment as they understand that it is having an adverse impact on their child's emotional wellbeing, and they wish to develop more meaningful ways of communicating their wishes to their child. MFGT in edge-of-care contexts is well placed to promote second order change when there is a focus on individuals and families identifying areas in their and their family's life that they would like to be different and developing strategies that will achieve this. For example, participating families might identify "fighting between siblings" as a shared difficulty in the first session; each family unit is then invited to consider their preferred type of sibling relationship and the different factors that might influence those interactions. Each family and the group as a whole can then proceed into finding and trying out ways that will help improve communication and minimise the unhelpful patterns of interaction leading to and maintaining "fighting".

Space may also be created within MFGT for the expectations and perceptions that family members have of themselves and each other to be explored. For example, families where parents have taken up concrete and opposing roles might be invited to reflect on what this role means to them, to other family members and for the overall function of the family, what the expectations, rights and responsibilities are that come with these roles and what would happen if they decided to swap roles for a day. In this way, an increased awareness of inter-

personal relating styles is coupled with opportunities to experience new ways of interacting, which makes it more possible for families to make meaningful changes to their circumstances (Thorngren and Kleist 2002).

For some families, the presence of many complex difficulties means the idea of setting and monitoring goals and gaining a sense of achievement might seem very distant. Some families will have had the experience of others—including professionals—telling them what they need to change or do. Helping families identify and share simple things that they would like to change, and which they can focus on achieving within a relatively short space of time, can signify the beginning of reclaiming control of their lives, reconnecting with lost or forgotten hopes and skills and planting seeds of hope for change. Hence, setting simple realistic and clearly defined goals is given priority at the first meeting of an MFGT group. For some, the MFGT group might be their first opportunity to think about change as a family, or to work as a team in the presence of others. As expected, significant dynamics can emerge. Some parents might struggle to give space to their children and go ahead to state what they think should change; some children might set out what they think the adults would like to hear. This provides opportunities for clinicians to consult and support, for example, by facilitating parents revising their pace to encourage and include their children's views. Examples of MFGT goals in edge-of-care contexts are given in Box 9.1.

Box 9.1 MFGT goals in edge-of-care contexts

Working as a team
Getting my children to listen to me
For children not to be nasty to each other
Spend more time with my kids
Stop family members arguing and fighting
Being able to manage the behaviour of my children
For us to listen more to each other
To keep my family safe

Another systemic concept connected to change is an understanding that behaviours and actions (almost always) serve a function according to the context within which they happen. For example, a child who "refuses" to go to school might be "protecting" their parent from an abusive partner. Likewise, problems may be understood as unhelpful patterns of interaction and communication, developed within a family as part of its members' attempted solutions (Cade 1987).

MFGT groups often help families and professionals reframe "bad parenting" and "the child's bad behaviour" as difficulties and challenges shared by many families, often created as intended solutions within the context of long-standing unhelpful patterns of communication. Families are then encouraged to discover other ways of interacting that can be more effective in resolving some of their difficulties. For example, families might decide to hold regular family meetings where they discuss challenges and brainstorm solutions together, instead of reacting in conflictual ways when there is a crisis.

Social learning approaches advocate that children's behaviour is informed by their real life experiences and exposures within their early care giving relationship and environment (Bandura 1977). Accordingly, social learning informed assessment and interventions promote specific parenting behaviours such as positive attention and praise for the desirable behaviour, clear instructions, consistent responses and setting limits to undesirable behaviours in order to achieve the desired change and improve the child's behaviour (O'Connor et al. 2013).

This thinking may usefully translate into MFGT in edge-of-care contexts, where children's behavioural difficulties and parenting issues are often presenting concerns. The group context can support implementation of new parenting practices and subsequent family relationship developments. For example, via the group discussions and experiences shared by other parents, a mother recognises the benefits of having clearly established boundaries and routines in the home and introduces bed time rules. She subsequently observes calmness in the home, more alertness in her children, less frustration in getting up in the morning and some well-needed "me time" for herself after a hectic but satisfying day caring for her children. As she restructures her family subsystems and strengthens boundaries around them (Minuchin 1974), her confidence advances

and moves on to allowing more self-caring responsibilities and autonomy to her preadolescent son. As he becomes proud of himself and grows in confidence, their relationship improves with rippling effects on the family and on others in the group as their experience is shared, acknowledged and emulated.

Mentalisation or mentalising is the process by which we make sense of ourselves and each other and our own and the other's actions, thoughts, feelings, intentions and interactions. Rooted in Bowlby's observations and thinking around attachment patterns, mentalisation processes are currently considered important in understanding and working with individuals and families affected by early trauma, difficult attachment histories and ongoing inter-relational difficulties. Consequently, mentalisation-based interventions find a good fit in the work with edge-of-care families and can be effectively applied within a MFGT context (Midgley and Vrouva 2012).

The aim of inviting family members to make sense of their own and others' cognitive and emotional processes in the group context is to identify ways in which their mentalising capacity might be hindered and help them develop reflexivity around their own and others' behaviours and interactions. For example, a parent who interprets their child's repeated detentions as intended to get them into trouble with school professionals might be given tasks that offer alternative understandings of how their children might be feeling and/or what they might be responding to. Similarly, children might be given the task of "looking" with a magnifying glass into their parent's brain and trying to "guess" what they might be thinking and feeling when they are disciplining them for an unwanted behaviour.

Each participating family will be different in terms of their openness and readiness for change, whilst differences might exist between different members of the same family. Some families become more motivated to question and change long-standing beliefs once they have experienced the positive outcomes of a first order level of change, as when a parent's interaction with their child becomes calmer and more effective when they take advice to refrain from raising their voice. There may also be instances where individuals report significant changes in their understanding of their parental role and identity soon after the end of the group process:

> *I now feel ok about showing how I feel to my kids; before I would hide it all away but I now know that they knew anyway and they'd prefer me to be honest. This whole process made me feel more confident about being a mother and having feelings*. (Maria, mother)

Group participants can sometimes experience their interaction with other families as the most helpful aspect of the process:

> *The best thing was being with the other parents and knowing that they go through what you go through; We are in the same boat*. (Pat, grandmother)

This may depend on particular local and cultural contexts. McKay et al. (1995) report similar experiences from their work with groups of inner-city families: "Change is achieved by identification with other families 'who have been there.' … In fact, the presence of other families can be more powerful than the therapist by providing motivation and encouragement for change. The feedback of other families can be less threatening than suggestions offered by the therapists".

MFGT as Collaborative Practice

Systemic and Narrative Therapy practitioners have written extensively about the need for collective methodologies and communal practices that promote meaningful and long-standing change in families, but also in the wider social context (Denborough 2008; Epston and White 1995; Hoffman 2007). As noted above, the presence of multiple families, all sharing similar difficulties, lends itself to the process of re-authoring one's own life and identity narratives and consolidating the new narratives through mutual contribution and appreciative witnessing that the group context can provide. In edge-of-care work, this is especially significant, as most of the families who have been, or are, subject to societal and state intervention have also experienced marginalisation and power differentials in their social position and status.

During MFGT sessions, various techniques, rituals, games and interventions may therefore be used to create a context of mutual learning,

developing curiosity about each other and exposure to various skills and competences that serve to develop confidence and enhance relationships within and outside of the family. Families are considered as experts in their lives (Anderson and Goolishian 1992). Professionals and other families therefore become "investigative reporters", trying to find out each family's strengths and aspirations for how they would like their future relationships to be. For example, Appreciative Inquiry (McAdam and Lang 2009) may be used so that the group becomes a space that provides parents and children with more positive experiences and brings forth their abilities and agency. This creates a sense of hopefulness amongst families and the professional systems working with them. Within this paradigm, hope is a significant predictor of change.

Similarly, the Tree of Life approach (ToL) is particularly fitting with the philosophy and intentions of MFGT within edge-of-care contexts. Originally developed as a psychological intervention for children and young people affected by trauma (Ncube 2006), the ToL uses the tree as a metaphor to represent influences, attributes and aspirations as well as significant family and social networks. Used within a narrative therapy framework as a tool for rich story development, it can be adapted and integrated in MFGT groups as a way of helping families reconnect with and share stories of their roots and history, identify and build richer descriptions of their strengths and abilities in the present and express their hopes and wishes for the future. The different elements of the approach also help facilitate a process of externalising problems, rather than situating these in individuals or an individual family. Feedback from families suggests the usefulness and relevance of this approach:

> *It was nice to do the Trees as it reminded me of the strengths we have as a family and all our networks.* (Jessica, mother)

Collective and community approaches rely on and base their effectiveness on the resourcefulness of groups; thus, the appreciative witnessing of improvements made by the participating families in the groups help identify, encourage and reinforce preferred parenting styles and responses, family scripts and patterns of communication (White 2006; Wulff et al. 2011).

To highlight and corroborate changes as they happen, time may usefully be allocated at the beginning of each MFGT session for each family member to feed back to the whole group one behaviour, interaction or family life experience that occurred since the previous sessions that was positive and/or different and they would like to continue building on.

In accordance with narrative collective practices, the last meeting of every MFGT group involves the celebration of the families' journeys and achievements. Each family is encouraged to reflect on their journey. First they are given the opportunity to review their goals and achievements, for example, through the use of scaling questions. They may be invited to present completed Trees of Life to the group, focusing on the values, resilient factors, skills and strengths, as well as some of their hopes and dreams for the future.

Table 9.1 Elements of an MFGT session

Family tea on arrival	This is used as an opportunity to help families develop positive interactions and joint routines—for some families, meal times can be an important focal point, a way of reconnecting, whilst for others, they can be an indicator of disconnection, with some families giving up on ever eating together
Circle and Ball time: checking in and feedback from the week	This is used as an important way for families to reconnect with each other. Usually, sitting in a circle, the ball is thrown by one member to another, with a question which has been agreed by the clinical team. This might include sharing one positive thing that happened to a child or another family member at school or home last week. Through the simple act of others noticing and listening, some children begin to take the steps to speak up with less embarrassment and inhibition and become more eager to identify and share positive stories, whilst negative stories reduce. The applause they receive lightens or brings a sense of happiness and pride. This can also help in reframing parents' views and reports of negative stories about their children. In the case of children who wander away or do not engage, the parent is encouraged—usually by another parent with suggestions—to "gently speak" with the child

(*continued*)

Table 9.1 (continued)

Joint family activity, as a big group or in single family units	These require families to work together. Clinicians observe, sometimes make suggestions to a particular family or give directions to the whole group, but in the main allow the family to get on with the activity
Parent and child groups: separate activities around the same theme (such as thoughts, feelings, rules and expectations, strengths and skills).	Separate sessions are offered to parents to provide them with the space to air their worries, discuss topics that are not suitable for discussion in the presence of the children and to address aspects of parenting which are problematic. These 40-minute sessions may be used to address issues about setting appropriate boundaries/ house rules and how to maintain them, how to manage when emotions get in the way and how to address the legacy of traumatic experiences. Parents tend to present as more relaxed and open in these sessions as they can let their guard down, acknowledge their struggles and learn and support each other in strategies that have worked for them. This also reduces their sense of isolation and frustrations and reinforces the idea that "we are in the same boat". During this time, the children are also occupied with activities around the themes discussed by the parents (such as how to express and understand difficult feelings in themselves and in others). We have found that some parents venture to raise their frustrations with social care involvement in their lives, sometimes presenting themselves as victims of the system. This can be a useful opportunity for the clinician to intervene and help families consider useful suggestions of how they might reduce statutory intervention in their family through appropriate actions and small but deliberate steps that will bring changes in their and their children's lives
Circle time: feedback and home task	About 20 minutes before the end, the group assembles again in a circle for some reflections and feedback. This is inspired by the "reflecting team" practice (Andersen 1987), but with some adaptation. Families are encouraged by the team to identify their experiences of the day, what they were taking away or what strength they have noticed in their child, themselves or as a family. At times, families are requested to tell each other what they have observed, for example, about interactions as a family and new skills and attitudes they may have noticed.

These are recorded on a certificate provided for this purpose, which each family takes home with them. Other families and the clinical team have the opportunity to comment on one or two qualities they have noticed a particular family have succeeded in developing. Families may bring gifts or shared food and drink to exchange in the last session, which highlights the level of connectedness that has developed and can extend beyond the group. Practice experience suggests that acknowledging improvements for themselves and by others helps families to sustain the changes they have made after the group ends and instils hope for further improvements. Families' growing wish to use their experience and acquired knowledge may translate into a desire to help others:

> *I feel much more confident as a parent. You should run it again and get us to come and help*. (Donna, mother)

This is an outcome often reported by practitioners of collective, community practices. Epston and White (1995) have inspired a lot of this work with their writings on the different positioning of therapists and clients within post-modern therapies. They advocate a practice that decentres the practitioner and instead positions them as the facilitators of the clients' (individuals, families or whole communities) movement to the position of "expert by experience". This may extend to the use of families who have successfully completed MFGT as co-facilitators for subsequent groups.

Box 9.2 Case example: Kai

Kai was a 35-year-old woman, of African origin, who attended a multi-family group with her four children: M a 9-year-old boy, D a 6-year-old girl and mixed gendered twins (3 years old). She was referred by her social worker who was concerned about the family's isolation, significant physical neglect of the children and Kai's limited skills in managing their difficult behaviour.

At the initial assessment, she reported concerns about her parenting abilities and wanted to expand her skills in managing her children's behaviour more effectively. She was feeling very tired and lacking sleep and opportunities to develop herself. She has not attended a group before, had very

Box 9.2 (continued)

limited social interactions generally and, as a consequence, was anxious about coming.

This is a short extract from an interview with Kai conducted by one of the authors after she had attended a group:

What were your experiences in MGFT?

Very positive! It has been helpful in building relationship with other parents, letting me know that I am not alone, my difficulties were common to other parents and so we were on the same boat. At first, I was very anxious to be in a group, but this disappeared in the first meeting, as I felt very welcome and comfortable. I felt accepted and realised that I was not the only parent struggling with my children. It helped to reduce the isolation of me and my children.

How did it help with your confidence as a parent on a scale of 1 to 10, 10 being the highest you can be?

I would say 9. I am more confident as a parent. Prior to MFGT, first I had no routine, my children would be going to bed at 10 or 12 am or when they are tired and we would have to get up late for school. I was doing everything in the house; I was therefore rushing all the time and very tired, not sleeping well. I was doing everything for my children including cooking, house chores, bathing and dressing all of them. I had gone to my GP complaining of back pains, I was unhappy. This is different now. I have learnt the importance of establishing a routine, boundaries, bedtime. No more late TV. Now my children have an established bedtime and I read them stories before they sleep. My 9-year-old son now bathes and dresses himself, helps with tidying the house and his room, this has increase his confidence. I am teaching the 6-year-old to do the same. I have time to myself when they have all gone to bed. I have a good night's sleep and I feel less tired and less pains in my body.

Before I used to shout but I do not do that anymore.

What helped you in achieving this?

I felt part of the group, I had the opportunity to learn and practice with other parents, I was able to ask questions and felt listened to.

The Role of the MFGT Clinician

It is important to review the context of the role of professionals using the MFGT model, based on the multiple theoretical frameworks and practice implementations described in this chapter. Clinicians and others facilitating multi-family groups in edge-of-care contexts may often be asked to inform decision-making about safeguarding by evidencing

of families' capacity to make changes in their interactions and communication within a prescribed time framework. Lang et al. (1990) argue that professionals acting out of this "Domain of Production" can still create space for the development of alternative explanations and possible change, if they adopt a curious and explorative stance towards the family's narrative and presentation. Lang also suggests that practitioners adopt an ethical and graceful position regardless of the actual task in focus, whether writing an informal record of the family's participation to the group to share with colleagues or contributing to a court report—with our formulations about the interactions within a family and with the other families in the group positioned within the context of the "Domain of Aesthetics" that should over-arch all actions in a professional context.

In therapeutic practice, it is well known that the practitioner's role is central to any intervention, whatever the modality, and evidence indicate that the therapeutic relationship is a major contributor to positive outcomes (Hubble et al. 1999). Both the personality and functions of the practitioner are key in MFGT interventions at the edge of care. Working with several families in the room at the same time holds more complexities than providing intervention with one family in the room. The MFGT practitioner has a "multi-positional" role that involves continually shifting positions in terms of physical and mental movement around the room, being temporarily engaged with one family and a distant observer to another in the attempt to facilitate intra- and inter-family connections. The MFGT practitioner has to be ready to intervene in small and larger ways, in an informal context with individual family members or a particular family when they execute a specific task, to direct instructions or comment on team work, to offer observations on the interaction between a parent and child or a whole family, to coach a child or a parent in practicing a skill, to invite thinking of new possibilities or to raise sensitive issues and encourage reflections. When families have complex difficulties and risk issues are present, the level of competence needed to do this requires skills development and ongoing supervisory and peer support.

For example, it may be necessary to intervene with a family whose conflictual interactions raise issues of emotional and physical safety within the group. The solution may be to respectfully but authoritatively advise

and support a short "time out" outside the group, which can offer space to ventilate and recalibrate whilst sending a clear message about mutual accountability and the level of concern raised. Such interventions also have implications for the practical aspects of MFGT, including the ratio of therapists to families and the choice of venue. Effective co-working is also paramount, as it can filter down to the families and can function as a model for their developing communication and negotiation patterns. The potential of co-facilitating and sharing tasks between two or three practitioners can also be maximised when roles and responsibilities are allocated in a way that is mindful of each therapist's strengths, limitations and resources. Setting aside time for pre- and post-session team meetings (for planning and debriefing) can prove a useful investment for sustaining reflexive practice.

Conclusion

Multi-Family Group Therapy offers a promising means to effectively address family risk factors and affect meaningful change, identified as key priorities in edge-of-care practice (Brandon et al. 2008; Munro 2011). Likewise, this approach offers a space for fostering dialogue, multiple perspectives and the co-creation of alternative—potentially safer—responses, which are often compromised in situations of high risk, uncertainty and professional and family anxiety (Campbell 2009). The epistemologically collaborative nature of MFGT also supports engagement and a shift from critical and sometimes blaming narratives to more supportive and facilitative interactions between professionals and families in edge-of-care contexts. Further practice development and formal evaluation of the approach in this setting is therefore recommended.

References

Anderson, C. M. (1983). A psycho-educational program for families of patients with schizophrenia. In W. R. McFarlene (Ed.), *Family therapy in Schizophrenia*. New York: Guilford.

Andersen, T. (1987). The reflecting team: Dialogue and meta-dialogue in clinical work. *Family Process, 26*, 415–442.

Anderson, H., & Gehart, D. (2007). *Collaborative therapy: Relationships and conversations that make a difference*. New York: Routledge.

Anderson, H., & Goolishian, H. (1992). The client is the expert: A not-knowing approach to therapy. In S. McNamee & K. Gergen (Eds.), *Social construction and the therapeutic process*. Newbury Park, CA: Sage.

Andreadi, H., & Mensah, E. (2015). *Presenting a pilot of multi-family group therapy with families known to Hackney Children and Young People's Services.* Hackney CYPS Clinical Service Away Day, London.

Asen, K. E. (2002). Multiple family therapy: An overview. *Journal of Family Therapy, 24*, 3–16.

Asen, K. E., & Scholz, M. (2010). *Multi family therapy: Concepts and techniques*. Oxford: Routledge.

Asen, K. E., Stein, R., Stevens, A., McHugh, B., Greenwood, J., & Cooklin, A. (1982). A day unit for families. *Journal of Family Therapy, 4*, 345–358.

Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice Hall.

Barratt, S. (2012). Incorporating multi-family days into parenting assessments: The Writtle Wick model. *Child and Family Social Work, 17*, 222–232.

Bateson, G. (1972). *Steps to an ecology of mind: Collected essays in anthropology, psychiatry, evolution, and epistemology*. San Francisco, CA: Chandler.

Brandon, M., Belderson, P., Warren, C., Howe, D., Gardner, R., Dodsworth, J., & Black, J. (2008). *Analysing child deaths and serious injury through abuse and neglect: What can we Learn? A Biennial analysis of serious case reviews 2003–2005*. London: Department for Children Schools and Families.

Burnham, J. (2005). Relational reflexivity: A tool for socially constructing therapeutic relationships. In C. Flaskas, B. Mason, & A. Perlesz (Eds.), *The space between: Experience, context and process in the therapeutic relationship*. London: Karnac.

Cade, B. (1987). Brief/strategic approaches to therapy: A Commentary [education update]. *Australian and New Zealand Journal of Family Therapy, 8*, 37–44.

Campbell, D. (2009). *The best decisions emerge from dialogue*. Presented at Moving Forward for Children and Families Seminar organised by AFT/Guardian/STP (23rd February 2009).

Carr, A. (2005). *Family therapy: Concepts, process and practice*. New York: John Wiley and Sons.

Cooklin, A., Miller, A., & McHugh, B. (1983). An institution for change: Developing a family day unit. *Family Process, 22*, 453–468.

Denborough, D. (2008). *Collective narrative practice: Responding to individuals, groups, and communities who have experienced trauma*. Adelaide: Dulwich Centre Publications.

Epston, D., & White, M. (1995). Consulting your consultants: A means to the co-construction of alternative knowledges. In S. Friedman (Ed.), *The reflecting team in action*. New York: Guilford.

Flaskas, C. (1997). Engagement and the therapeutic relationship in systemic therapy. *Journal of Family Therapy, 19*(3), 263–282.

Fredman, G. (2004). *Transforming emotion: Conversations in counselling and psychotherapy*. London: Wiley.

Gonsalez, S., Steinglass, P., & Reiss, D. (1989). Putting the illness in its place: Discussion groups for families with chronic medical illnesses. *Family Process, 28*, 69–87.

Hoffman, L. (2007). The art of withness. In H. Anderson & D. Gehart (Eds.), *Collaborative therapies: Relationships and conversations that make a difference*. New York: Routledge.

Hubble, M., Duncan, B., & Miller, S. (Eds.). (1999). *The heart and soul of change: What works in therapy*. Washington, DC: American Psychological Association.

Kaufman, E., & Kaufman, P. (Eds.). (1979). *Family therapy of drug and alcohol abuse*. New York: Gardner.

Lang, P., Little, M., & Cronen, V. (1990). The systemic professional: Domains of action and the question of neutrality. *Human Systems: The Journal of Systemic Consultation and Management, 1*, 34–49.

Laqueur, H. P. (1973). Multiple family therapy: Questions and answers. In D. Bloch (Ed.), *Techniques for psychotherapy*. New York: Grune and Stratton.

Laqueur, H. P., La Burt, H. A., & Morong, E. (1964). Multiple family therapy: Further developments. *Current Psychiatric Therapies, 4*, 150–154.

Mason, B. (2010). Six aspects of supervision and the training of supervisors. *Journal of Family Therapy, 32*, 436–439.

McAdam, E., & Lang, P. (2009). *Appreciative work in schools: Generating future communities*. Chichester: Kingsham Press.

McFarlene, W. R. (1982). Multiple family in the Psychiatric hospital. In H. Harbin (Ed.), *The Psychiatric hospital and the family*. New York: Spectrum.

McKay, M. M., Gonzales, J. J., Stone, S., Ryland, D., & Kohner, K. (1995). Multiple family therapy groups: A responsive intervention model for inner city families. *Social Work with Groups, 18*, 41–56.

Meezan, W., & O'Keefe, M. (1998). Multifamily group therapy: Impact on family functioning and child behaviour. *Families in Society: The Journal of Contemporary Human Services*, *79*(1), 32–44.

Midgley, M., & Vrouva, I. (Eds.). (2012). *Minding the child: Mentalization-based interventions with children, young people and their families*. London: Routledge.

Minuchin, S. (1974). *Families and family therapy*. London: Tavistock Publications.

Minuchin, S., Lee, W. Y., & Simon, G. S. (2006). *Mastering family therapy: Journeys of growth and transformation* (2nd ed.). New York: Wiley.

Munro, E. (2011). *The Munro review of child protection: Final report, a child-centred system CM 8062*. London: Department for Education.

Ncube, N. (2006). The tree of life project: Using narrative ideas in work with vulnerable children in South Africa. *International Journal of Narrative Therapy and Community Work, 1*, 3–16.

O'Connor, T. G., Matias, C., Futh, A., Tantam, G., & Scott, S. (2013). Social learning theory parenting intervention promotes attachment-based caregiving in young children: A randomized clinical trial. *Journal of Clinical Child & Adolescent Psychology, 42*(3), 358–370.

Rober, P. (1998). Reflections on ways to create a safe culture for children in family therapy. *Family Process, 37*, 201–213.

Sayger, T. V. (1996). Creating resilient children and empowering families using a multi-family process. *The Journal for Specialists in Group Work, 21*, 81–89.

Slagerman, M., & Yager, J. (1989). Multiple family group for treatment for eating disorders: A short term program. *Psychiatric Medicine, 7*, 269–283.

Thorngren, J. M., & Kleist, D. M. (2002). Multiple family group therapy: An interpersonal/postmodern approach. *The Family Journal, 10*(2), 167–176.

Tomm, K. (1987). Interventive interviewing: Part II. Reflexive questioning as a means to enable self healing. *Family Process, 26*, 153–183.

Walters, J. (2010). *Working with fathers: From knowledge to therapeutic practice*. London: Palgrave Macmillan.

Wattie, M. (1994). Multiple group family therapy. *Journal of Child and Youth Care, 9*, 31–38.

Watzlawick, P., Weakland, J. W., & Fisch, R. (1974). *Change*. New York: Norton.

White, M. (2006). Working with children who have experienced significant trauma. In M. White & A. Morgan (Eds.), *Narrative therapy with children and their families*. Adelaide, Australia: Dulwich Centre Publications.

Wilson, J. (1993). The supervisory relationship in FT training. *Human Systems: The Journal of Systemic Management and Consultation, 4*, 173–178.

Wulff, D. P., St George, S. A., & Besthorn, F. H. (2011). Revisiting confidentiality: Observations from family therapy practice. *Journal of Family Therapy, 33*, 199–214.