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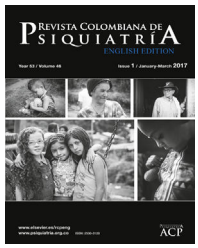

Original article

Implementation of a multi-family intervention for children with behavioural and emotional problems in a semi-rural population☆

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ABSTRACT

Objective: To determine the feasibility of implementing a community-based, multi-family group intervention in a semi-rural population in Aranzazu, northern Caldas, Colombia.
Methods: Qualitative study. A convenience sample was taken of 10 families with children with affective and behavioural disorders, previously identified by the Child Behaviour Checklist (CBCL). The Multifamily Psychoeducational Psychotherapy (MF-PEP) model was adapted to the culture and needs of the families.
Results: The contents of the sessions and the topics and experiences that were most significant for the children and their families are described.
Conclusions: The adaptation to the cultural context of the multi-family intervention had a very good acceptability by all participants: caregivers, children and therapists.

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Implementación de una intervención multifamiliar para niños con problemas conductuales y emocionales en una población semirrural

Palabras clave:
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RESUMEN

Objetivo: Determinar la factibilidad de implementar una intervención grupal multifamiliar, basada en la comunidad, en una población semirrural en Aranzazu, en el norte de Caldas, Colombia.

Métodos: Estudio cualitativo. Se tomó una muestra de conveniencia de 10 familias con niños con alteraciones afectivas y conductuales, previamente identificados mediante la *Child Behavior Checklist* (CBCL). Se adaptó a la cultura y a las necesidades de las familias el modelo de Psicoterapia Psicoeducativa Multifamiliar (MF-PEP).

Resultados: Se describen los contenidos de las sesiones y los temas y las experiencias que fueron más significativos para los niños y sus familias.

Conclusiones: La adecuación al contexto cultural de la intervención multifamiliar tuvo una muy buena aceptación de los participantes, tanto cuidadores como niños y terapeutas.

Introduction

Mental disorders cause a huge burden of disease throughout the world, and also in Colombia. According to the 2015 Colombian mental health survey, Encuesta Nacional de Salud Mental (ENSM), the prevalence of any mental disorder in the last 12 months in the 7-to-11-year-old population was 4.7% (95% confidence interval [95% CI], 3.6–6.2%). This means nearly 5% of all children in the population have or have had a mental disorder in the last year, according to the perception of their caregivers.[1]

For this age group, the most common mental disorders in the last 12 months were attention deficit disorder (3%; 95% CI, 2.1–4.1%), with the hyperactivity subtype being the most common (1.7%; 95% CI, 1.2–2.4%), followed by separation anxiety disorder (1.8%; 95% CI, 1.1–3%) and generalised and oppositional defiant anxiety disorders (0.4%; 95% CI, 0.2—0.8%). In the same survey, when applying the Reporting Questionnaire for Children (RQC) to the 7-to-11-year-old population, it was found that 44% needed mental health professionals to assess them, according to the following indicators: language disorders (19.6%), nervousness (12.4%), headaches (9.7%) and poor ability to play (9.5%).[1]

To respond to mental health problems, both the Mental Health Law of 2013 and the Mental Health Policy of 2018 consider children and adolescents a priority population for public health in Colombia. Policy in Colombia seeks to prioritise care for children and adolescents through strategies of promotion and prevention and access to timely and evidence-based care. Moreover, the early stages of life are a key period for implementing care strategies, as 70% of mental disorders have their onset before the age of 24.[2,3]

However, the present healthcare system in Colombia does not have sufficient capacity to cover the mental health needs of children and adolescents. There are simply too few general psychiatrists and specialist child and adolescent psychiatrists and psychologists, and most specialised human resources are concentrated in large cities.[2] For rural areas in particular, the provision of mental health services for children and adolescents is plainly inadequate.

An example of populations with insufficient mental health resources is the municipality of Aranzazu, Caldas, where nonspecific affective or behavioural symptoms have been identified in children described as triggers or as a consequence of problems at home and at school.[4] Similarly, children who have made suicide attempts and have severe behavioural symptoms (largely related to underlying affective disorders) are referred to Manizales for hospital treatment. After having the crisis situation attended to, they return to the town of Aranzazu with follow-up appointments that are rarely kept and sometimes with drug treatment. There are no other strategies in place to help maintain the improvement or regain their place at school, at home, or in their environment in general. There is also no care for the families.

Before seeking to have specialised individual care for each of these children and adolescents, we need to find an alternative form of care close to the community, which can be carried out in the local area and with the healthcare staff already in place. Additionally, to attend to children's emotional and behavioural difficulties more comprehensively, it is also essential to work with their families.[5]

While searching for interventions with evidence that met these characteristics,[6–12] we found a systematic review that evaluated the feasibility and efficacy of intensive short-term dynamic psychotherapy. We determined this type of intervention was more effective than the control conditions, although the authors propose more studies to specify which factors are associated with an adequate response.[6] It has also been specified that community-based mental health interventions, especially through the family setting, may hold promise for improving approaches that address the mental health service quality gap and disparities in services.[7,8] With another type of intervention in Ireland called functional family therapy, clinical recovery rates were significantly higher than in the control group. Both parents and adolescents reported an improvement in family adjustment maintained at the three-month follow-up[9]; in addition to improving symptoms, this

type of intervention brought families closer to the healthcare system.[13] Some studies that implemented this approach found predictors and moderators of response to psychosocial interventions. A greater functional deterioration in the children is a predictor of a worse outcome, while a history of stress or trauma in the children and the emotion expressed by the parents would be moderators of these outcomes.[14]

Our literature search also came across multi-family psycho-educational psychotherapy (MF-PEP), designed by Fristad and MacPherson[15] at Ohio State University in Columbus, Ohio (United States). Multi-family therapy consists of a brief, adjunctive group treatment, which incorporates psycho-education techniques, family therapy and cognitive-behavioural therapy (CBT). This method was originally designed for young people with mixed mood diagnoses, but has been shown to be effective in treating school-age children with bipolar disorder.[16–20] Various studies based on observations and self-report questionnaires had implementation outcomes of acceptability, adoption, appropriateness, feasibility, implementation cost and sustainability of this type of therapy. Furthermore, parents also showed significant improvement in their knowledge of mood disorders after the treatment, and in both clinical and community settings.[21,22]

With the above in mind, our aim was to study the feasibility of implementing the multi-family psychotherapy model in a semi-rural Colombian population. This intervention was an indicated prevention strategy, as it primarily addressed children who were struggling but did not yet meet categorical diagnostic criteria. It is also important to note that this intervention was part of a community-based rehabilitation (CBR) strategy in operation since 2016, which is recognised by the Ministry of Health and Social Protection as a successful experience.[2,3]

Background

It is common to find extended family groups in Aranzazu, which have members diagnosed with mood disorders in several generations.[23] As described in the literature, added to the difficulties in obtaining holistic treatment, this means that the adults (parents, grandparents, teachers) responsible for the children's care in turn have difficulties managing their own emotions, and express their discomfort through affective or behavioural symptoms, and this situation has been reported in children and adolescents with these affective disorders.[24,25] Consequently, there are few resources for resolving conflicts, which can easily lead to an unfortunate chain of events, which lead to breakdowns in family life, such as abuse of the children at home.[24,26] Mistreatment can also occur at school, because children do not fit the mould of the "ideal student", with the subsequent risk of them dropping out of education. When this happens, parents feel even more helpless, and being exhausted, they fight so that their children do not lose their place at school and can learn and establish valuable relationships with children their age.[25,27,28] A study of 7–12-year-old children found that the most consistent predictors of intraparental conflict were the level of hostility expressed in the interaction, the children's previous experience with physically aggressive interparental conflict, and the age of the children.[29] Considering the reciprocal relationship between affective disorders and problems and the family system, interventions must include this system to achieve better outcomes. According to a systematic review carried out by Reinares et al. in 2016,[11] most evidence-based studies support the efficacy of adjunctive family intervention on the outcomes of the disease, both in the juvenile and adult population, as well as the benefits for caregivers.

In 2018, in collaboration with the Pontificia Universidad Javeriana and Universidad de Manizales, screening with the Child Behavior Checklist (CBCL) was applied to 277 schoolchildren aged 4–10 (200 of them between 5 and 8 years old) in three educational institutions in Aranzazu, two urban and one rural. In the population to which this scale was applied, it was found that 135 (45%) of the children aged 5–8 had affective and/or behavioural problems.[4] An association was also found between these scores and alterations in school experience, forms of bonding with their main caregivers, and some neuropsychological domains, such as sustained attention and working memory. These results indicate a higher risk of mood disorders and other mental illnesses, in addition to their complications (suicidal behaviour, school dropout, etc).

The study by Agudelo-Hernández et al.[4] in 2018 found a statistically significant relationship between the risk of psychopathology according to the CBCL for children and the level of caregiver depression according to the Patient Health Questionnaire-9 (PHQ-9), with p values <0.0001 in both cases. They also showed that a higher percentage of adults have symptoms of depression when the child has medium- or high-risk symptoms, compared to parents whose children have lower-risk symptoms. Similarly, the proportion of children with some degree of risk is greater when the parents report perceived difficulties in daily life according to the PHQ-9, with these values increasing as the children's risk increases. In summary, the study suggests that, in the Aranzacita community, emotional difficulties occur in both children and their families, reinforcing the need for a holistic approach to children and families.

Methods

Exploratory, qualitative-descriptive study, focusing on the description of the experiences of children and their families through ethnographic tools of observation, field diary and group and individual interviews, carried out during the first period of 2019 in the municipality of Aranzazu Caldas in Colombia. The population consisted of children with affective and behavioural symptoms or problems identified with the CBCL and their families. From this population a sample of ten families was taken by criterion of convenience.

The objective of this study was to determine the feasibility of implementing a multi-family psycho-educational psychotherapy intervention in a group of children and their families in Aranzazu, aiming to assess the possibility of effective, workable psychosocial interventions adapted to the particular context of the population.[30]

The research group was made up of three child psychiatrists, a general psychiatrist, a neuropsychologist, a social worker and a rural doctor. After obtaining verbal and written informed consent, the group meetings were held and

Table 1 – Priorities for the caregivers, focal group.

Needs prioritised by carers	Perception of the carers
Sadness	"My other son is another matter, he's like a dead person" "... I have an emptiness inside because I didn't enjoy myself when I was a child"
Fear	"According to the children's perception, emotional symptoms predominate, headed by sadness and anger, and added to the components described is fear". (Facilitators' notes)
Anger	"He makes his younger brothers cry, his sister too, even me, one minute he's fine, then the next he's looking for a fight"
Changes in temperament	"My son's really temperamental, he doesn't like studying, he doesn't like doing anything, one minute he's happy, and then he doesn't want to do anything"
Worry	"My daughter's very hyperactive at school, at home she's an A"
Isolation	"He's a very quiet person, I would like to help him talk to others, he's very nervous"
Impatience	"I look on the internet for strategies to help him and understand him, the only thing I see for him to improve is his impatience"
Low self-esteem	"He's treated as silly and stupid because he can't do his schoolwork"
Family difficulties: beyond the "patient"	"Do we only talk about the child who is *sick* or should we talk about the others too?"
Difficulty resolving problems of day-to-day family life	"I wanted to throw them over a cliff"
How to communicate? How to communicate with each other?	Between parents, with the children, with their children's teachers
Specific problems; "What do I do if...?"	General request for support and expectation of help for specific situations
"What's not there, what's not said"	The above subject areas are not the people's only concerns and fears. They hint at things they would like to talk about at some point, or also that they need to find ways to express in words certain experiences and distressing situations which cause them pain, but are difficult to identify and so difficult to share.
Difficulties of their children at school: Behaviour Performance Learning Attention Memory	"He was very rude to the teacher". "They have some challenging behaviour". "The teachers tell me they can't cope with X, he screams, grabs the girl by the feet and throws her to the ground... I've been very unhappy" "My daughter needs help paying attention". "What can you do to make the girl pay more attention the classroom?"

recorded, and a field diary was created for subsequent analysis and preparation of the article. One person was responsible for observing the context without interfering in the progress of the session, and another, as a general observer, was responsible for recording the dynamics of the group, the context and the environment, as well as the opinions, consensuses, agreements and disagreements of the participants. A total of six sessions were held.

The information obtained was discussed with the children and their families in a consultation process, to make it easier for families to decide what information should be published. By applying ethical principles, we were able to maintain a relationship of respect and privacy in the processing of information, with the consequent socialisation of the results with the participants, and to assess the possibility of expanding the intervention and repeating it in other places for children with emotional and behavioural problems.

The protocol was approved by the Research and Ethics Committees of Hospital San Ignacio-Pontificia Universidad Javeriana and Universidad de Manizales. The following steps were followed for the adaptation and implementation of the MF-PEP:

1 *Adaptation to the context*. Based on the contents and sessions described in the method by Fristad and MacPherson, the research team members made a cultural adaptation and determined the priorities of the group of parents.[15,20] In the original model, the psycho-pharmacology component figures prominently, probably because behaviour problems are often treated with medications in the United States, whereas psychoactive drugs are rare in our study population. Therefore, the discussion of medications does not take up so much time. Care routes were also simplified to reflect the care processes of the study population. It is worth noting that the focus group participants did not mention either of these two points as priorities.

2 *Focal group: validation of priorities with caregivers*. To validate the priorities in areas significant for caregivers, a focus group was held with 9 of them: 8 mothers and 1 grandmother, facilitated by 2 of the investigators (FA and MIJ) and 3 members of the local healthcare team (AA, social worker, ACD, neuropsychologist and LFC, rural doctor). None of the fathers attended on this occasion. At this session, affective symptoms, difficulties in the family beyond the patient, difficulties in resolving problems in day-to-day family life and at school, lack of communication, behaviour and performance at school, particularly learning, attention and memory concerns, were all established as priorities for them (Table 1). Of the affective symptoms, anger and changes in temperament were the points of interest for the group, followed by sadness, restlessness, isolation, impatience and low self-esteem. The mothers and grandmother present were asked to think about the fathers and share their perception of the problems. They answered that their priority was emotional symptoms, mainly anger, followed by difficulties in the family, lack of communication, behaviour at school and difficulty in resolving problems. According to the mothers, when asked about the children's point of view, emotional symptoms predominated, headed by sadness and anger. When asked about their children's perspective, the mothers mentioned the children's fear for the first time. They also mentioned the need for help to

Table 2 – Contents adapted from the caregiver's and children's sessions.

Session number	Caregiver group subject area	Children's group subject area
1	Emotional problems in the children, their symptoms	Emotional problems in the children, their symptoms
2	Negative family cycle	Connection between thoughts, feelings and actions
3	Develop skills for resolving problems	Develop skills for resolving problems. Stop-think-plan-do-check exercise
4	Improve verbal and non-verbal communication skills	Improve non-verbal communication skills
5	Treatment of the symptoms	Improve verbal communication skills
6	Review the second part of the programme. Graduation	Review and graduation

resolve fights between family members, problems at school, and lack of communication in both places as possible concerns for their children.

3 *Contents defined*. The issues considered by the team after the cultural adaptation incorporate the concerns of the caregivers. Taking into account the needs noted by the caregivers and the initial adaptation, the intervention was designed with the subject areas outlined in Table 2.

4 *Execution of the group sessions*. From 9 March to 1 June 2019, six meetings were held (on each occasion, one with the group of children and another with the group of caregivers). Table 3 shows a summary of the contents covered in these sessions.

Analysis of the information

Members of the research team transcribed the group interviews and the field diary kept during observation of the sessions. This enabled a comparative analysis between the different ethnographic tools used, and helped identify the data related to the subject area of interest and any emerging subtopics, with subsequent pooling and feedback among all the healthcare professionals in the group. Analysis of the individual interviews helped supplement and consolidate the subject areas covered in the sessions, and identify central points of agreement and disagreement among the participants.

Results

The joint multi-family sessions with the children and their families involved active participation and allowed exploration of the subject areas prioritised by the parents. For the group, the participatory structure of the subject areas to be covered during the sessions was also a positive element that allowed a greater appropriation of the method. What the group members also found very valuable was the chance to share and help others based on their own experience, and, at the same time, learn from the experience of others. This helped underline the therapeutic role of the groups, as this was a new experience for them. Added to that was the containing role of the group.

The group discussion of the subject areas with emotional importance for the adults helped them find alternatives for understanding and changing patterns of family interaction. For adults, sharing their difficulties with others and understanding that they were common experiences resulted in relief from isolation, feelings of loneliness and helplessness. In the groups of children, through play and verbalisations, they were worried about the sadness and anguish of their caregivers, and their fear of facing tasks that exceeded their abilities. This shows that their role in the family includes elements of being cared for, but also of having to take on a more adult role at an early age.

For the adults, their children's emotional difficulties evoke the fear of losing them, either definitively or because they change radically. As examples of losing them definitively, they fear they may commit suicide or disappear, and in terms of losing them through change, they expressed ideas like the "dead son" (physically alive, but so unhappy that he has withdrawn from all activity and relating to people). At the same time, they expressed anguish at the failure of their role as carer, which we can interpret as a fear that their difficulties will overwhelm them. They do not know how to set limits and/or if they can contain things. Sensitivity to their children's mental states leads to the same anguish in parents, who sometimes understand and manage them, but at others, react impulsively because these emotions overwhelm them ("the problem is that mum is sad").

Discussion

Communication difficulties were top of the agenda in several of the sessions. These difficulties are played out on several levels: between parents and their children; between parents themselves; and between parents, teachers, and other adults. Parents often know that they cannot understand or communicate with their children, and this leads to the fear that the same thing occurs with other adults the children interact with. The caregivers acknowledged that the difficulty in recognising the children's message (mediated by their behaviour) results in actions or punishments that do not respond to the children's emotional needs; something that happened both at home and at school.

In the parallel groups of children, it stands out that the ability to play and verbalise during all sessions reflects a symbolic and creative capacity with its own therapeutic value. The children already feel "marked out" as problematic, and even express adult and controlling language, like when they say of another child, "Let them tie him up like a mad person", and of themselves, "I get distracted, I can't keep still, I love running and at school they don't want me". Therapists support the expression of this pain, seek to explain the manifestations, and show no disapproval or judgement. It is hoped that parallel work with caregivers, by enabling them to bet-

Table 3 – Multi-family interventions.

Sessions	Activities carried out
Session 1. 9 March	
Caregiver group	Emotional problems in the children and their symptoms
Contents covered	Difficult situations experienced at school, and the pain they felt when their children were required to behave or learn "like children who have nothing" Frustration generated by them being punished at school Despair and hopelessness The anger/sadness sequence was shared by several parents Pain from the "shunned": when they are cold-shouldered
Reflections	After stating that it is difficult to achieve a good relationship because the adults get exasperated, and this only leads to inadequate responses and misery, desperation and frustration; the group focuses on how the attitude of a caring and trusting adult promotes a better response from the children (containment) There is evident initial confusion, especially in the parents, as to whether the group is to talk about the children's feelings or also those of the caregivers
Children's group	Emotional problems in the children and their symptoms
Contents covered	Difference between problem and disorder What is affection, what is an emotion, what are emotions? When emotions are similar and get confused What are feelings and sensations Difficulty of children in general to differentiate between emotions, sensations and feelings Many in this group believe that unhappiness is anger "Hyperactivity" to not feel fear; anxiety to avoid feeling unhappy: "if I'm unhappy, I don't play"
Reflections	This group experiences what is indicated by neurodevelopment: difficulties in mental preparation, in defining emotions There are also difficulties (and this is an objective of individual interventions) in managing to symbolise these emotions: defining to demarcate what they feel and experience it as such This does not happen only in children: caregivers, as they express in this session, also have difficulty finding a symbol that illustrates their emotions
Session 2. 23 March	
Caregiver group	Develop skills for resolving problems
Contents covered	Difficulties parents have with authority: they cannot get their children to do what they are asked, or they have to repeat an instruction many times Punishments: there is a debate about whether children should be prevented from "getting away with it" before they break the rule, or whether the punishment should come after the infraction (the situation prompting the debate is that a girl goes out cycling when her mum has told her she can only go out when she has finished her homework). Some think the mum should take away her bike (to stop her leaving) and others, that she should only take away her bike if she actually leaves. Respect: changes in the way of enforcing the rules related to generational changes, perception of verticality, "Before, your parents told you to do something, and you jumped to it. . . not any more".
Reflections	The need to establish authority figures, the importance of authority (as distinct from authoritarianism) Discrediting of one parent by the other
Children's group	Develop skills for resolving problems. Stop-think-plan-do-check exercise
Contents covered	One opens saying they have come "to be better". The children report their problem is "the other"; "putting up" with their sibling (in a specific case, rescuing their sibling from a suicide attempt); but it is also them who put up with the sibling's bad temper and unfortunate behaviours, and who give them support. Another boy says his problem is that his mother is sad because his father is in prison. Another one, who suffers because they don't want him at school; and another, who gets infuriated when another child behaves "like a mad person", and thinks they should tie him up. Two children remain silent; they don't put forward anything, they just wait The therapist perceives them as unhappy When they are told they can play and toys are put out for them, several elements appear: the need to defend themselves in a world where there are goodies and baddies; possible solutions to problems, including fighting, talking, thinking. One boy only manages to contain himself by hugging the therapist In one of the stories, evil is exerted with "rat poison", a product with which there are several reported suicide attempts
Reflections	There is a cultural reference to "gota a gota" (loan sharking), internalisation of aggression or identification with the aggressor They already know about suicide
Session 3. 6 April	
Caregiver group	Negative family cycle
Contents covered	They fear repeating certain dynamics centred on anger, criticism, abuse and lack of understanding of the child's development

Table 3 (*Continued*)

Sessions	Activities carried out
Reflections	Parents, seeing their children and reflecting on what happens to them and the behaviour that arises around this, then manage to reconnect with their childhood. Then, they may consider some reactions they have had towards their children inappropriate or excessive.
Children's group	Connection between thoughts, feelings and actions
Contents covered	The therapist asks what they do when they are angry. They are all waiting for a turn to answer: "When I'm really angry, it makes me want to hit the pigs or my mother. Sometimes I do, but not so much anymore. Now I only damage things, I throw them on the ground" One boy refers to his brother as a "mad dog" (that particular boy has made two serious suicide attempts at times of great anger). "I pull my hair out" "My brother's anger makes me angry… and I hit him" Two children, who have previously been defined as "the bravest" and are considered very active, remain still, embracing each other. The moderator perceives them as unhappy, as if sadness was behind the anger The therapist then asks about the ideas that accompany the anger: "The moments of anger seem never-ending" "I think I'm going to get into a lot of trouble, but sometimes it's too late because I've already reacted badly" "I think a bunch of people need to catch me and hold me down; if not, I do damage" "It goes through my mind that it would be better if the world didn't exist or if I didn't exist"
Reflections	When they calm down and assess what happened, they see that anger can lead to misguided actions and poor decisions. Then comes the guilt
Session 4. 4th May	
Caregiver group	Improve verbal and non-verbal communication skills
Contents covered	The therapist talks about language. The entire group initially associates language with the spoken word Other forms of language are proposed: the group begins to say that we also say things with our eyes, "I know when he looks at me that the child is unhappy"; and so they talk about the anger, joy and worry with words Social work does body language exercises to also identify a form of communication through body movements
Reflections	Parents very much prefer the spoken word to communicate with their children at an age when the word comes in second place They learn that not all motor restlessness is hyperactivity, and that not all abdominal pain, headaches, and "pee or pooing accidents" are illnesses The body is also a message, for identifying symptoms, to provide signals in parenting
Children's group	Improve non-verbal communication skills
Contents covered	An exercise is proposed to tell a story without words, only with gestures In the construction of the story, they repeat the "gota a gota" story about loan sharking, for which they go back to using the toys and the pretend banknotes. This is done as a small script They say someone borrowed money, he could not pay, they used violence to get paid back, and that the person who owed the debt and his family had a bad time at the end of the story As a final activity, they were asked to retell the story in words; a volunteer is requested, and two brothers do it
Reflections	They have a special facility to build the story without words It was also relatively easy to turn the story into words, in which hatred and revenge prevailed, which were the easiest situations to identify for them; they did not narrate the sadness of the family at the end in words The image of "gota a gota" (loan sharking) persists as a way of making money, which could be seen as a proposition of their culture
Session 5. 11 May	
Caregiver group	Treatment of the symptoms
Contents covered	The therapist mentions that the dynamics of the group were steering him towards the power situation parents experience with their children: "Sometimes we don't know who's bossing who" Aspects of the negative family cycle are taken up, where it is mentioned that the only way caregivers knew when they were children to do as they were told was through fear, because of abuse from their parents. Some fear abusing, and sometimes identify as "flexible" The concept of emotional support is put forward, very necessary for children and adolescents with the symptoms specified in this group
Reflections	Many parents view physical violence as necessary to treat behavioural and emotional symptoms. The vast majority are afraid to deal it out because of what happened to them, and they tend to be permissive or despondent, leaving aside the ability to contain and take a firm stance to tackle the urgent task of supporting their children's emotional development

Table 3 (*Continued*)

Sessions	Activities carried out
Children's group	Improving verbal communication skills (the therapist, considering the topic "symptom management" for the adults, called it an "emotions session" for the children's group)
Contents covered and reflections	Many children came, also the younger siblings of the usual attendees "who are doing well." Another difference was that the session was held in the hospital courtyard because it was raining and they couldn't go to the sports field where the other meetings had been held The therapist brings toys and makes them available, so everyone can build a story with them. They stage the "gota a gota" (loan sharking): an activity several young people in the region are engaged in, which puts them at risk when they have to collect the interest payments. Amid the excitement and anxiety of some of the children, they manage to identify and verbalise fear and sadness. They also talk about madness (one of the children would go mad because they didn't take their pill), which is described as loss of control. They also report their happiness at being able to tell the story
Session 6. 1 June	
Caregiver group	Closure of the first phase. The second part of the programme is reviewed. Graduation
Contents covered	Ten caregivers attend, the two participating dads come. The moderator of this session is a therapist who the participants recognise as part of the team, but who had not been present until the closing session "They helped to nudge our children, show us how we should educate them better, not treat them badly, to be more united with the family" "We've been learning a lot" They describe feeling accompanied, finding complicity, regaining confidence that their initiatives can be useful to others, and also in the chance that their situation may improve if they use an initiative proposed by another participant They felt united, accompanied "Sometimes we turn a blind eye to things, or to avoid arguments, we allow them to do some things or stop doing others, and I hadn't realised" (mother who reports the group made her realise she set the rule, but she herself was responsible for not enforcing it to avoid arguments) It was a surprise for all of them to realise that they could help other people Lastly, when asked if they wanted to talk about anything else, they began to talk about their children's moments of crisis, deep sadness, loss of interest, bad temper, rage, attempted suicide. And also about the anguish caused by thinking they might harm themselves again, and (linked to this) "a guilty conscience": the fear of prohibiting and setting rules, thinking they might react even more, and that the chain of reactions could lead to another suicide attempt They also reported that they perceived changes in themselves, and that this had led to a change in the dynamics of the house, from which everyone benefited.
Reflections	We had thought that individual consultations would be required later in certain cases, as the group made it easier for them to express themselves through trust, openness, evoking something of their own when hearing the intervention of another participant, the company, the fact of being able to identify with the sufferings of others, reflected in others… Participation in the group makes them feel they are not alone facing problems that are difficult to talk about for various reasons: because they do not think it is of any use in finding possible solutions; out of shame; because they do not know who to talk to…
Children's group	Review and graduation
Contents covered and reflections	It becomes difficult to talk as a group, because the children begin to play together. The therapist chooses to interview them one by one. One child says he likes coming to the group and begins to tell a love story, "She makes me very happy, because now I have someone to talk to" The game of going to collect money, the fear and the need for protection by someone reappears. They go from war to building a game that more participants join in with, also to building with building blocks. There is a war, a secret weapon appears: "It's the rage machine… If I use it, the fight ends, but it's for emergency situations, when you can't take it anymore". They manage to end the war without using the secret weapon which has the risk of killing animals as well. In the game, a pair of young brothers play, the usual role between caregiver and cared for is reversed. At the end of the session, the game becomes disorganised and it is striking that they destroy the toys

ter understand what underlies problem behaviours, will also help break the cycle of accusing, blaming and stigmatising the child.

The modality of parallel sessions with the therapists facilitating enabled group work involving the parents and the expression of emotional difficulties which had not been possible in other contexts, including individual consultations. In the closing session, the parents acknowledged the value of the contributions of the other group members, not only of the therapists, but also the contributions they had been able to offer to others from their own experiences, all of which resulted in a supportive, therapeutic and restorative experience. In other words, despite having problems, they are not just problems; on the contrary, they can use their experience to help others. Both the caregivers and the children understood how the difficulties are not just of one of them, but of the parent–child dyad.

The treatment of the parents' frustration, anger and helplessness was a central element. Related to this, the fear of the negative consequences of limits arose, including fear of suicide, possibly reflecting an outcome that has been painful in the community. This is also expressed in the children's play,

"Pay attention to him and let him win, if not he'll get angry and kill himself", and similar comments from several members of the children's group, in various sessions.

Other significant contents were the fear of an exclusively symptomatic reading of the children's difficulties in schools, and that this leads to disciplinary consequences that end up with the exclusion of the child, instead of an understanding of their difficulties. This situation is to a certain extent an echo of the same response of the parents in the family context, when they expressed pain when thinking about disciplining at home, and not knowing if they were setting necessary limits or, on the contrary, punishing their children for emotional problems. Finally, in the closing session, the caregivers showed their acceptance of multi-family psychotherapy by saying they wished many other people could have the same experience.

The study also enabled us to find a number of difficulties and limitations. Despite the fact that the sessions were held in the main town, and on a market day (when they usually come into town), there were still access difficulties. Secondly, some of the co-therapists did not live in the same town, which meant additional logistics and costs. Last of all, it is clear that, due to the difficulty in some cases, it is necessary to complement multi-family therapy with individual approaches.

Conclusions

The participants well accepted the multi-family intervention to the cultural context, whether caregivers, children or therapists. The groups were formed in a semi-rural community, far from the big cities.

The planned contents allowed working on the difficulties prioritised by the parents, with active participation and open dialogues between themselves and the therapists. In particular, the group allows people to mention difficulties they had previously not been able to talk about. Additionally, the caregivers were surprised to find that their problems were not "strange", "unique" or isolating, and that they could learn from and help each other. This allows a new role for them, which is not just that of "problem mum or dad with problem child".

Once again, the acceptability of the intervention is made plain by the conclusions of the parents' group, expressed in their clear wish to have more group sessions and in their open recommendation to offer it to other members of the community who could benefit as much as they did. The investigators were themselves surprised to a certain extent by the dynamics of the groups, which enabled identification and expression of emotional difficulties and possible solutions found by the group itself.

This first pilot was implemented by general and child and adolescent psychiatrists, which is a limitation for the expansion of the model to other populations. The next step involves training other healthcare professionals in the community to implement multi-family groups. The local staff are closer physically and culturally, it would help with continuity and regularity, it is more accessible and less expensive.

A second phase should examine clinical and social outcomes for children and parents, including the children's performance at school. Finally, as part of a community model, teachers and the school environment need to be included, so that the achievements of these groups find an echo in the school environment.

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Conflicts of interest

None.

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