

MULTI-FAMILY THERAPY USED IN WORKING WITH FAMILIES WITH DOMESTIC VIOLENCE PROBLEM

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Summary

The aim of the present paper is to familiarize the audience with the model of multi-family therapy used in working with families with domestic violence problem. The inspiration for the present text was the authors' involvement in the European project EU's Daphne III: Multi-Family Pack Training for Professionals Working with Abusive and Violent High Risk Families (MFT-V). The objective of the above mentioned project was to develop a manual and training materials for professionals engaged in family therapy for families in which violence against children was identified. The project used the experiences of multi-family therapy conducted at the Marlborough Family Centre in London, which for many decades has creatively developed this concept of therapy and has particular experience in providing complex treatment to families with domestic violence problem. One of the main characteristics of the Marlborough Family Centre model, which is based on systemic therapy and psychodynamic group therapy approach, is using numerous techniques, including workshop techniques facilitating working on difficult problems in family relations, in working with a group consisting of parents and children. The experiences of the London team, due to their originality, may be of interest to other therapeutic teams, not only those facing the problem of violence in family.

Key words: multi-family therapy, multi-family therapy with the problem of domestic violence (MFT-V), rules and techniques of therapy

Introduction

Multi-family therapy (MFT) is a combination of rules and techniques of systemic family therapy with psychodynamic group therapy [1]. Therapists running such therapy meet a number of families simultaneously. This kind of therapy is most often used together with other therapeutic methods but can also become a stand-alone form of therapy. Multi-family therapy has a long history: its beginning dates back to the 40's and 50's of the previous century and is connected with family therapy of psychotic patients. Ross (1948), Abraham & Varon (1953), Kahn & Prestwood (1954) wrote about it [after: 2] in their works. Peter Laquer is often considered the founding father of MFT [3, 4] after he described positive aspects of working with groups of families of psychotic patients. His list of beneficial aspects of such form of therapy included, among others, mutual experience sharing, opportunity to support each other, constructive criticism, modelling, and encouraging hope for change.

In the following decades, multi-family therapy gained in significance, i.e. in the 60's multi-couple group therapy was introduced [5, 6]. Asen and Scholz [2] in their research overview emphasized the wide spectrum of usage for multi-family therapy in treatment of adult psychiatric patients, as well as – in a greater degree – in treatment of patients in developmental age. They

highlight the fact that this form of therapy brings beneficial effects especially in treatment of bipolar disorder, OCD, alcohol and drug addiction, borderline personality disorder, adolescent eating disorders, problems with coping with emotions in children, such as ADHD, Asperger syndrome, educational difficulties, learning disabilities, or emotional neglect. Moreover, multi-family therapy is valuable as a supporting method in treatment of somatic disorders in children and adults, as well as in persons that experienced trauma [7–11]. Depending on the context, MFT may take different forms and may incorporate psychoeducational elements.

Despite its long history and results indicating its effectiveness, multi-family therapy is still not enough used in clinical practice on regular basis. The Marlborough Family Centre in London, an institution established in 1977 by doctor Alan Cooklin and later run by doctor Eia Asen, has made invaluable contribution in the development of the therapy. This systemic-oriented institution for years has been working with socially-marginalized families. Striving for a work model for multi-problem families, the centre's staff, as the first in England, used multi-family therapy incorporating it in a holistic system of therapeutic and psychosocial interactions [1, 12, 13]. Years of practice allowed for the creative development of this form of therapy and at the same time for establishing its numerous versions, appropriate for specific types of disorder. Using multi-family therapy in treatment of anorexia and in working with families with domestic violence problem and/or neglect [2, 14] turned out to be one of the most interesting implementations.

In Poland, multi-family therapy has not been put to practice enough. It is regularly used only in the Family Clinic of the Psychosis, Day Treatment Centre of the University Hospital in Krakow [15, 16]. The Family Therapy Centre at the Department of Psychiatry of the Jagiellonian University has undertaken some interesting attempts in multi-couple therapy [17].

Assumptions of multi-family therapy

Main and basic assumption of multi-family therapy is enabling families and their members to step outside of their own perspective and to use the resources existing within the group. This process occurs through using techniques based on the theory of mentalization process and rules of reflecting team. Families are encouraged to help others – to share their observations, suggestions and their understanding of the situation. Helping others allows families to view their own problems differently and build their self-esteem. Family therapist in multi-family therapy is a catalyst allowing for building relations and entering interactions that otherwise might not have happened. He or she should be sensitive towards potential ethnic-related differences or differences resulting from belonging to different social classes that may only reinforce existing stigmatization and ostracism. It should be noted that group problem solving and mutual teaching accompanied by the catalytic role of the therapist is in line with the modern paradigm of family therapy which assumes the value of family experience and considers family an expert in solving its own problems [18, 19].

When comparing multi-family therapy with classic forms of family therapy and group therapy, field researchers often draw attention to the differences in rules existing with each form and the differences in application. Asen and Scholz [2] point to the number of processes occurring in multi-family therapy and possible problems in conceptualization of intra and inter-group boundaries. Working with a group of families triggers complex interactions and processes that take place within particular families (intra-family processes), between families (inter-family processes), between family therapists and families and their individual members (family therapist – patients relation processes), as well as between families and family therapists, i.e. the whole group and a wider context (external processes). For therapy participants it may be difficult to establish clear and straightforward rules concerning keeping the information within the group, known as the confidentiality rule. On the other hand, the researchers emphasize a number of positive phenomena. Being part of a group limits social isolation, feeling of being different, and stigmatization; it reduces defensive attitudes and so encourages openness and self-reflection. It is easier to rationally look at own problems when you see that others have similar ones. Asen and Scholz [2] also point to the fact that although it is hard to think clearly and objectively when it comes to our own matters, it is much easier to be sensitive and reasonable when it comes to other people's problems. Therefore – if right conditions are created – sharing own problems and suggestions for their solving may become possible.

Multi-family therapy may be treated as individual, specific form of therapy or as a part of a more extensive program of treatment. It can be understood “as context in which other therapeutic actions such as working with a single family, working with a couple or working with an individual person, be it a child or an adult, can be undertaken. If families take part in meetings for a whole day, spontaneously things similar to those that happen in everyday life occur. Such occurrences and crises can often be analyzed and “treated” on the go. Undertaking a 10-minute ad hoc session in a multi-family group can be more beneficial than regular and scheduled 50-minute session a few days later” [20, p.8].

Multi-family therapy for abusive and violent families

The aim of this form of therapy (*Multi-family therapy for abusive and violent high risk families, MFT-V*) is to limit and stop violence within a family as well as the abuse and neglect of children. It covers families in which educational failures, difficulties in social functioning, and conflicts with law are related to violence and/or neglect. Such complex and difficult situations require intensive actions that include, apart from multi-family therapy, usually also individual family therapy, parents, child therapy and other psychosocial actions, such as interventions in school environment or court-appointed guardians. Years of experience of the London's centre show

that the model, created and established there, based on working with a group of families with similar experience is the most effective method of treatment [2, 12, 13]. As the authors of the above works mention, intensive MFT-V therapy is recommended when it can cover the most socially discriminated families with diverse problems, caught in the cycle of domestic violence. In lighter and less chronic cases, less intensive approaches are applicable.

The first and the basic task for the therapist when preparing to run MFT-V therapy is to guarantee a “safe enough” setting – safe working environment for the group and its participants. Therefore, before a given family can join a MFT-V therapeutic group, each of its members has to be assessed in terms of risk they represent to their children and other people. It should be noted that families are referred to the centre by the welfare institutions, courts, and other authorities. Therapists have to assess violence risk level in the context of the binding legal system not only at the stage of qualifying a given family for a group therapy. Risk monitoring is an ongoing process occurring during each form and each stage of treatment. If during the process of MFT-V therapy parents are not able to protect their children from their emotional states or their hostility and physical or emotional aggression, their participation in therapy may be considered an abuse. If the level of risk cannot be reduced and children will be exposed to maltreatment by their parents, therapists must end their work with such family and inform appropriate child protection institutions. Confidentiality is another important thing in MFT-V therapy since building an environment of mutual trust is essential for the families and their members to be able to share important information concerning their family life. The rule, which should be set at the very beginning, is that no one has to talk in the group about matters they are not comfortable talking about, and that everybody is responsible for the information they decide to share and reveal. Family therapist may also start a discussion on whether group participants should sign a confidentiality agreement that they will not share any information on what happens in the group outside of the group. Confidentiality matters may be particularly important to families that knew each other before MFT-V or those who live in small communities where “everybody knows everybody” what can only trigger additional fear of being a subject of rumours. Children should also be invited to the discussion with parents as confidentiality matters discussed during MFT-V therapy, often discussions and talks held in families regarding what can be said outside of family and what can be not said. For example, children may think about what their colleagues at school might want to know about therapy. Family therapists often struggle with confidentiality matters as during individual or family sessions they learn about things that cannot be revealed during group therapy. Discussions with a family or individual persons on why some things should not or cannot be revealed to others is therefore an important matter. In MFT-V therapy some rules and regulations are created and established within and by a therapy group. Addressing the group members with the question “What rules should be

guiding our work?” aims to initiate a long discussion in which “old” rules may be verified and validated and new ones, resulting from the existing situation and experience, introduced. It is important to encourage the group to discuss sanctions for breaking the set and agreed rules and whether the same sanctions should apply at the first offence as at the subsequent. Engaging families in establishing rules and consequences of their breaking allows them to experience their own agency.

Multi-family therapy textbooks present a number of specific and detailed rules that are important in therapeutic work focused on resolving domestic violence problems. These include [20, p.7]:

- building solidarity (*We are all in the same boat*);
- breaking stigmatization and social isolation (*We are not the only ones who have those problems*);
- stimulating new perspectives (*When I see the same issues in other people, they are clear to me, while in myself it is hard for me to notice them*);
- mutual teaching and learning (*I like how other people cope with this*);
- reflecting in other people (*We do it just like you do*);
- positively using group pressure (*I see that we cannot avoid difficult topics*);
- mutual support and feedback (*You are doing great, and how are we doing?*);
- discovering and building new competencies (*I can do more than I thought I could, I am not helpless*);
- experimenting with “foster” families and baby-sitting other children (*We can baby-sit other children – I like the way in which your parents take care of my child*);
- intensifying interactions and experiences (*This is like a beehive of activity, there is something going on*);
- empowering and igniting hope (*There is a light at the end of the tunnel – even for us*);
- practicing new behaviours in safe surroundings (*We can experiment here even if sometimes it does not work out well*);
- broadening self-reflection (*I see myself more clearly – differently than before*);
- promoting openness and reinforcing self-esteem through “public” speaking and interactions (*Nobody judges us here, we can be open*);

Legal aspects

Most of the families covered by MFT-V use some kind of social assistance, are under court guardianship or guardianship of other institutions. For some families, participating in MFT-V is the only way of contact with their children and a chance to have at least some custody of them. Some children given to foster parents can meet with their biological parents only during MFT-V sessions.

Considering safety of children and other family members, the London team established contraindications for participation in MFT-V [2]. First, adults (children or caregivers) with serious mental disorders such as escalated positive symptoms or deep depressive disorders accompanied by suicidal thoughts and tendencies should not participate in this form of therapy. It also applies to persons taking psychoactive substances or addicted to alcohol. Prerequisite for participating in MFT-V for an addicted person is their 6-month abstinence. Further exclusions concern adults and adolescents who are sexual abuse offenders or who have been diagnosed with pedophilic inclinations or who have committed serious crime or attacked other people.

Institutional context

MFT-V project can be executed by teams or centres connected with social welfare, health care or education. Multi-family therapy can be conducted with diverse intensity. In case of the Marlborough Family Centre, MFT-V constitutes a part of the Family Day Centre Unit work. Families are taken in for a 12-week intensive program which consists of daily meetings and activities from 9.00 am until 3.30pm. The program includes 2 multi-family therapy sessions, individual activities of family members as well as meals prepared together. In other centres, multi-family therapy is conducted once a week or once in two weeks, or once a month. In such situation, therapy does not require much space: to run 2-3 hour MFT-V sessions, one big room is sufficient. It is helpful if the session can be recorded so that afterwards it can be analyzed, difficult moments can be discussed and further therapeutic strategy can be prepared.

MFT-V can be run by two family therapists; in that case, one plays an active role, the other remains an observer. Therapists can change their roles and in experience teams such change can happen seamlessly even during a therapeutic session. The observant therapist can remain in the therapy room or in a room with a one-way mirror or observe the work on a screen, if technical conditions permit. In practice, it is beneficial if the team consists of 3 therapists – it guarantees work continuity in case of sickness or holiday of one of the therapists.

Beginning of MFT-V is usually preceded by a meeting with representatives of institutions involved in resolving the problem of a given family, adult member of the family, and the centre's therapists. Such meeting has a couple of objectives. First of all, it helps in creating a "road map" for all people professionally managing a family together with details of their work scope, objectives, and attitude towards a family. Besides, such a meeting facilitates understanding of the relations between the professionals and a family, fosters mutual open sharing of comments and doubts by the professionals, and also allows the parents to present their stance and describe their fears and needs concerning the problematic situation and their participation in therapy. Finally, it helps to identify and establish the scope of work, necessary time span, and expectations concerning the change in family relationships as well as to specify consequences if such change should not occur.

Therapist's role

In multi-family therapy, the role of the therapist is particularly important. Although systemic education and experience in working with families and groups help to develop many skills, including using therapeutic techniques, nevertheless running multi-family therapy in the presented model requires very specific qualifications. As it was already mentioned, therapist is a catalyst that enables building relations and entering interactions which otherwise could not have happened and that allows the families to get closer. This requires the therapist to take an active role; he has to be constantly in motion, building bridges between families. As soon as families or individual participants get acquainted and more comfortable, the therapist should gradually withdraw, leaving them the floor. Therapist's attitude and his or her skills of using appropriate therapeutic techniques are very useful in this process. Asen and Scholz [2] emphasize that the ability of not making and maintaining eye contact with one person only, but swiftly turning to other people during the session is important. Making eye contact with all people in the room, described by Asen and Scholz as *scanning*, is a signal of a partial presence and helps to establish and maintain metaposition without emphasizing therapist's own role. *Multipositioning* is another important aspect. Scanning can be backed up by physical movement – family therapist can walk among the group participants like a satellite. The aim of such behaviour is to pick up on the discussed issues, make observations, and activate family members. MFT-V therapist usually does not need a chair, he or she does not need to sit as they should be in constant motion, wandering, stopping or kneeling next to a family or a particular person. For example, therapist can stop and kneel down next to a given person when they notice that this person has difficulties with engaging in a task or a discussion and by doing so help them to overcome those difficulties. In this sense, MFT-V therapist's behaviour differs from the behaviour of a group therapist working in psychodynamic approach and from a family therapist working with a single family. It means that MFT-V therapist is active only for some time and then they should bow out. The work of the therapist consist of entering the situation and then withdrawing from it, moving as if in a dance, thanks to which they are simultaneously close and far away from the group. Therapists working in this model have to have the skill of establishing good contact with both adults and children. It should be noted that in multi-family therapy part of therapeutic sessions is conducted in a large group that include parents and children, and part in separate sub-systems of parents and children.

When summarizing the role of therapists, their objectives need to be emphasized. Building safe setting is the first one; second - encouraging families to actively participate in specific therapeutic actions, third - leading to change of behaviours assessed by the parents as non-adaptive. The whole therapeutic process needs to be accompanied by the therapist resigning from the role of

an expert and handing it over to the members of the group. Cooperation between therapists occurs through changes in their activity. Therapeutic techniques are introduced and conducted interchangeably by one or the other therapist. The presence of two therapists and the third member of the team allows for a better understanding of the group dynamics, emotions, relations and it also provides constant possibility of support during and after the sessions.

When working with people who have experienced many traumas – which is often the case when confronting violence – a therapist has to know how to react flexibly and direct the group process in a way that it is beneficial for all involved parties. Thus, structuring meetings is an important aspect; therapist should introduce tasks – sometimes common for the whole group, sometimes separate for parents and children, and discuss difficult issues using workshop exercises and techniques. Foreseeing difficult moments, critical in the group work, and the ability to therapeutically resolve them is an important objective on the therapist's list.

Stages of therapy

Families invited to participate in MFT-V therapy may be known to family therapists from prior or current therapeutic practice and work, or may be referred from other institutions such as social welfare, centres related to psychological and psychiatric care, and schools. Most families initially are very reluctant to meet with other families and discuss subjects they consider very personal and interfamilial and which should not be “revealed publicly”.

Initial meeting

Therapy should be preceded by an initial meeting. Its objective is to create a situation in which families may experience benefits of participating in the group and which would encourage them to come back. Family therapists should clearly and straightforwardly explain how the group works. They also should find out what are the expectation of the family and why it seeks help. This kind of meeting gives a family a foretaste of what multi-family therapy is and facilitates making a conscious decision whether they want to take part in it.

The meeting may take up to two hours and should be organized in late afternoon or evening so that the excuse of having to work is removed. It should be well-planned as 12 to 25 people may appear, so potentially it may cause some chaos. To avoid situations which may trigger unnecessary fears in participants, family therapist should take control over the course of the meeting. The room where the meeting is supposed to take place should look inviting and encouraging; it is also advisable to organize some snack and drinks so that families can focus on informal aspects of the meeting. During the meeting, therapists use a number of exercises and techniques to facilitate getting to know each other combined with some fun activities, which is always entertaining not only for children. For example, instead of traditional introduction, therapist may suggest a quick play with a ball. In round one, the person who is thrown a ball should say their name, in the next round

an animal they like, in the subsequent yet something else, i.e. their hobby. In this way, getting acquainted in the group happens almost naturally and the exercise helps to reveal differences and similarities and develops interest in each other. Freeing up high level of group energy and building comfortable atmosphere are the greatest benefit of this ice-breaking exercise.

Initial meetings can help families in reducing fear of participating in group therapy. If the group is run in an open system and families that have finished therapy are also invited to the meeting, their experience may be inspirational for the new joiners.

Focusing on the problem stage

After the initial round of meetings, when some bonds are already formed between the members of the group, the stage of identifying problems and directly addressing them takes place. Its objective is to limit the problematic behaviours presented by a given member of the family. It boils down to parents taking full responsibility for difficulties and problems of their children. Thus, setting boundaries, introducing acceptable disciplining behaviours, mutual support between parents, the ability to discuss adult matter without the presence of children are really critical issues in therapy. At this stage of treatment, identification of communication issues and problems with interactions related to violence, abuse and neglect take place. For majority of families, hard times moment turns out to be extremely difficult and motivating them to survive those hard times brings best effects only when solidarity within the group is high and parents from particular families support each other.

The objective of family therapist is to support parents in their efforts, not to model behaviours or assume educational functions. At this stage, as in the subsequent ones, used fun games techniques and exercises play a crucial role. For example, the following exercise might be an introduction to a discussion on difficult feelings: the game is called *statues* – each participant is asked to freeze in position signifying some emotion while other participants need to guess what emotion that is. This activity can be supplemented with taking photos or recording. Participants may compile a list of emotions and match them with photos or movie scenes. Next, each participant can be asked to present the emotion that is most common, for example, in their relations with other family member. This exercise can be further developed, e.g. participants can be asked to show the emotion they would like to experience with a given family member. This technique, modified depending on the objective and group's problems, provides experiences that can be further discussed: In what way one can express and identify different emotional states in others, especially anger and aggression? Is it possible to appropriately identify those? How can we know what the other person is feeling? How can we pretend that we feel something? In what situation did any of the participants feel that way? [20].

Focusing on relations stage

At this stage initially the main focus is on interfamilial patterns of interactions and communication, in which violence and abuse is present. Gradually, focus is shifted towards other aspects of relations. These include hierarchy in the family, triangulation, specific difficulties in communication, inappropriate emotional involvement, hidden coalitions, family secrets, etc. During this stage, the significance role of violence in the closer and more distant family as well as existing permanent and transgenerational family patterns are studied and analyzed. Available internal and external support resources are identified and families are encouraged to use those. Drawing a so-called conflict map is one exercise that can be helpful at this point. The aim of this exercise is to discover relations between the social context and problematic situations and interactions. Another exercise uses a TV remote metaphor where in a symbolic form participants may experience how people control each other.

Preventing regression stage

At this stage, therapeutic work focuses on the future and concerns not only how family copes with violence, abuse and child neglect, but also with other domestic and familial matters. The aim is to prevent regression and identify signals that can foretell this early. At the end of the therapeutic work, family therapists focus on accompanying families in maintaining changes and take part in rituals concluding the therapy process.

Recapitulation

The present article is an attempt to familiarize the audience with the model of multi family therapy for families with domestic violence problem created and implemented by the Marlborough Family Centre under the supervision and lead of Alan Cooklin and Eia Asen. One of the crucial aspects of their approach is the ability to combine the achievements of different trends in family therapy and psychotherapy as a whole with the input of group dynamics. The Marlborough Family Centre emphasizes the significance of structural and strategic work that presupposes responsibility of the parents for proper childcare, mutual support in parenting, need for maintaining clear boundaries, implementing appropriate control strategies – aspects especially critical in families with violence and emotional neglect. The presented approach takes into account transgenerational context, attachment patterns, and identity issues related to culture, ethnicity, and race. Close cooperation between Eia Asen and Peter Fonagy, the co-creator of mentalization therapy, has had its impact on the assumptions of MFT and family therapists in this model are more sensitive towards the development of mentalization processes in family relations while also using therapeutic techniques that favour and encourage that development [21]. The structure and the course of the sessions which combine workshop techniques with reflecting processes taking place in different sub-groups and in the whole group allow for implementation of modern family therapy ideas and

foster broadening of family maps, change of meanings, and appearance of new descriptions. Therapeutic process constructed in such a way seems to be particularly beneficial for families with domestic violence problem. Structuring sessions through exercises and tasks provides new experiences which are further commented and reflected upon during a group process both by adults and children. It gives a chance to better understand different points of view as well as similarities. Due to those reasons, development of this form of therapy in our country through regular trainings and workshops and in the further course through supervision of therapeutic practice would be advantageous and valuable.

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