WORKING WITH FAMILY AND COMMUNITY RESOURCES IN EDUCATIONAL, SOCIAL AND MENTAL HEALTH CONTEXTS

Coordonatori:
Claudio Fuenzalida
Javier Sempere
Mihaela Gavrilă-Ardelean

Presa Universitară Clujeană

WORKING WITH FAMILY AND COMMUNITY RESOURCES IN EDUCATIONAL, SOCIAL AND MENTAL HEALTH CONTEXTS

COORDONATORI:
CLAUDIO FUENZALIDA
JAVIER SEMPERE
MIHAELA GAVRILĂ-ARDELEAN

PRESA UNIVERSITARĂ CLUJEANĂ

2022

ISBN 978-606-37-1427-6

Universitatea Babeş-Bolyai
Presa Universitară Clujeană
Director: Codruţa Săcelean
Str. Hasdeu nr. 51
400371 Cluj-Napoca, România
Tel./fax: (+40)-264-597.401
E-mail: editura@ubbcluj.ro
http://www.editura.ubbcluj.ro/

Funded by
the European Union

WORKING WITH FAMILY AND COMMUNITY RESOURCES IN EDUCATIONAL, SOCIAL AND MENTAL HEALTH CONTEXTS[1]

Coordinators: Claudio Fuenzalida, Javier Sempere & Mihaela Gavrila-Ardelean

Editors: Mihaela Gavrila-Ardelean, Aurel Vlaicu University of Arad, Romania
Claudio Fuenzalida, Centre de Teràpia Interfamiliar, Spania

Reviewers:

- **conf.dr. Anca Egerău - Aurel Vlaicu University of Arad, Romania**
- **prof.dr. Cosmin Goian – West University of Timișoara, Romania**

[1] The project "DigiFamily" is co-funded by the Erasmus+ program of the European Union. The content of this book is the exclusive responsibility of Centre de Teràpia Interfamiliar and neither the European Commission nor the Spanish Service for the Internationalization of Education (SEPIE) are responsible for the use that may be made of the information disseminated here.

Therapeutic intervention for family and family's network: An example of family therapy in Athens, Greece

Chatzi I., Deredini P., Ioannou C., Kolokotsa A. Skourteli M., Tsagaraki E. Moraitou M.

Abstract
The aim of the present article is to encapsulate the therapeutic intervention implemented in a family and their community from the therapeutic team of the "Franco Basaglia" Daycare Centre Operated by the Association for Regional Development and Mental Health (E.P.A.P.S.Y.) in Greece.
Overall, during therapy, family members found a common, shared space where the communication and trust between them were empowered. The therapists working in the 'here and now' managed to establish a family environment where the difficulties of the past do not constitute a barrier for the creation of new, safer relations. The therapists made appropriate use of family's network, acting as a connecting link between the different systems and frameworks.

1. Introduction

The family constitutes a global institution and possibly society's most important one, as it contributes to the transmission of social values and connects its members through common assumptions, values, expectations and goals. The family is, in this way, satisfying its members' moral, financial and emotional needs.

According to the systemic approach, a family is treated as a unified system, as a whole. This whole does not only include

the members of the family, but also the interactions and processes that take place between its members. A family does not only include the parents and the child, but it also includes the dynamic organisation and interaction between them (Papadioti – Athanasiou, 2014).

Stressful events in the life of the family:

There are events and situations during the life cycle of a family that can cause sudden or prolonged changes to the family and demand the activation of adaptive mechanisms (Tomaras, Pomini, & Gournellis, 2013). The process of adapting to new situations can be the cause of intense stress in the family life. A large number of stressful events are not instantaneous but rather, can consist of a composite of changes that evolve over time (Walsh, 2003, 2007). For example, the experience of parents' break-up can evolve over a period of conflict before ending up in divorce and, for that reason, adaptive mechanisms are required from the very early days of the break-up, in order to ensure new living arrangements between each parent and the children.

Family and Community Intervention

Research highlights that stressful events in the family life can cause a series of psychological difficulties (Madianos, 2005). Critically, it points out that children of parents with mental health difficulties are themselves vulnerable to the expression of psychological difficulties. Consequently, in such cases, the development of interventions targeting parents with mental health difficulties and their children, is of critical importance (Madianos, 2005). Such an intervention needs to be holistic and to target the involvement of not only parents and children, but also of other individuals and structures that relate to the family (e.g.

the school), given that when a more holistic participation is achieved, the results of the therapeutic intervention are clearly more effective (Pantelidou, Antonopoulou, Poulios, Soumaki & Stylianidis, 2014) .

The present article attempts to encapsulate the therapeutic intervention implemented in a family and their community from the therapeutic team of the "Franco Basaglia" Day Centre Operated by the Association for Regional Development and Mental Health (E.P.A.P.S.Y.) in Greece. The daycare Centre "Franco Basaglia" is located in Athens and targets the provision of mental health services to individuals who live in the 5th Mental Health District of Athens. It is funded and supervised by the Directorate of Mental Health, Ministry of Health. The aim of the present article is to highlight the importance of the collaboration between mental health specialists, the family and the community for the establishment of a continuity of support and care for the individuals and their family.

2. Clinical Case

From individual to family therapy

Catherine and George, the parents of the family presented in the current paper, arrived at the Daycare Centre in July 2017, following their request for individual, one-to-one therapy. Following their first evaluation, individual psychotherapy and a psychiatric follow-up was recommended for Catherine and individual psychotherapy was recommended for George. However, very soon both of them dropped out of the service.

After a while, they resubmitted a request for therapy, this time concerning the behavioural difficulties faced by their son, Konstantinos, following a referral by the Children

Assessment Centre that they attended. In January 2019, an agreement was reached to start a family therapy process.

Family History

The mother, Catherine, 45 years old, was born in a provincial city of Greece. Since her 20s she has been facing difficulties with depression and alcohol abuse, and at the age of 25 she was hospitalized in a psychiatric clinic. The father, George, 58 years old, was born in Athens, the capital of Greece, has retired from the Greek Armed Forces and is now taking care of the children.

The couple met in 2001 and their relationship is described as a stormy, turbulent love. They moved in together straight away, while George was still married to his first wife. Soon, Catherine got pregnant but had a miscarriage. Not long after the miscarriage she got pregnant with their son, Konstantinos, and one year later with their daughter, Maria. In 2005, while Catherine was pregnant with their daughter, George divorced his first wife, and Catherine and George got married.

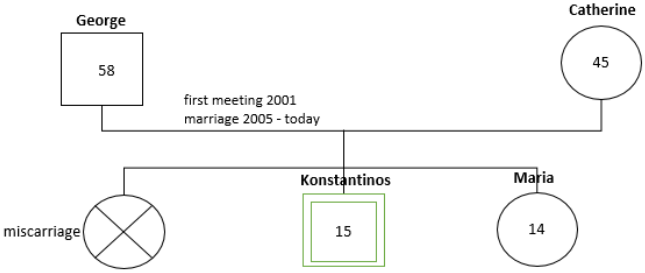

Figure 1: Nuclear Family Genogram

Their relationship is described as conflicting: Catherine did not want to take care of the children, she consumed large quantities of alcohol and when she was in a good mood she

would get involved in extramarital affairs. When they arrived at the Daycare Centre, they were separated and the children lived with George because Catherine had not claimed the children's custody and had not initiated the relevant proceedings.

Their son, Konstantinos, presented delinquent behavior, had to repeat a year in school and had changed three different schools because of his problematic behaviour. Their daughter, Maria, was 14 years old by that time. Catherine's request was to find a better way of coping with matters arising with her children, and at the same time to find ways in which she could feel good with herself in order for everyone to feel good too. The request of the father was to help their son.

Family therapy – First meetings

The children live with their father and Catherine lives in a different house with her new partner (see Figure 2: Genogram at entry, January 2019).

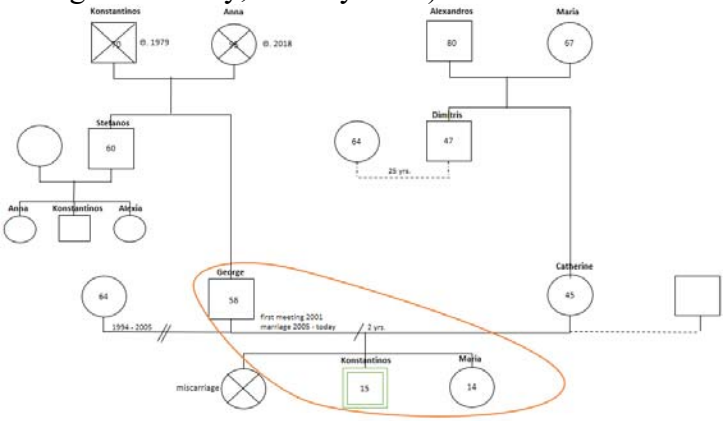

Figure 2: Genogram at entry, January 2019

This time, both parents had agreed to come to the Daycare Centre with a common request to help their son and improve their parental skills. During the induction, the children were not present and the session focused on the parents. The communication between them was difficult; in the meetings they accused each other of a range of things, while at the same time they would make funny comments between them. Characteristic references include the time when George said *"I have feelings for her but alcohol spoils her"* and when Catherine mentioned that *"whatever I do I am not enough. He always takes on others' opinions of me"*. The father, George, appeared as a savior of the children, accusing Catherine for her role as a mother and wife. The importance and usefulness of the children's presence was discussed and the meetings were arranged to take place once every two weeks.

During the first meetings, there was one critical topic that dominated the discussion and that was their son's, Konstantinos, behaviour at school. Konstantinos expressed provocative and delinquent behaviour, such as that he could get into the classroom with his hoodie and headphones on, without indicating any interest in the lessons, he would smoke in the school's premises where smoking is forbidden and would threaten his schoolmates in order to extort money. His father, George, supported Konstantinos' teachers, the headmaster and the school in general, while the mother had started to differ from this. Catherine perceived the school's approach as aggressive towards herself, who was trying to support some of Konstantinos' behaviours. Moreover, every time Catherine would contact the school, Konstantinos would become aggressive towards her.

The above resulted in conflict between the parents, division of their parental role into two opposites and in confusing,

unclear or double messages regarding their children's behaviour. As a result, the primary target of the sessions was the achievement of a consensus between parents for the development of a common stance towards their son, so that the aforementioned division and conflict between parents could be avoided. Critically, the first meetings also shed light into the dysfunctional communication between the school, the parents and Konstantinos, which was often the cause behind conflicts, frictions and disputes that took place in the family.

Meetings with the children

The following sessions took place in the presence of the children, where parents were given the chance to discuss topics such as Konstantinos' behaviour at school and the division of parental time, openly with their children. Most importantly, the children themselves were given the chance to express themselves openly about how they feel about and towards their parents. The therapists believed it to be important that they had a session solely with the children, where they discussed how the children perceived the situation at home, expressed their own needs and discussed with the therapists the ways in which they could be helped by the therapeutic process.

During the first family meetings, alliances were noticed between the women and men of the family. Father and son made derogatory comments about the mother's partner, while the daughter expressed that she wanted to move in with her mother, without changing school, because she felt that her mother understood her better. The alliances changed during the meetings. An interesting moment was when the children agreed with the mother, stating to the father that he does not want to assume responsibilities for his actions and

that he never says that someone else is right ("you are right").
Following those sessions, the parents got a divorce by mutual consent and appeared to cooperate better following it. Konstantinos started to trust the process more, resulting in him being more punctual to the meetings. He started to relate with the difficulties that he faced in school, he stated that he did not want to be moved to another school and asked for the therapists' advice on that, while in previous meetings he had denied it. The therapists took on the communication with the school and while the headmaster was negative at the start, he accepted to hold a meeting with all relevant individuals from the school community.

Intervention at school

The following meeting took place at Konstantinos' school, where everyone was given the chance to speak openly about matters that created tension, conflict and frequent disputes. The network that attended the meetings consisted of Konstantinos, his parents, the headmaster, the teacher responsible for Konstantinos' class and the two therapists. During the meeting, the headmaster spoke about the difficulties that he was facing in his collaboration with Konstantinos and the pressure that he was receiving from the parents of other children. He mentioned that, due to Konstantinos' large number of absences from class, it would be the responsibility of the teachers' association to determine whether he would be allowed to take part in the end of the year exams, which he needed to be able to pass the academic year. During the discussion, the mother was not very tolerant and would argue with the headmaster.
At the same time, the contribution of the teacher, responsible for Konstantinos' class, was of critical importance. He was

directed, primarily, towards Konstantinos, with the intention of approaching him and creating a cooperative climate between him and the school. More precisely, he stressed the positive elements that Konstantinos contributed, and asked him to make an effort towards the school and expressed the teachers' association intention to help him. This was considered a critical stance towards Konstantinos and supported him in recognizing and talking about his behaviour, in mentioning the positive relationships that he has with many students and in expressing his feelings towards the prejudices that he faced because of the fact that he had changed schools. At the same time, it was noted that he started to discretely set some limits to his mother, when she was in disagreement with the headmaster of the school. Konstantinos committed to his role as a student, the father took on the responsibility to communicate with the school, and the educators appeared willing to help Konstantinos. The therapists recognized the difficulties that each member of the network faced and related to their role, stressing the fact that it was the first time that such a coordinated effort was in place from all sides to tackle the aforementioned difficulties. The therapists discussed with the educators the implications of the continuous transfer of a child from school to school, and explained its complicated nature, as it could constitute punishment, therapy or a temporary deferral of the problem.

Final meetings

The final meeting included the participation of all members of the family and was especially encouraging. Konstantinos started to be responsive in his role as a student and a cooperative climate was created between him and the school. Maria decided to move in with her mother, her

grades increased by two points and she was very happy. Both parents shared the day-to-day care of their children and cooperated without conflicts.

Therapeutic Outcome

Overall, during therapy, family members found a common, shared space where the communication and trust between them were empowered. Through the therapeutic process, it became apparent that the interaction between members of the same family was dynamic and every person was important, reflecting upon the mothers' request for "her to feel good with herself in order for everyone to feel good". This became evident through the steady involvement of the family in therapy as well as through their emotional investment in the process. The safe environment created within the therapeutic process allowed for the children to respond positively through their attempt to achieve better results at school. A crucial element during the family therapy process was that for the first and unique time in the life of the specific family, nobody was accused of their past actions. The therapists working in the 'here and now' managed to establish a family environment were the difficulties of the past did not constitute a barrier for the creation of new and safer relations.

The therapists made appropriate use of Konstantinos' network, acting as a connecting link between the family and the school, resulting in the discussion of matters that had arisen in a manner where all voices were equally heard. The interventions at school took place only after having been discussed with the family, as the therapists thought that supporting the parents in their communication with the school, which had become stressful and included threats

regarding whether Konstantinos could remain there, would be relieving for the family.
The family was cooperative, and its members joined together in a common goal. The importance of cooperation was recognized, while the family adopted alternative techniques for the management of such future difficulties.

Discussion

The current paper presents the effectiveness of a holistic family psychotherapy intervention by members of the interdisciplinary team of the Daycare Centre "Franco Basaglia" in Athens, Greece, with the participation of the wider family and educational system of adolescents with intense behavioural difficulties.
What has been observed in the therapeutic process, is how present the dynamic interactions among family systems are during sessions, as a family constitutes a unified system that involves the dynamic organisation and interaction between each member (Papadioti – Athanasiou, 2014). Therefore, therapists need to incorporate the dynamics of family members into helping each member feel important.
Regarding this matter, there is a necessity of creating a climate of trust within the therapeutic relationship. The family's trust placed on the professionals is not complete and is built gradually. The decisive factor in this was the acceptance of the family who participated, who ended up avoiding placing labels on the people who participated in the network, and did not accuse any member of past acts. An important example is the attitude of Konstantinos, who although at the beginning was ambivalent about his participation, he later observed the genuine interest of the therapists in his issues, and he committed himself to the treatment and asked the therapists for help. Critically, it was

not only Konstantinos who was supported and benefited through the process, but throughout the duration of the meetings, every member was empowered so as to be treated as equal and free to express themselves. This created a sense of coherence and equality in all the voices in the network.

An important element that makes this intervention particularly interesting is the community character of the intervention at the school level. The participation of the school is important in order to prevent punitive treatments. In many cases the social needs of the beneficiaries, such as the quality of the school life of the children, become part of the therapeutic process and are not ignored. The therapeutic team must be flexible and adaptable so as to be able to recognise and integrate social interventions into the treatment process, acting as a link between the patient and their community context (Pantelidou et al, 2014).

In this way, the psychosocial and psychiatric interventions in the community contribute significantly to the prevention and promotion of the mental health in the community, and constitute a leading factor in the direction of a humanistic psychiatric reform.

References

1. Madianos M. (2005). *Eisagwgi sthn Koinoniki Psychiatriki. [Introduction in Social Psychiatric]*. Athens: Kastaniotis.
2. Pantelidou St., Antonopoulou V., Poulios A, Soumaki E. & Stylianidis St. (2014). Community Child Psychiatry: The Example of Mobile Mental Health Units in the NE and Western Cyclades. In Stylianidis St (Ed.). *Social and Community Psychiatry Towards a Critical, Patient-Oriented Approach*. Springer: pp.193-213.
3. Papadioti – Athanasiou V. (2014). *Oikogeneia kai Oria. Systhmikh Proseggisi.[Family and Orientation. Systematic Approach]* Athens: Topos.
4. Tomaras V., Pomini V., Gournellis R. (2013). Systhmikh – Oikogeneiakh Psychotherapeia. [Systematic and Family Psychotherapy]. In: Papadhmtirou G.N., Liappas I., Lykouras E. (Ed.). *Synchornh Psychiatriki*. [Modern Psychitriatic]. Athens: VHTA. pp. 607-61.
5. Walsh F. (2003). Family Resilience: A framework for clinical practice. *Family Process*, 42: 1-18.
6. Walsh F. (2007). Traumatic loss and major disasters: Strengthening family and community resilience. *Family Process*, 46: 207-227.

Calgary Family Nursing at Akureyri Hospital

Snæbjörn Ómar Guðjónsson, Bernard Gerritsma

Introduction

The literature has reported the importance of family support when it comes to illnesses. Numerous studies have shown that health care services that collaborate with patients and their families improves quality and safety. In the following chapter discussion of ideology and clinical use of Calgary family Nursing is introduced as a treatment option to support families.

Background

In recent years, there has been a growing recognition and knowledge that social health is an important part of health and can affect physical and mental illness. Family and friends are important factors in a person's social health (Deatrick, 2017). The nursing literature specifies that family has a significant impact on the health and well-being of everyone within the family (Wright & Leahey, 2013; Mackie, Mitchell & Marshall, 2018), especially if a family member has an illness. This can increase family stress, affect attitudes and the relationships within the family, and short stays in a hospital setting can place a burden on families. The fundamental aspect of the Calgary family nursing is the vision to see the individuals within the family as well as the family as a whole (Wright & Leahey, 2013;

Sveinbjarnardottir, Svavarsdottir and Wright, 2013). In modern health care, efficiency and effective nursing care and continually shorter inpatients admission is important (Leahey & Svavarsdottir, 2009; Blöndal et al., 2014). A short therapeutic conversation intervention (STC-intervention) with a patient´s family where nurses emphasize what concerns the family and discuss their questions can prevent or reduce family members´ suffering (Thome & Arnardottir, 2013; Halldorsdottir & Svavarsdottir, 2012; Sveinbjarnardottir et al., 2013; Svavarsdottir, Tryggvadottir & Sigurdardottir, 2012; Sigurdardottir et al., 2015).

Calgary model

The International Council of Nurses considers Calgary family nursing as one of the leading family assessment models in nursing (ICN, 2002). The model is based on ideology from the nurses Dr. Lorraine M. Wright and Dr. Maureen Leahey (Wright & Leahey, 2013; Leahey & Wright, 2016). This is based on two models, the **Calgary Family Assessment Model (CFAM) and Calgary Family Intervention Model (CFIM)**. CFAM is a multidimensional framework consisting of the following three major categories - structural, developmental and functional (Wright & Leahey, 2013). These categories and subcategories can help nurses to identify the family´s strengths, weaknesses and problems (Wright & Leahey, 2013; Svavarsdottir, Sigurdardottir & Tryggvadottir, 2014). CFAM procedures guides nurses to understand the family

structure through genograms and ecomaps. These are important and useful tools to assess the family. When a genogram becomes a visible part of the patient´s medical record, nurses are constantly reminded to take care of the patient within the context of the family. Function and family structure can be essential to understand how people respond to life changing events such as a serious illness. Nurses who have insight to the structure, development and functioning of families can use that knowledge to empower the family (Wright & Leahey, 2013; Svavarsdottir et al., 2014; Sveinbjarnardottir, Svavarsdottir & Wright, 2013). CFIM is an organizing framework conceptualizing the intersection between the domain, cognitive, affective and behavioural components, of family functioning and is a specific intervention offered by health-care professionals, used in context with the CFAM (Wright & Leahey, 2013). According to CFIM the family is given an opportunity to express their experiences of the illness. Instead of focusing on the family's problems, the nurse assists the family to discover their strength. The goal is to provide patients' families increased support and to promote changes towards the recovery process. With successful information gathering, care, respect and with reflective therapeutic questions asked, nurses can reduce family suffering and contribute to recovery (Wright & Leahey, 2013). The authors of the Calgary Family Nursing report that a 15-minute family interview (STC-Intervention) can be of great significance and, even contribute to recovery thus reduce inpatient admission at hospitals. The key points in STC-

Intervention is to have specific goals such as, be polite, introduce yourself, make a genogram and ask therapeutic questions. It is good to have at least three key therapeutic questions ready, analyse the family's strengths, and point them out. The nurse promotes and assists the family to remain active and guides the family coping with suffering. Allowing the family to share their illness story and, identifying their constraining and facilitating beliefs may result in a decrease of suffering and increased well-being and recovery (Wright & Leahey, 2011; Sveinbjarnardottir et al., 2013; Sveinbjarnardottir & Svavarsdottir, 2019).

Nurses´ attitudes

Nursing is an important profession which is intensely involved in patient care (Mackie et al., 2018). Nurses' attitudes may influence whether they provide family nursing, those who believe that illness is a family issue can gain successful and clinical skills in providing family nursing (Svavarsdottir, et al. 2015). The Families Importance in Nursing Care – Nurses' Attitudes (FINC-NA) questionnaire is an assessment tool designed by Swedish nurses to measure nurses' attitudes towards family nursing regardless of their work environment (Benzein, Johansson, Årestedt, Berg & Saveman, 2008). FINC-NA has been used in numerous studies and findings from FINC-NA studies indicate that in general, nurses have a positive attitude towards families (Benzein, et al., 2008; Sveinbjarnardottir, Svavarsdottir & Saveman, 2011; Blöndal et al., 2014; Svavarsdottir et al., 2015). Nurses who have been trained

and dedicated to family nursing experience more job satisfaction, have a stronger professional identity, experience less stress at work and are more positive when offering family nursing (Sigurðardottir, Svavarsdottir & Juliusdottir, 2015; Svavarsdottir et al., 2015; Al Mutair et al., 2014; Blöndal et al., 2014; Coyne & Dieprink, 2017; Gusdal, Josefsson, Adolfsson & Martin, 2017; 2017; Laidsaar‐Powell 7 al., 2017; Linnarsson et al., 2015; Simpson & Tarant, 2006; Sveinbjarnardottir et al., 2011). Nurses who use genogram and ecomaps have better insight into the family structure and what support is needed, both during hospital stay and after discharge (Eggenberger & Sanders, 2016).

Benefits of Family Nursing

Family nursing has a great impact on the quality of treatment and work processes in hospital wards; it increases collaboration with families, can lead to shorter admissions and even prevents re-admissions at hospitals (Blöndal et al., 2014; Gusdal, et al., 2017; Laidsaar-Powell, Butow, Bu, Fisher & Juraskova, 2017; Chesla, 2010; Voltelen, Konradsen & Østergaard, 2016). Studies have demonstrated that health services that collaborate with patients and their families improves the quality and safety of the provided services (Berger, Flickinger, Pfoh, Martinez & Dy, 2014; Mackie et al., 2018). An Icelandic study that uses STC-intervention with families and patients (in one of the four acute inpatient wards) at the psychiatric division at Landspitali University Hospital in Reykjavik (LUH)

confirms that STC-intervention enhances family members' experience of cognitive and emotional support (Sveinbjarnardottir et al., 2013). Calgary Family Nursing helps the family to be aware of their strength and guides the family to cope with suffering and maintain effective functioning (Svavarsdottir, Sigurdardottir & Tryggvadottir, 2014). Calgary Family Nursing procedures can support families and the patient in the recovery process. Reflective discussion about development of diseases, prognosis, treatment and, understanding of health problems can be clarified. The effects can reduce the suffering of families and potentially reduce inpatient admissions. Benefits of providing family nursing care can affect the quality of work, and work processes in the health care system (Chesla, 2010; Sveinbjarnardottir et al., 2011; Gusdal et al., 2017; Laidsaar-Powell et al.; 2017; Voltelen et al.; 2016). Health systems should strive to continuously improve the quality of services and transfer knowledge from the curriculum to the clinical environment (Leahey & Svavarsdottir, 2009).

Implementation of Calgary Family Nursing at SAk

The Akureyri Hospital (SAk), in Northern Iceland, provides general and specialized health care services in the northern and eastern part of Iceland and focuses on cooperation with health care institutions in rural areas and participants in the development of national health care.

The main objective of the implementation of Calgaru Family Nursing was to transfer knowledge of family nursing from academic fields to the clinical environment, and thus

improve the quality of nursing care. Nurses and midwives were educated and supported to use Calgary family nursing in their clinical work. Research and studies at LUH confirm unequivocal results in better services; more positive experience of patients and their families and a more positive experience of professionals (Svavarsdottir et al.; 2012; Christer Magnusson, 2009; Sveinbjarnardottir, Svavarsdottir & Hrafnkelsson, 2012).

In modern societies there is an increased demand from patient´s family to be better informed and more involved in patients treatments in the health care system. Therefore, the aim of implementation is to enhance nurses' skills in providing family nursing and thus foster collaboration with patients and their families so that clients receive excellent services at SAk (SAK, 2017). It is important to consider family nursing practice in general for the work environment (Gusdal et al., 2017; Coyne & Dieperink, 2017).

Prior to implementation, the head nurse of the psychiatric ward was appointed as Project Manager. A job description for liaison nurses was prepared and a provisional agreement was created. During a 3-month preparation period central quality protocols were prepared in the quality handbook of SAk (standardized operational procedures, work instructions, policy, standardized nursing diagnosis etc.). Pocket cards were given to all nursing staff, with instructions in making genograms, ecomaps and guidelines for STC-Intervention. Each nurse liaison as well their head nurse, defined the criteria and the target group of patients in each ward. The experience, knowledge and educational

material gained at LUH was shared and adapted to the occupation at SAk. This implementation has been carried out in collaboration with the University of Akureyri's School of Health Sciences and with support from LUH.

All nursing staff underwent learning of the Calgary Family Nursing Model from January to May 2017, delivered by the liaison's nurses. Central quality protocols lead to coordinated/standardized documentation. According to the protocol of family nursing at SAk the nursing staff in collaboration with the patient/family draw genogram in the medical record. The genogram is visible and permanent part of the medical record which is one part of the items used in the family nursing interviews. Patients' health records are available to all health care workers at SAk who provide treatment. All healthcare professionals at SAk can easily see what nursing staff are working on in connection with family nursing, including problem analysis, goal setting and treatment plans. Calgary family nursing can enhance interdisciplinary teamwork (Duhamel, Dupuis, Turcotte, Martinez & Goudreau, 2015). The family nursing protocols contributes and provides opportunity for other health care workers to use the information in their treatment.

Before implementation, nurses and midwives were asked to complete the Families 'Importance in Nursing Care - Nurses' Attitude Questionnaire (FINC-NA) and 14 months later again. Background and qualitative questions according to Calgary Family Nursing were included. Participants' rates were good, at Time 1 (92%/133) and Time 2 (89%/132) in the implementation wards. The main results

from the quantitative aspect of the research was that nurses/midwives at SAk are generally positive to family nursing and participants with higher education and more job experience, experience less burden on families. The same study revealed at Time 2 it was stated that 97% of participants considered family nursing a general policy in their ward. Culture in a workplace can influence whether family nursing is provided, and the of supervisors' attitudes plays a major role. Supervisors with a positive view are more likely to make efforts to promote the implementation process (Duhamel et al., 2015; Gusdal et al., 2017; Coyne & Dieperink, 2017). By having a policy according to the Calgary Family Nursing decided by the Board of Chief Executives of SAk the importance of family nursing is highlighted. It can set the tone for positive attitudes for the nursing staff. Results from the qualitative aspect of the study at SAk (87 answered both in Time 1 and 2) showed that nurses/midwives' experienced better communication / collaboration with family members when Calgary Family Nursing was applied.

Conclusion

After a meeting with all the health care institutions in the region (SAk, HSN and) the procedures and protocols of the Calgary Family Assessment and Interventions Models were introduced at SAk. The main purpose was to invite cooperation and collaboration between institutions who provide health care services to individuals and families in northern Iceland. These institutions have shown interest in

the project; the collaboration would mean more continuity in health care services for the entire population in this region to be ensured. In the coming months, efforts will be made to establish collaboration according to family nursing. All institutions i.e. SAk, HSN and HSA utilize the same electronic health record system (SAGA). In this way, it is relatively easy to ensure continuity in the treatment of patients and their families in all fields of the health care system.

The implementation process ends 31st of May 2020 at SAk. To follow up on the project a professional group of nurses will be established in September 2020. The professional group will work in collaboration with the School of Health Sciences at UNAK. The main goal of the professional group is to ensure continued family nursing at SAk. The family nursing professional council at LSH and the professional group at SAk will cooperate. Family nursing procedures are under the terms of international certification; those conditions will help the project to be permanent. Family nursing is here to stay.

References

Al Mutair, A., Plummer, V., Paul O'Brien, A., & Clerehan, R. (2014). Attitudes of healthcare providers towards family involvement and presence in adult critical care units in Saudi Arabia: A quantitative study. *Journal of Clinical Nursing*, 23(5-6), 744-755. doi:10.1111/jocn.12520

Benzein, E., Johansson, P., Ĺrestedt, K. F., Berg, A., & Saveman, B. I. (2008). Families' importance in nursing care: Nurses' attitudes—an instrument development. *Journal of Family Nursing*, *14*(1), 97-117. doi:10.1177/1074840707312716

Berger, Z., Flickinger, T. E., Pfoh, E., Martinez, K. A., & Dy, S. M. (2014). Promoting engagement by patients and families to reduce adverse events in acute care settings: a systematic review. *BMJ Qual Saf*, *23*(7), 548-555.

Blöndal, K., Zoëga, S., Hafsteinsdottir, J. E., Olafsdottir, O. A., Thorvardardottir, A. B., Hafsteinsdottir, S. A., & Sveinsdóttir, H. (2014). Attitudes of registered and licensed practical nurses about the importance of families in surgical hospital units. *Journal of Family Nursing, 20*(3), 355-375. doi:10.1177/1074840714542875

Chesla, C. A. (2010). Do family interventions improve health?. *Journal of family nursing*, *16*(4), 355-377. doi:10.1177/1074840710383145

Christer Magnusson (2009). Fjölskylduhjúkrun á Landspítala. *Tímarit hjúkrunarfrćđinga, 85*(5), 12-16

Coyne, E., & Dieperink, K. (2017). A qualitative exploration of oncology nurses' family assessment practices in denmark and australia. *Supportive Care in Cancer, 25*(2), 559-566. doi:10.1007/s00520-016-3438-1

Deatrick, J. A. (2017). Where is "Family" in the social determinants of health? implications for family nursing practice, research, education, and policy. *Journal of Family Nursing, 23*(4), 423-433. doi:10.1177/1074840717735287

Duhamel, F., Dupuis, F., Turcotte, A., Martinez, A., & Goudreau, J. (2015). Integrating the illness beliefs model in clinical practice. *Journal of Family Nursing, 21*(2), 322-348. doi:10.1177/1074840715579404

Eggenberger, S. K., & Sanders, M. (2016). *A family nursing educational intervention supports nurses and families in an adult intensive care unit* doi://doi.org/ 10.1016/j.aucc.2016.09.002

Gusdal, A. K., Josefsson, K., Thors Adolfsson, E., & Martin, L. (2017). Nurses' attitudes toward family importance in heart failure care. *European Journal of Cardiovascular Nursing, 16*(3), 256-266. doi:10.1177/1474515116687178

Halldórsdóttir, B. S., & Svavarsdóttir, E. K. (2012). Purposeful therapeutic conversations: Are they effective for families of individuals with COPD: A

quasi-experimental study. *Vĺrd i Norden, 32*(1), 48-51. doi:10.1177/ 0107408312032200111

International Council of Nurses/ICN. (2002). Nurses Always there for you: Caring for families. Information and action tool kit. Geneva: International Council of Nurses.

Laidsaar‐Powell, R., Butow, P., Bu, S., Fisher, A., & Juraskova, I. (2017). Oncologists' and oncology nurses' attitudes and practices towards family involvement in cancer consultations. *European Journal of Cancer Care, 26*(1), e12470.

Leahey, M., & Svavarsdottir, E. K. (2009). Implementing family nursing: How do we translate knowledge into clinical practice?*Journal of Family Nursing, 15*(4), 445-460. doi:10.1177/1074840709349070

Leahey, M. & Wright, L. M. (2016). Application of the calgary family assessment and intervention models: Reflections on the reciprocity between the personal and the professional. *Journal of Family Nursing, 22*(4), 450-459. doi:10.1177/10716667972

Linnarsson, J. R., Benzein, E., & Årestedt, K. (2015). Nurses' views of forensic care in emergency departments and their attitudes, and involvement of family members. *Journal of Clinical Nursing*, 24(1-2), 266-274. doi:10.1111/jocn.12638

Mackie, B. R., Mitchell, M., & Marshall, A. (2018). The impact of interventions that promote family involvement in care on adult acute-care wards: An integrative review. *Collegian*, *25*(1), 131-140. doi:10.1016/ j.colegn.2017.01.006

Sjúkrahúsið á Akureyri. (2017). *Árskýrsla SAk. Innleiðing á Calgary-fjölskylduhjúkrun.* Akureyri: Sjúkrahúsið á Akureyri. https://www.sak.is/static/files/arskyrslur/arsskyrsla-sak-2017-02-del.pdf

Sjúkrahúsið á Akureyri. (2018). *Welcome to Akureyri Hospital.* Akureyri: Sjúkrahúsið á Akureyri. https://www.sak.is/is/akureyri-hospital

Sigurdardottir, A. O., Svavarsdottir, E. K., & Juliusdottir, S. (2015). Family nursing hospital training and the outcome on job demands, control and support. *Nurse Education Today, 35*(7), 854. doi:10.1016/ j.nedt.2015.03.003

Simpson, P., & Tarrant, M. (2006). Development of the family nursing practice scale. *Journal of Family Nursing*, 12(4), 413-425. doi:10.1177/ 1074840706290806

Svavarsdottir, E. K., Tryggvadottir, G. B., & Sigurdardottir, A. O. (2012). Knowledge translation in family nursing. *Journal of Family Nursing, 18*(3), 303-327. doi:10.1177/ 107484072449202

Svavarsdottir, E. K., Sigurdardottir, A. O., & Tryggvadottir, G. B. (2014). Strengths-oriented therapeutic conversations for families of children with chronic

illnesses. *Journal of Family Nursing, 20*(1), 13-50. doi:10.1177/ 1074840713520345

Svavarsdottir, E. K., Sigurdardottir, A. O., Konradsdottir, E., Stefansdottir, A., Sveinbjarnardottir, E. K., Ketilsdottir, A., . . . Guðmundsdottir, H. (2015). The process of translating family nursing knowledge into clinical practice. *Journal of Nursing Scholarship, 47*(1), 5-15. doi:10.1111/jnu.12108

Sveinbjarnardottir, E. K., & Svavarsdottir, E. K. (2019). Drawing forward family strengths in short therapeutic conversations from a psychiatric nursing perspective. *Perspectives in psychiatric care*, *55*(1), 126-132. doi:10.1111/ppc.12329

Sveinbjarnardottir, E. K., Svavarsdottir, E. K., & Hrafnkelsson, B. (2012). Psychometric development of the Iceland-Family perceived support questionnaire (ICE-FPSQ). *Journal of Family Nursing*, *18*(3), 328-352. doi:10.1177/ 1074840712449203

Sveinbjarnardottir, E. K., Svavarsdottir, E. K., & Saveman, B. (2011). Nurses attitudes towards the importance of families in psychiatric care following an educational and training intervention program. *Journal of Psychiatric and Mental Health Nursing, 18*(10), 895-903. doi:10.1111/ j.1365-2850.2011.01744.x

Sveinbjarnardottir, E. K., Svavarsdottir, E. K., & Wright, L. M. (2013). What are the benefits of a short therapeutic conversation intervention with acute psychiatric patients and their families? A controlled before and after study. *International Journal of Nursing*

Studies, 50(5), 593-602. doi:10.1016/j.ijnurstu.2012.10.009

Thome, M., & Arnardottir, S. B. (2013). Evaluation of a family nursing intervention for distressed pregnant women and their partners: A single group before and after study. *Journal of advanced nursing*, *69*(4), 805-816. doi:10.1111/j.1365-2648.2012.06063.x

Voltelen, B., Konradsen, H., & Řstergaard, B. (2016). Family nursing therapeutic conversations in heart failure outpatient clinics in Denmark. *Journal of Family Nursing, 22*(2), 172-198. doi:10.1177/1074840716643879

Wright, L.M. & Leahey M. 2013. Nurses and Families: A Guide to Family Assessment and Intervention. FA Davis.

University Educational Resources for Empowering the Mental Health of the Arad Community

Mihaela Gavrila-Ardelean, PhD.
Alina Costin, PhD.
'Aurel Vlaicu' University of Arad, Romania

Abstract:

This chapter presents an overview of the university educational research resources regarding the empowerment of the family and the local Arad community, in the case of people with mental health problems in Romania. The chapter shows examples of good practices in this field, resulting from the university experience accumulated through multiple European projects, with the aim of making recommendations for collaboration in multidisciplinary intervention teams. The research process of the *Digi Family Project* also intends to integrate families with special needs in therapeutic social networks. Educational resources prevent stigma and social exclusion of the beneficiaries, and also facilitate finding a job for people with mental health problems.

Brief introduction to the issue of disability

In Romania there remains a mentality which has persisted since the communist period, regarding the schooling of children with psychopathology. Some parents still face the mentality that a childwith special needs may need to be transferred to a special school. There are known cases

of children with mild or moderate disabilities who have regressed in a special psychoeducational system. Another problem beyond the stigmatizing mentality of the system is that of the absence ofvocational training in Romania, which instead prioritizes a typical educational system. In this system, children with special needs are confronted with the stigma attached to the system, in addition to experiencing stigma related to their mental or psychological health problems. Thus, children with mental health problems are seen as a danger to the other children. The lack of counselling for parents with children with mental disorders, can consequently make the child seemto be a burden for the family and for society.

In Romania, the divorce rate in families with children with mental illness is high. This causes children with mental health disorders to have a double vulnerability: medical and social, because when they reach the age of schooling, access to the education system is hindered by the financial means of the single parent family (poverty). Discrimination, stigma and even social exclusion come from a dual motivation: the illness and the social status of the family, associated with family poverty.

Risk factors for the mental health of parents of children with disabilities

Parents of children with disabilities are at risk of mental health. A number of studies highlight the need to

understand and support the mental health needs of parents of children with disabilities (Tomoka et al., 2012). More than half of parents caring for children with disabilities have mental health problems due to the psychological suffering of the enormous pressure of caring for them (Johnston et al., 2003; Plant, Sanders, 2009; Yamaoka et al., 2015). All the studies in the field illustrate heightening the awareness of the population regarding the implications of disability at the individual, family and community level as part of their recommendations.

A 2013 EFA[1] report estimates that approximately 5.1% of children live with a severe or a moderateform of disability. In Europe, it is estimated that almost 15 million children have special needs. The National Authority for Persons with Disabilities shows that in Romania, on September 30, 2019, the number of children with disabilities living in the family was 67,639 out of a total of 3,857,100 children (according to the National Institute of Statistics, December 31, 2019), (www.insse.ro). Various governmental or European projects initiated by the non-governmental sector address the needs of families of children with disabilities. Focus groups conducted with parents show that the main obstacles are the lack of services/day care centres in the immediate vicinity, lack of transportationto travel from home to the centre (which is most often the city) and lack of centres providing services in an integrated system. We understand by integrated services, the way of providing social, medical,

educational services in the same institutional framework / context, which facilitates the simplest access by the beneficiary. Osvath (2011) identifies the following dysfunctions of the Romanian social system:

- difficulties in accessing specialized medical services
- problems regarding the integration of children in an educational structure due to insufficient financial resource
- difficulties of children and families from the rural environment in accessing services (specific therapies, medical recovery services, etc.)
- lack of information on the services they can benefit from,
- lack of protected workshops, occupational therapy centers, residential centers. These aspects that hinder the family's functionality are amplified by the poverty of these families, which is generally higher than in families with children without difficulties. Thisappears to be due to the inability of the mother, who tends to be the primary caregiver, to keep a job, dedicating herself to the care of the child with special needs (Baldwin, 1985). The time cost of caring for a child with severe disabilities is significantly greater than caring for a non-disabled child and does not decrease with increasing age. The majority ofthe mothers in the study were not in paid employment with subsequent loss of income to the family. We propose that the time costs of caring for a child with disabilities should betaken into account in determining appropriate levels of benefits.

[1] EFA Education For All (EFA) is a global movement led by UNESCO, that strives to provide free education todisadvantaged underprivileged children

What impact does disability have over a family? The family, as a system, can experience distress, frustration, despair, shame, fear, isolation, but especially a deep sense of helplessness. The level of family functionality is also affected (Hayes & Watson, 2013) because child care often requires resources such as additional physical, emotional, social and financial (Murphy, Christian, Caplin & Young, 2007). Many risk factors have been identified for the health of even parents of children with disabilities: few opportunities to interact with the child, low income, lack of religious beliefs, and parental suffering (Hung et al., 2010). Osvath (2011,p.165) shows that the caretaker'ssubjective well-being is an important predictor of family functioning which, in turn, is determined by two important factors: joint action and solidarity. Cantor,…, Hagerty, & al. (2001) describes two categories of factors that interferes and affects the functionality of families:

- Endogenous forces (the mental, emotional and physiological responses of the individual to living conditions);
- Exogenous forces (social, cultural and social structures, the psychological influences of thesocial environment).

Therefore, the well-being and ability of the family to manage the child's disability are largely determined by the potential of the parents, their self-image, and the way they relate to the situationthey are living. However, the success of this driven by different challenges, is also determined by environmental influences, such as the mentality towards, and way in which disability is perceived, and especially by the services that provide support to the family and the child with disability. The highest levels of stress identified in parents of children with

disabilities may have financial difficulties, lack of social support and fewer coping mechanisms (Pisula, 2011).

Empowering and maintaining the mental health of families

The question we need to ask is how can professionals sustain families with children with special needs? The family of the child / young person with disabilities falls into the category of the vulnerable group, due to the special needs of the disability. There is rich literature that addresses the issues of the family of the child with disabilities, as well as many papers regarding the empowerment of both the family and the young person with disabilities. In this paper we discuss theories about the empowerment process of the families of children with developmental disabilities. There are various support programmes for parents of children with disabilities, some of them provided in the online environment. Particularly effective are those where parents are motivated to pursue this difficult journey with children with special needs.

The term 'empowerment' has aroused great interest among specialists, and the complexity and variety of dimensions under care can be addressed under the formulation of several definitions.The Webster Dictionary (1913) defines the term 'empower' as: "to give authority, to delegate power to give moral or physical power, faculties or abilities to give more opportunity for independent action." (Webster & Porter, 1913). The same definition can be found in the Oxford Dictionary: "empower somebody *(to do something) (formal)* to give somebody the power or authority to do something" (Stevenson, 2010). In 2013, as a priority theme in social

policies, the IFFD[2] proposed "promoting the empowerment of people in achieving poverty eradication, social integration and full employmentand decent work for all." On this occasion, a reduction or clarification of the concept of empowerment and have a potential greater than 30 definitions. A careful analysis shows that there is a consensus regarding the spiritual dimension, the regulation of the processing qualities associated with empowerment with notions such as allowing *freedom, capacity, participation, control over destiny, resources*, etc. The same document *Statement Promoting empowerment of families (2013)* [3] identifies four dimensions of family empowerment: social, economic, political and legal empowerment, and active participation of certain social groups in society. These four dimensions take into account greater control over their resources and life choices, and the possibility of people to "demand and exercise their rights." The concept empowerment is very common currently, used in different subjects and study areas (e.g. economics, community development, education, psychology); and has a history related to the social movement and the protests of various discriminated groups. Some of the most relevant works that refer to this term are: *Pedagogy of the oppressed* (Friere, 1970), *Black Empowerment: Social Work in Oppressed Communities* (Solomon, 1976), *Women and the politics of empower* (Bookman, & Morgen, 1984), *Studies in empowerment: Introduction to the issue. Prevention in Human Services* (Rapport, 1984).

Page and Czuba (1999) suggest three components/ aspects that remain constant which are necessary to understand this very complex term. In their opinion,

empowerment is multi-dimensional (because it occurs in many areas such as sociology, economy, psychology, etc.), social because it occurs at various levels (individual, group and community), and empowerment is a process.

'Empowerment' has become a very popular term used in mental health services as well (atleast in the United States) as Chamberlin (1997) observes in his work *A working definition of empowerment,* where the author outlines some defining elements of the empowerment process.

Research projects and practical results for children and young people with mental disorders,conducted by the 'Aurel Vlaicu' University of Arad, Romania

In Romania, the services addressed to children with disabilities and their families are organised within the General Directorate for Social Assistance and Child Protection. These services are organised at the county level. They are complemented by services provided by NGOs (Non - Governmental Organisations), which have a crucial role in investigating the cases of the families of children with disabilities. Both public and private services focus on empowering families and maintaining their mental health. Mental health services are mainly organised in urban areas. Therefore, there is a significant deficit of such services in rural areas. However, they can be supplemented by the primary Social Services Department of local councils.

[2]IFFD- International Federation for Family Development

[3]IFFD, 2013, *Statement Promoting empowerment of families, available at* http://www.familyperspective.org/seun/WrittenStatement.pdf

Leliugiene and Barsauskiene (2003) note that, in recent years, the problem of social empowerment of the modern community has become increasingly studied. Empowerment would be almost impossible to attain without the intellectual resources shared by universities – as research and education institutions. Empowerment is a fundamental concept of the World Health Organisation's (WHO) vision for health promotion. Between the second and third millenia, the importance of etiopathogenic links between mental disorder and socio-cultural life has been emphasised, a connection based on the anthropological structure of the human individual. As a result, social and psycho-social therapies were introduced in the case of mental disorders. In this sense, the Arad Branch of the Academic Society of Anthropology was established. Within this framework, Vice-President Prof. Dr. Mihaela Gavrila-Ardelean initiated, together with the management of the 'Aurel Vlaicu' University of Arad, Rector Ramona Lile, and the management of the 'Vasile Goldiș' Western University of Arad, President Prof. Dr. Aurel Ardelean, starting in 2018, the autumn edition of the *International Anthropology Symposium, 'Francisc I. Rainer'.*

The symposium brings together specialists from various fields of anthropology, academics,and scientists who, through their studies, bring elements of novelty to all areas of human health, including mental health. In the field of Children's Mental Health, collaborations were made with the National Institute for Maternal and Child Health "Alessandrescu - Rusescu", through the headof the Research Laboratory in Pediatrics and Social Obstetrics, and the

founding president of the Academic Anthropology Society, academic Prof. Dr. Andrei Kozma.

As we have shown in the paper *Education for Children with Special Needs* at the International Children's Rights Congress in Turkey, Düzce University, for children with educational needs, these non-formal learning modalities help children with special needs to recognise and undertake their own social role. This increases their inclusion and, over the time, determines a series of positive effects on their psycho-social health (Gavrila-Ardelean & Gavrila-Ardelean, 2017).

The following types of activities fall among the most common methods of non-formal education for children with special needs in our country: playful activities (interactive group games), tours, sports, socialising, cultural, vocational and artistic activities (painting, drawing, graphics, origami, sculpture, ceramics, theater, film, music, dance), as well as intercultural activities (international mobilities, through Erasmus projects), animal therapy, horse riding,occupational activities (housekeeping, gardening, growing vegetables, cooking, baking, etc), and professional activities (typography, editing, etc).

All these teaching methods are learned by our students during their training for professionalcompetencies. Practical skills are acquired in practice classes, carried out in schools, in social, andeducational units for children with special needs, and their families.

Through the projects in which our university has been involved, in the field of formal andnon-formal education for children with special needs, the positive effect of learning was quantified.

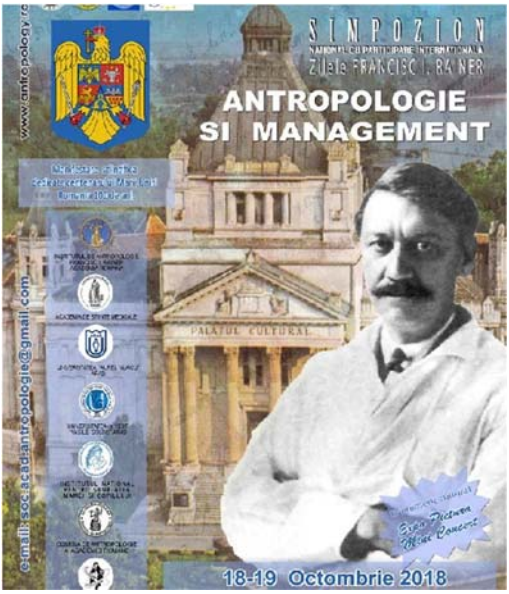

Fig.1. Poster of the *International Anthropology Symposium, 'Francisc I. Rainer', 2018, 'Aurel Vlaicu' University of Arad*

School drop-out rate among children with special needs and young people was reduced, while school compliance (reduced absenteeism) and motivation for formal learning (improved class results – better grades) increased.

Practical examples of non-formal educational activities for children with special needs:

1. Erasmus + mobilities through the international project 'The future through our eyes', in which a group of visually impaired students and students with multiple deficiencies from the Special S.M. High School of Arad, participated in an Erasmus mobility in Greece. Within the international

exchange of good practices, they developed skills andacquired habits and abilities in the field of eco-industry, mechanics and public nutrition.This was achieved through professional visits and practical activities, carried out directly with the economic agents. Through this project, young people acquired new professional and transversal skills. They improved their ability to communicate in a foreign language and their cultural skills, through socialising and intercultural activities.

2. A cultural artistic project was organised in Arad, by students from the Special High School, along with former graduates and students with disabilities from the ‘Aurel Vlaicu’ University of Arad. They put on a charity show on the stage of the Classical Theatre of Arad. They recited poems, sang and performed in five short plays. The funds raised were used in projects dedicated to children with special needs in Arad.

Good practices for training teachers for pedagogy in the field of special educational requirements

The 'Aurel Vlaicu' University of Arad, Romania, participated in several European project exchanges, which focused on educational models for people with special needs, mental deficiencies and multiple deficiencies:

- In 2005-2007 university delegates participated as members of the management team in the international project for people with special needs: *Unity in educational diversity*, organized by the School Center for Inclusive Education of Arad (school for visually impaired students and students with multiple deficiencies), in partnership with the Dominikus-Savio Schule, Pfaffendorf, Germany. The project was part of the Leonardo daVinci projects. It took place in Germany, where the delegates observed learning processesand techniques for children with special needs. Some of the visiting teachers in the specialschools were former students at the same special school.
- In 2008-2009 university delegates participated in a project organized by Leonardo da Vinci Lifelong Learning Program. In the International Project: *Modern Education for the Supportof Visually Impaired Students*, LLP-LdV / VETPRO / 2008 / RO / 241, National Agency for Community Programs in the Field of Education and Professional Training, Arad - Budapesta, they observed the special learning activities developed by a school for the visually and mentally impaired students, in Budapest. An educational experience consisted of navigating (for several hours) through an obstacle tunnel, in complete

darkness. This exercise helped the participants experience life as a blind person, with the aim of increasingthe level of empathy towards these children.

Current social pedagogy trends in the European Union member states show that inclusionbrings people with mental illness to the same workplace with healthy people, all together, in enterprises. Research has shown that the reduction of stigma towards a vulnerable category is also achieved through socio-occupational inclusion, along with educating the public opinion to changethe social representation of the population, towards people with mental illness (Gavrila-Ardelean,2016).

Fig. 2. Gradual effects of education and intervention on the social inclusion of peoplewith mental health problems
(author work)

'Aurel Vlaicu' University of Arad took part in the following international educational andstrategic projects for mental health, which are included in the axis of Erasmus +, KA 2:

1. *Santé Publique - Santé Mentale, Employabilité en Europe* (S.P.S.M.) Project. The project partners were five Francophone countries: Luxembourg, through the Luxembourg Institute of Health (LIH, European project coordinator: Sociologist Dr. Laurence Fond-Harmant), France, Belgium, Switzerland and Romania ('Aurel Vlaicu' University of Arad, national coordinator of the project: Mihaela Gavrila-Ardelean). Through this project, we developed a method of preventing the stigmatisation of people with mental health problems in Romania, by informingand educating the population. Stigma can be reduced through the strategies mentioned by Grawez, M. (2008):
    - Occupational accompaniment;
    - Training specialists in occupational insertion, who can inform the population;
    - Primary prevention through training of professionals in awareness-raising;
    - The theory of amplification of ridicule and stereotypes, which induces humour.

In 2017, in Romania, 732 Authorized Protected Units employed only 1.897 people with disabilities and 124 people with a third degree of disability; that is 0.26% of the total number of people with disabilities. This, in the context in which a total of 33,449 people with disabilities areemployed in Romania, out of over 700,000 disabled people with the right to work (Gavrila-Ardelean, 2017).

The objective of the project was to improve the skills of the specialists, for a better professional insertion of people with mental health problems (http://sante-mentale-insertion.org).

The impact of the project, at the microsystemic level, translates through professional developmentof specialists and improvement of the quality of life of people with mental disorders, facilitating their inclusion. At the mesosystemic level, as a result of the employment of the beneficiaries, the family income is improved and the Gross Domestic Product grows (GDP), resulting into an increased well-being for both the family and the community. At the macrosystemic level, the project has a modulatory impact in the elaboration of social insurance policies for mental health, in the sense of reducing mental illness.

2. Professional tutoring activities in mental health through two European projects carried out by CNP Saint-Martin, Belgium, Dave, Namur, coordinator Jocelyn Deloyer:

- The Project *European TuToring Process in Psychiatry and Mental Health* trains, experiments and evaluates a European guidance process for new professionals who intend to work in the field of psychiatry and mental health.
- *Vocational Education Process in European Tutoring for Immersion Trainees in the Mental Health Sector* – in this project, trainers built international courses based on formal and non-formal methods, aimed at improving the professional skills of the mental health specialists and at building transversal, international and transcultural competences.

3. *Digi Family* is a European project for integrated family therapies. This project aims to be clearly linked to the development of efficiency and high-quality services in social and

therapeutic interventions, thus helping professionals to collaborate with the community resources within their reach. This can allow them to provide assistance to more patients in lesstime and also provides a more efficient and high-quality service for both patients and their families.

Empowerment of families – good practices: the studies we have conducted demonstrate that many of the psychiatric patients in Romania suffer from associated social problems: unemployment, poverty, economic problems, abuse.

The community interventions – that we have carried out through European projects: meetings with employers and entrepreneurs from Western Romania; focus groups with families of people with mental health problems, with specialists in the field of psychiatric care, and with mental health service providers – have shown a facilitation in both the employment of people with mental health problems in the western part of the country, and the labour mobility for users.

The project partnership focuses on creating a digital platform that allows a better understanding of these techniques. It also allows learning through collaboration with otherinstitutions, as each partner institution can share its vision and work procedure with the communityand the families of the beneficiaries. Quality can be improved through mobility and cross-border cooperation. Working with community and family resources implies a cultural specificity for the countries participating in the project, which leads to easy integration in

practical interventions of the new professionals from several disciplines.

Often times, disability is associated with devaluation or labeling - this is the premise fromwhich the *Social Role Valorisation Theory* (SRV) stems. Kendrick (1994) observes a paradigm shift in addressing disability by shifting the medical model to the social model

— also, not all people are positively valued in their society and this fact makes SRV important. Osburn (2006, p.6) points out that the image and competency enhancement as role-valorising actions can be carried out on four distinct levels and sectors of social organisation: the individual;the individual's primary social systems, such as the family; the intermediate level social systems of an individual or group, such as the neighborhood, community, and services the person receives; the larger society of the individual or group, including the entire service system. Romania, through the 'Aurel Vlaicu' University of Arad, is one of the project's reporting partners, along with Spain (project coordinator), Greece, Finland, Iceland and Belgium. People with mental disorders are at high risk of social exclusion, which makes our project bring therapy closer to the community. By collaborating with community and family resources in the field of mental health, group therapy, inter-family therapy, and open dialogue are designed as a new form of therapy, considered more appropriate to approach isolated beneficiaries and optimise social inclusion of people with mental health problems.

Education for mental health, integration of community resources, collaboration with partner institutions, work procedure with the community and families of

beneficiaries, knowledge of local and national community resources, was conducted through collaboration contracts. Practice sessions for the students from our university were carried out in collaboration with two social workdepartments: Directorate for Social Assistance and the General Directorate for Social Assistance and Child Protection of Arad, together with the Psychiatric Hospital, and local NGOs. Thus, new professionals from several socio-human disciplines were easily integrated into practical interventions. As part of the Digi Family project, we will develop, at the level of Romania, digital networks in mental health: for professionals and for beneficiaries. According to Chamberlin (1997,p.44-46)[4], these services generate, among other things, learning skills, effecting change in one's life and community.

People with mental disorders are at high risk of social exclusion, which makes our projectbring therapy closer to the community. In this way, they can find opportunities for the formation of therapeutic social networks, which lead to the collaboration of different institutions and imply a first step towards getting a job.

The role of the university in the community is complex. On the one hand, it addresses the trainingof young generations through university studies. The university provides professional training andthus empowers all people for work and life, in a non-discriminatory way, through equal access to education. *The Law of National Education* in Romania stipulates the facilitation of access to education for people with special needs through university social scholarships. There are 10 years of compulsory and free education in Romania. This includes primary school, and

secondary school, up to grade 10 (lower secondary education – middle school, and upper secondary education – high school, up to grade 10) (*The Law of National Education* No. 1/2011, with amendments).

On the other hand, the university represents the emblem of a community's intellect. In collaboration with the Territorial Labour Inspectorate, local NGOs and other state institutions, it regularly organises labour markets, where young people can find a job – a starting point in their life. This is the community support that the university provides, thus bringing together training, practice and society. A student can apply to the offered jobs and work part-time.

The training of specialists in special psycho-pedagogy, social work, psychology and socialpedagogy, who will work directly with people with special needs and their families, is carried outthrough counseling, mentoring, and social work services, which are made available to students.This ensures a connection between people with special needs, state institutions and the community.

All these practical measures help empower young people for life, and aid in the preventionof community mental illness and professional integration.

[4] Chamberlin, J., (1997), A working Definition of Empowerment, Volume 20 Number 4, available at file:///C:/Users/Cosmin/Desktop/Working-definition-of-empowerment.pdf

References

1. Bookman, A., & Morgen, S. (Eds.). (1984). *Women and the politics of empowerment.* Philadelphia: Temple University Press.
2. Cantor, D., Waldfogel, J., Kerwin, J., Wright, M. M., Levin, K., Rauch, J., ... & Kudela, M. S. (2001). Balancing the needs of families and employers: Family and medical leave surveys. *Report submitted to the US Department of Labor. Washington*, *DC*: Westat.
3. Chamberlin, J. (1997). A working Definition of Empowerment, Volume 20 No. 4, p.44-46, available file:///C:/Users/Cosmin/Desktop/Working-definition-of-empowerment.pdf
4. Friere, P. (1970). *Pedagogy of the oppressed*. New York.
5. Gavrila-Ardelean, M., Gavrila-Ardelean, L. (2017). Review of Need for Health Education in the Bio-Psycho-Social Approach of Mental Health, *Journal Plus Education*, 17(1):276-285.
6. Gavrila-Ardelean, M. (2016). Reducing the Stigma of People with Mental Handicap, *Agora Psycho-Pragmatica, X* (2): 39-45
7. Gavrila-Ardelean, M. (2017). Personal Needs and Psycho-Social Expectancies of People with Mental Chronic Disorders Regarding Professional Insertion ... *Revista De Cercetare Si Interventie Sociala.* 56, 57-69.
8. Grawez, M. (2008). Le prix du handicap, *Revue nouvelle.*
9. Hayes, S. A., & Watson, S. L. (2013). The impact of parenting stress: A meta-analysis of studies comparing the experience of parenting stress in parents of children with and without autism spectrum disorder. *Journal of autism and developmental disorders*, *43*(3), 629-642.

10. Hung, J.W., Wu, Y.H., Chiang, Y.C., Wu, W.C., Yeh, C.H. (2010). Mental health of parents havingchildren with physical disabilities. *Chang Gung Med J.* Jan-Feb; 33(1):82-91. PMID: 20184799.
11. IFFD. (2013). *Statement Promoting empowerment of families, available at* http://www.familyperspective.org/seun/WrittenStatement.pdf. Building Bridges: Promoting Social Inclusion and Wellbeing for Families of Children with Special Needs.
12. Johnston, C., Hessl, D., Blasey, C., Eliez, S., Erba, H., Dyer-Friedman, J., Glaser, B., Reiss, A. L. (2003). Factors associated with parenting stress in mothers of children with fragile X syndrome. *Journal of Developmental and Behavioral Pediatrics,* 24, 4, 267–275.
13. Kendrick, M. (1994). Some reasons why Social Role Valorization is important. SRV/VRS: *The International Social Role Valorization Journal/ La Revue Internationale de la Valorisation des Roles Sociaux,* 1(1), 14-18.
14. Leliugiene, I., & Barsauskiene, V. (2003), The university role in community development: responding to challenges of globalization, Paper presented at the *European Conference onEducational Research, University of Hamburg*, available on http://www.leeds.ac.uk/educol/documents/00003245.htm
15. *** Legea educației naționale nr. 1/2011, *The Law of National Education* No. 1/2011, with amendments, http://revista.universuljuridic.ro/legea-educatiei-nationale-nr-12011- modificari-legea-nr-562019/ accessed in 31.01.2021.

16. Murphy, N. A., Christian, B., Caplin, D.A., Young, P.C. (2007). The health of caregivers for children with disabilities: caregiver perspectives. *Child Care Health Dev. Mar*; 33(2):180- 7. doi: 10.1111/j.1365-2214.2006.00644.x. PMID: 17291322.
17. Osburn, J. (2006). An Overview of Social Role Valorization Theory, *The SRV Journal*, 1(1), 4-13.
18. Osvath, C. (2011). *Calitatea vieții în familiile copiilor cu dizabilități neuro-motorii.* Teza de Doctorat, Universitatea Babeș-Bolyai, Cluj-Napoca
19. Page, N., & Czuba, C. E. (1999). Empowerment: What is it. *Journal of extension*, *37*(5), 1-5.
20. Pisula, E. (2011). Parenting stress in mothers and fathers of children with autism spectrum disorders. *A comprehensive book on autism spectrum disorders*, *5*, 87-106
21. Plant, K. M., Sanders, M. R. (2007). Predictors of care-giver stress in families of preschool- aged children with developmental disabilities. *Journal of Intellectual Disability Research*, 51(2), 109–124. 10.1111/j.1365-2788. 2006.00829. x17217475
22. Rapport, J. (1984). Studies in empowerment: Introduction to the issue. *Prevention in Human Services*, 3, 1-7.
23. Solomon, B. B. (1976). *Black empowerment: Social work in oppressed communities.* Columbia University Press, New York.
24. Stevenson, A. (Ed.). (2010). *Oxford dictionary of English*. Oxford University Press, USA.
25. The National Authority for People with Disabilities – http://anpd.gov.ro/web/wp-content/uploads/2019/12/ANPD-Buletin-statistic-trim-III-2019.pdf, https://insse.ro/cms/

26. Tomoka, K., Masumi, I.,Makiko, K. (2012). Professional Caregiver's View on Mental Health in Parents of Children with Developmental Disabilities: A Nationwide Study of Institutions and Consultation Centers in Japan, *International Scholarly Research Notices*, https://doi.org/10.5402/2012/121898
27. Yamaoka, Y., Tamiya, N., Moriyama, Y., Sandoval Garrido, F. A., Sumazaki, R., & Noguchi, H. (2015). Mental Health of Parents as Caregivers of Children with Disabilities: Based on Japanese Nationwide Survey. *PloS one*, *10*(12), e0145200. https://doi.org/10.1371/journal.pone.0145200
28. Webster, N., & Porter, N. (1913). *Webster's Revised Unabridged Dictionary of the English Language: The Dictionary Proper Being the Authentic Ed. of Webster's International Dictionary of One Thousand Eight Hundred and Ninety,* Ed. Under the Supervision of Noah Porter... to which is Now Added a Department of New Words, Together with Many Valuable Special Features. Merriam.
29. https://insse.ro/cms/
30. http://sante-mentale-insertion.org
31. https://who/

Many decades of dialogical work together with young people and their social networks in the mental health services of Finnish Western Lapland

Tomi Bergström, PhD, psychologist, researcher
Riikka Savolainen Psychologist MSc
Anne Näätsaari Nurse, Family therapist
Ulla Piipponen Nurse, Family therapist
Jaana Laakso Social worker MSc, Family Therapist
Kari Valtanen Child- and Adolescent Psychiatrist MSc, Family and Psychotherapy trainer
Elina Löhönen psychologist MSc
Sirkku Maikkula nurse, Family – and psychotherapy trainer
Piia Pajari Social worker MSc
Satu Piippo, Occupational therapist
Mia Kurtti Nurse MSc, Family- and Psychotherapy trainer

Open Dialogue is an integrated approach to mental health care, originated from Finnish Western Lapland region. In Open Dialogue-based services treatment involves service users social network members, first meeting can be arranged within 24 hours of initial contact within the context of the service users' everyday life. Open Dialogue approach has demonstrated promising treatment outcomes in the treatment of severe mental health problems, and currently it is widely implemented, trained and studied in many parts of the world. After the original development and implementation of Open Dialogue approach in Western Lapland region in 1980s and 1990s, the local *Children and Adolescents clinic* continued more systematic development,

research and delivery of Open Dialogue-based services for all under-aged people with the need for mental health services in the Western Lapland region. In this chapter we describe the main premise of Open Dialogue-approach, and how approach is currently developed, practiced and trained in the *Children and Adolescents clinic* of Western Lapland.

The origin of Open Dialogue approach

The term Open Dialogue (OD) refers to a need-adapted and integrated approach to mental health care, whose primary aim is the creation of shared understanding of difficult life-situations together with service users and their social network-members (Seikkula et al., 2006). In OD-based services one of the main premises is to address life difficulties and psychological crises by organizing social network treatment meetings, aiming to gather all relevant people together as soon as possible. These meetings are often organized at the peoples' home or in another safe environment of their own choice (Bergström et al., 2021).

The development of Open Dialogue approach based on a research of need-adapted treatment approaches, conducted in Finnish public healthcare system since the 1970s (Alanen, 2009; Tuori, 2009). In the early phases of Western Lapland's development and research projects in 1980's, it was observed that conventional systemic family and other psychotherapy was often too objectifying to address changing and complex situations occurring in the public healthcare sector (Seikkula et al., 2006). Eventually, this led to an adaptation of more flexible and open ways to arrange therapeutic meetings with clients and their families.

Further research evidence (e.g. Haarakangas, 1997; Keränen, 1992; Seikkula, 1991) indicated that more unstructured ways of working with families led to outcomes in which clients and their families were more actively involved in treatment process, and staff could no longer follow their conventional roles in planning and conducting pre-determined interventions (Seikkula et al., 2011). Instead, they became part of the joint interaction process, when clients and their social networks had more space to both determine the actual problems and also the potential solutions to that problem. This may have promoted more therapeutic process simultaneously assisting the solution of those real-life difficulties that were actually causing symptoms interpretable as a mental health problems (Bergström, 2020). Constructivist perspectives - and especially the concept of dialogism as described by Bakhtin (1984) - were applied to understand new phenomena that arose from practice: the co-evolving process of listening and understanding was viewed to create new and shared meanings for difficult experiences.

Such dialogical responses to crises seemed to be beneficial in in dealing with difficult life situations, and guidelines to guarantee dialogical response in all mental health crises were drawn as a part of naturalistic research conducted in the region of Western Lapland (Seikkula et al., 2011). For example, based on systemic case note analyses, it was observed that a successful treatment process, which was associated with favourable outcomes, consisted of several elements.

Immediate help
A social network perspective
Flexibility and mobility
Responsibility
Psychological continuity
Tolerance of uncertainty
Dialogue

Later these became known as the seven treatment principles of Open Dialogue (Seikkula et al., 2006). In further phases of research and development, these seven principles were used to guide the arrangement of the entire regional adult psychiatric treatment system in the way that dialogical and needs-adapted responses to crises became possible in all cases, regardless of the diagnosis. In this sense, the term 'Open Dialogue' does not refer to a specific therapy technique, but instead to both the dialogical way of working with clients and their families, and at the same time guiding principles for the arrangement of entire psychiatric healthcare systems to enable this kind of response.

The effectiveness of the Open Dialogue approach in the treatment of psychosis was studied in the Western Lapland area as a part of original implementation projects in 1990's (Seikkula et al., 2003; Seikkula et al., 2006; Seikkula, Alakare, & Aaltonen, 2011). In these studies, Open Dialogue associated with favourable outcome including good social functioning and low prevalence of residual symptoms. Later large-scale register-based studies has confirmed stability of these good outcomes, and also their superiority as compared to standard care (Bergström et al., 2018).

Preliminary information, obtained from outside of the Western Lapland area, indicates that with this kind of approach there may be a favourable effect on the outcome of mental health treatment especially for young people and their families (Buus et al., 2019; Gordon, et al., 2016; Granö et al., 2016). Approach has also been generally well received by the service users and their social network-members themselves (Bergström et al., 2021; Gidugu et al., 2020; Hendy & Pearson, 2020; Freeman, Tribe et al., 2019). Especially in other parts of Scandinavia, there have been reports on the implementation of family-oriented Open Dialogue, including promising outcomes and experiences, but as of yet there have been no rigorous trials to evaluate the effectiveness of the approach (Buus et al., 2017; Freeman et al., 2019). The Open Dialogue approach was included into the World Health Organization's guideline (2021) as an one example of practices aiming to promote human-rights and recovery-orientated approaches to a community mental health care services.

Despite the promising results described above, organizational changes in Finnish healthcare system and other structural factors have challenged systematic maintenance of need-adapted and Open Dialogue-based approaches to mental healthcare in the region Western Lapland (Alanen, 2009; Bergström, 2020). However, following the municipalizations of Finnish healthcare services at the end of the 1990s, the local adolescent clinic of Western Lapland continued to operate under the healthcare district, and to deliver, research and develop OD-based services to all residents in the Western Lapland region aged 13-20 years. Next, we will give more detailed description about the history of

Children and Adolescent Psychiatric Clinic of Western Lapland, and how mental health services and training are organized in the region in the early 2020s.

Context and history of the Children and Adolescent Psychiatric Clinic of Western Lapland

In 2020, Western Lapland healthcare district consists of the south-western parts of Finnish Lapland, and it is responsible for special-level health care services of two towns (Kemi and Tornio) and four smaller municipalities of the region. In 2020, the population of the area was approx. 61 000 inhabitants. The Children and Adolescent Clinic has units in both towns, and the total number of healthcare staff in these units is around 30 people with various professional backgrounds. In the year 2020 majority of staff-members were nurses with 3-year on-the-job psychotherapist training tailored specifically to support the Open Dialogue-based social network and need-adapted responses to mental health crises. Since the 1990's, Open Dialogue training has been funded via regular in-service training funds granted for Finnish healthcare districts. The staff of the Children and Adolescent Clinic also include several doctors, psychologists, occupational therapists and social workers. Over the years people with lived experiences of mental healthcare services have become part of the clinical and developmental work of the Children and Adolescent clinic with the title of peer-expert.

As noted previously, mental health services for adolescents diverged from adult and children psychiatry at the end of the

1990s, after the major organizational changes in Finnish mental healthcare system. At the beginning, the clinic employed four clinicians and one part-time psychiatrist. In the early 2000s, the government offered funding to ensure increased capacity for municipalities to develop the family- and network-based work together with local schools and social services. Hired project workers took part in meetings in schools with teachers and school nurses and integrative meetings between primary health care and special health care organisations. They also organised and offered supervision and training for all the staff in agencies working with families. The aim was to build a collaboration with all the operatives in the area so that the network would be available in a need-adapted manner for the individuals and families, align with the Open Dialogue approach. One outcome from these processes was improving the understanding that the professionals working with adolescents and families could recognise their actual real-life worries and problems.

Building on these outcomes*, The Children and Adolescent Psychiatric Clinic of Western Lapland* started to offer services to different operatives and families without bureaucratic boundaries– being thus align with already established Open Dialogue-based psychiatric services for adults, in which it was possible to immediately commence social network- and dialogically-oriented response to mental health crises by directly contacting services without a need for referral from other medical authorities. Additional result from this process was that there was no longer need to build hospital beds for adolescents, as the social network could be activated to provide support for individuals in difficult life situations.

During the last twenty years, the collaborative work and system of care has been further developed in Western Lapland together with social services, police, youth work, counselling, student services, congregations, supporting working agencies and many other partners. Basically, this means working together with families, and creating a collaborative culture in joint development processes and in network meetings. In the qualitative study by Karttunen (2012) cooperation between the public health nurses operating at schools and the workers of the adolescent psychiatry is experienced as easy and flexible, especially at beginning of the treatment process. Vuokila-Oikkonen et al (2011) described Open Dialogue as good practice for the early recognition and intervention of severe mental health problems.

Clinical practice in the Children and Adolescent Psychiatric Clinic of Western Lapland

In 2020, The Children and Adolescent Clinic of Western Lapland is a low threshold outpatient clinic operating without referrals. Basically treatment contact can be immediately established by contacting directly any of the healthcare staff members or via phone call to the service manager, responding 24/7 from local mental healthcare service number. The service manager is always trained and experienced professional, as the one of the premises is that the phone call itself forms an initial therapeutic contact, as opposed to being simply considered as an 'information gathering' exercise. This is based on an idea, that when people contact the clinic, it is at a crucial point in their lives, and that families themselves are best experts to evaluate

their own situation and actual need of help. This differs from more conventional practice in Finnish healthcare system, in which treatment is usually based on expert's referrals and/or pre-determined treatment protocols focusing primarily on group-level symptom-reduction and psychiatric diagnoses.
Sometimes professionals from other services who already have contact with the family makes the first call. These professionals can be for example school nurses, counsellors and social workers. Service manager maps out all professionals who already are in contact with the family and always checks that the caller has spoken with the parents before calling. Quite often service manager contacts the parents before the first treatment meeting is arranged. Sometimes parents themselves can be the ones who make the first call. During the phone call service manager listens to the worries of the caller and makes the first evaluation regarding the urgency of the treatment together with the caller and the family. The crisis orientation of the clinic means that if needed, the first meeting is arranged within 24 hours.

After the initial contact, the service manager evaluates the problem and identifies who might be the most suitable workers for the family and/or social network in question. The multidisciplinary treatment team is gathered based on existing needs of client and their social networks, and it varies by the family's needs and treatment goals. There is usually at least two familiar staff members in each family's treatment team, who are responsible for the treatment process and who are ensuring the continuity of treatment as long as needed.

When help is assigned to the family, treatment team establish contact and the first meeting is arranged. With the clients' and parents' consent, those people are invited to the first meeting who are worried and familiar with the current situation, and/or who may be important for the solution of the problem. In practice social network means people close to the child or adolescent, and who know his/her strengths and qualities, and who are concerned. Usually social network consists parents or foster parents, but it could also include friends as well as professionals from other services who know the child or adolescent, and who are in touch with him/her e.g. in the environment in which concerning behaviour manifests. Social network could also include other professionals and experts who may have role in planning the support and/or proper solutions. If the problems manifest at school, for example teacher, special education teacher, study advisor, school counsellor or school nurse may be invited to the first meeting with parents and the client.

Over the entire treatment process, the clients and their family members are considered active participants in both interpretation of current situation as well as in planning and conducting of the treatment (Valtanen, 2019). In this way treatment is tailored to the individual and constantly changing needs of client's and their social network members (Alanen, 2009). It has noted that in dialogic way of working the stance or attitude of therapists is crucial. I.e. therapists treat clients as a subjects with agency instead of objects of treatment (Anderson 2012), and instead of asking what is wrong with particular individual, the main goal is to create shared understanding what

has actually happened to people and what is currently going on in their life. This attitude reflects basic values behind Open Dialogue approach, and serves the essential aim to invite and make use of families and their network's own natural resources. After all, the primary goal of public mental healthcare treatment process should be that at some point people won't anymore need the treatment and services, and they can rely on those factors and support that can be found from their everyday life.

The treatment team is constantly assessing the client's and family's needs and invites professionals or therapists with different kind of perspectives and backgrounds to participate in the client's treatment based on the needs of the family. At the clinic, a number of professionals are available, specialized in occupational therapy, physiotherapy, social work, psychology, as well as experts who have deeper knowledge of trauma, neuropsychiatry or group therapy. Before implementing a chosen intervention into a client's treatment, it is planned and jointly discussed in network treatment meetings. It is important to schedule when and who will meet with the family, whether there any individual meetings for parents and how long the specialized intervention (for example, occupational therapy) will last. Specialized experts and workers from Child and Adolescent unit and from other services are also an essential part of a client's treatment team, and therefore they also join the family and network meetings, even though they may also have their own individual meetings with the child or adolescent.

The correct timing is important when different views, interventions or treatment and therapy methods are integrated

into a client's treatment process. Flexible and needs-based therapy processes can include a pair of therapists only, or many different professionals throughout the process. From the family's point of view, it is very important that they are aware of who those professionals are who work alongside them throughout the entire treatment process.

Private sector therapists and third sector agents can also be invited onto the client's network to support the client's treatment process, although in the region of Western Lapland multidisciplinary support is integral part of public healthcare service, when most of the families tend to use only public healthcare services. Moreover, the client's treatment team carries the responsibility of official treatment and rehabilitation plans, even if client's actual treatment and therapy takes place within the private sector and/or would be funded by the local council or by a public insurance company.

In general, during the treatment process, line-up of the network treatment meetings vary depending on the situation and client's individual needs. For example, having individual meetings during a period of time can be a part of the process if adolescent is motivated and if he or she may benefit for such a work. Additionally, network meetings with schools are arranged if problems manifest in the school environment. Flexibility of the services means that frequency of meetings could be changed and temporarily increased in the crisis situations.

Many levels of everyday teamwork

In addition to the organizational level service delivery described above, the main principle of Open Dialogue also guides the way how people are actually encountered and helped in difficult life-situations. First of all, predetermined interpretations and symptom-based categorization of people and their problems are not essential for practice. Instead of specific diagnoses, families' situations are approach based on their own perspective and subjective interpretations. Thus, the focus in the meetings is on the topics which clients and their social network members themselves find relevant at the present moment. In this way dialogue in the treatment meetings aims to promote the shared understanding what is going on in people's life. For instance, how are things at school, day-care, work, how people are communicating at home and other places etc. The focus is on the relationships with other people, which also allows workers to understand what has happened in people's life, and what is actually causing distressing experiences and worry. Primary task for workers is ensure safe space where everyone can be heard as a part of joint dialogue.

When there are two or more workers present, it is easier to notice different perspectives that are brought up into the dialogue. Therefore, collaborative and reflective team- and pair-work is one of the basis for a rich dialogue with multiple views and voices. In meetings with social networks, therapists will constantly face different kind of needs, hopes and expectations from many different people. As there are always two therapists present in meetings, one can listen and reflect while the other maintain more active interaction (Andersen,1990; Jäppinen,

2005). This way it can be easier to comprehend ‘what is going on’, to see where one’s feelings in the interaction come from and to keep one’s role and focus clear. Working with pairs is also essential in tolerating uncertainty, which is one of the main premises of collaborative care and dialogue.

In treatment process therapists need to tolerate uncertainty even at times of crisis, to create space for unexpressed experiences to find their expression in words and for shared understanding to emerge (Seikkula, Alakare & Aaltonen, 2011). Resisting the urge of extinguish worry by making fast decisions and persistently seeking understanding is not possible if therapists themselves doesn’t feel emotionally safe. In many occasions, co-operation with co-therapist is the most essential source for safety. Approaching emotionally loaded themes is different when other therapist is listening and participating to a dialogue from a slightly different perspective. There are also elements from trauma-informed approaches. For example, need for a stabilization phase is recognized (Steele, Boon & Van der Hart, 2017), and ideas of stabilizing family therapy (Rautkallio, 2018) has later affected practices in Child and Adolescent clinic. According to this, discussing or working through emotionally difficult issues is not yet possible if situation in client's life and family relations isn't stable enough, and energy and resources are needed to survive everyday life. By learning means to strengthen agency and safety, it's possible to stabilize everyday life and family relations, enabling also therapeutic processes (Rautkallio, 2018).

As family and other professionals from child's everyday life take part to treatment meetings when needed, it's possible to address problems in everyday environment immediately and to reduce current stress in similar vein as Granö et al (2016) describe. This can be part of stabilizing work. Therapists also need to say in touch with all the levels of the situation taking into account emotional and interactional elements to avoid treatment process reducing into mechanical solution seeking. Therapists listen to themes that evoke emotions, give partakers time to shape their thoughts to words as this process can produce insights (Anderson, 2012) and courage dialogue that is rooted to everyday life and helps to create rich understanding with multiple perspectives. In network meeting strong hopes for clear solution like medication or hospitalization may come up or the need to somehow immediately intervene or classify child's behaviour that is seen problematic. Together (and with family and he network) therapists consider the need to make plans for ensuring the safety of the child and necessity to continue dialogue about the role of interactional and environmental elements in problematic seen behaviour, alternative views of behaviour and alternative explanations to behaviour, hopes and views of the child, resources and views of parents etc. Balancing the need to find practical level solutions together and being sensitive to emotional, interactional and therapeutical themes in the course of treatment process is where observation and views of two therapists can be of essential importance.

The space for reflexivity and safety created by team- and pair-work is also important when it comes to working with difficult and strong feelings. Teamwork can help therapists to be open to

their own emotional responses which could support treatment process. For example, Jäppinen (2005) states that in therapy, the problems of the family transfer to the inner experience of the co-therapists. The task of the co-therapists is to work through and to return these contents to the family. Pair-work makes it easier for therapists to maintain multiple perspectives in their thinking and in relation to family. In some families there may be the tendency to remain at a practical, concrete level in discussion and fear or cautiousness may surround emotional themes. If one of the therapists adapts too much to the family's way of interacting the other therapist may add another perspective to dialogue by starting to reflect the lack of emotionality in the discussed themes. Through cooperation and reflection, it is possible to make new themes safe for the family (Haarakangas, 1997).

Finally, it should be noted that team- and pair-work also protects the resources and wellbeing of the therapists themselves. When working in a low threshold system, clients or their families may not be ready for the therapeutic process for some time. The family may be reluctant to attend meetings, but treatment contact may be still needed, if there are e.g. severe worries about the child's wellbeing. The professional network around the family may have significant expectations of the psychiatric team. In these situations, cooperation and clear communication with other professionals around the family is essential. These situations evoke feelings like worry, helplessness and even fear or anger in therapists. Working as a pair helps therapists to be reflective in relation to their own feelings and to maintain professionalism as they build relationships with the family. The

knowledge that the responsibility for the treatment process is shared can protect therapists from becoming burdened or exhausted.

Training and maintenance of Open Dialogue

As described earlier in this chapter, the practice and research have been evolving in Western Lapland Health Care District in a coexistence during the last decades. In publicly funded social- and health care systems, the aim is to provide essential care and treatment to all people in need, despite their social or cultural roles and circumstances. How this core task is defined and how the treatment processes are created, depends on the culture - in both the surrounding society and in the particular organization. How the systems and organizations function is largely based on the settings created by the people who work there – how are they able to create common values that frames-their practice? How are the roles and responsibilities designed and defined? Is that a dialogical and shared process or is it a more regulated procedure where people fall in-to the given roles and tasks?

Haarakangas (2002) refers to the summary published by Association of Finnish Hospitals in 1987, and writes that the foundations for the development of the service system were built from the research and analysis of the Western Lapland population and social and health service structures. A unique part of collaboration during 1980`s with the Department of Psychology at Jyväskylä University was to establish a profound psychotherapeutic training programme which would be informed by the local knowledge emerging from cultural

aspects. A strong objective was that all staff members would have training in family therapy or other therapeutic modalities in order to be ready and have the tools to respond to any challenging mental health crises.

Trainings have been open for other local collaborating services, such as staff from social services, family guidance clinics, school nurses and counsellors, etc. This has also developed further collaboration and shared understanding between services about working together with families and networks. Since 1986, seven three-year family therapy training programmes and two individual psychodynamic trainings have been completed, one advanced level (trainer's) training took place between 2002 and 2004. Training programmes have been influenced by the integrating principles of the Need-Adapted Approach and further Open Dialogue Approach. (Aaltonen et al, 2011). In addition, several shorter trainings for staff on dialogical family therapy, family interventions, trauma therapy, cognitive therapy etc have been carried out. Different trainings and new ways of working have been aimed to be integrated as a part of the Open Dialogue model of treatment (Valtanen, 2019; Van Os, 2019).

During training processes, the trainees learn from their practice in supervision seminars, together with the clients and families, and become familiar with their own family narratives and histories and the impact this has on their clinical practice. This has created a new kind of culture within organisations where mutual trust has been created through sharing stories and experiencing the trust in other people to be able to bring one's

own (sometimes painful) experiences into the shared space. Additionally, witnessing the practice of others has been crucial in creating—better care for people who are using the services. Key-principle is that in the training process the emphasis is on horizontal aspects of expertise rather than on vertical, authority-emphasizing aspects (Aaltonen et al, 2011). During days where theoretical material is taught, trainees explore the theoretical background of systemic- and family and network- based thinking, alongside theories that are seen to be crucial in the changes in systems.

Dialogism is the elemental and theoretical thread that underlies the training process. People are invited to learn from the theoretical aspects, but moreover to build dialogues between different voices and views in themselves and in the networks where they work. It also allows the training itself to develop responses to questions which are at the current cultural and social context. In further enabling dialogical facilitation in this process, working in pairs also applies in training as it does in clinical practice. This helps to tolerate the uncertainty that is present in every process when gaining new skills and insights and dialogue between trainers offers wider perspectives regarding the theory for the trainees. In the current training format, the training team which teach the theoretical material is formed by two trainers in psychotherapy and a trainer from the organisation's peer/expert by experience team.

There are certain considerations when thinking about conducting-in-house training. What does an organisation want to achieve? What are the goals and visions regarding its working

strategies? Coexistence of practice, research and training is important when developing new practices in health care systems. It can be important to ask does the organisation meet the criteria for staff to work dialogically with the focus being on family- and network-based approach? If an organisation has an aim to make the decisions in dialogical spaces, the clinical practice can also evolve and find new forms through dialogues to where the training process invites trainees to enter.

On the other hand, dialogical practice can also contribute to the human resource management in a very profound way and by doing this, it creates the possibility of increasing the sense of autonomy and self-agency within the whole staff (Haaraniemi & Kurtti, 2011). In WL people in administrative positions also take part in the training processes. This way they can understand the real-life challenges people meet in their everyday work and can take responsibility in creating the structures for the people to work according to seven principles of Open Dialogue. In the early stages of developments administrative level was also building up the research projects, which were crucial for the organisation and practice to evolve. The local politicians were allies in creating the structure for public health care to develop the system of care.

Ongoing and coherent training for all staff members is a corner stone for the sustainability of dialogical and family and network-based practice in social- and health care organisation. The significance of studying the practice and the structure of system delivery is continuously recognised. The WL health care organisation has several research projects going on

where the aim is to study long-term effectiveness of adult psychiatric services and the elements in treatment processes that are considered to sustain and improve the wellbeing, health and autonomy of clients and their networks.

In sum, *In Children and Adolescent Psychiatric Clinic of Western Lapland*, the Open Dialogue doesn't mean any specific method that can be applied in certain situation if needed. Instead, Open Dialogue refers to a comprehensive orientation of how public healthcare services are arranged, how their effectiveness are continuously evaluated, how people are trained and most importantly, how people are treating each other. Mental health services are developing only in an open dialogue.

References

Alanen, Y. O. (2009). Towards a more humanistic psychiatry: Development of need-adapted treatment of schizophrenia group psychoses. *Psychosis*, 1(2), 156-166.

Andersen, T. (1990). The reflecting team. In T. Andersen (ed.) *The reflecting team: Dialogues and Dialogues about the dialogues* (39-41). New York: W.W. Norton.

Anderson, H. (2012). Collaborative relationships and dialogic conversations Ideas for a relationally responsible practice. *Family process,* 51, 8-24.

Bakhtin, M. (1984). *Problems of Dostojevskij's poetics. Theory and history of literature: Vol 8.* Manchester, UK: Manchester University Press.

Bergström, T. (2020). *Life after integrated and dialogical treatment of first-episode psychosis. Long-term outcome at the group and individual level*. JYU Dissertations, 207.

Bergström, T., Seikkula, J., Alakare, B., Mäki, P., Köngäs-Saviaro, P., Taskila, J. J., Tolvanen, A., & Aaltonen, J. (2018). The family-oriented open dialogue approach in the treatment of first-episode psychosis: Nineteen-year outcomes. *Psychiatry Research*, 270, 168-175.

Bergström, T., Seikkula, J., Holma, J., Köngäs-Saviaro, P., Taskila, J. J., & Alakare, B. (2021). Retrospective Experiences of First-Episode Psychosis Treatment Under Open Dialogue-Based Services: A Qualitative Study. *Community mental health journal*,

Buus, N., Bikic, A., Jacobsen, E. K., Müller-Nielsen, K., Aagaard, J., & Rossen, C. B. (2017). Adapting and Implementing Open Dialogue in the Scandinavian Countries: A Scoping Review. *Issues in mental health nursing*, 38(5), 391-401.

Buus, N., Kragh Jacobsen, E., Bojesen, A. B., Bikic, A., Müller-Nielsen, K., Aaqaard, J., & Erlangsen, A. (2019). The Association between Open Dialogue to young Danes in acute psychiatric crisis and their use of health care and social services: A retrospective register-based cohort study. *International Journal of Nursing Studies*, 91, 119-127.

Freeman, A. M., Tribe, R. H., Stott, J. C. H., & Pilling, S. (2019). Open Dialogue: A Review of the Evidence. *Psychiatric Services*, 70(1), 46-59.

Gidugu, V., Rogers, E. S., Gordon, C., Elwy, A. R. & Drainoni, M. L. (2020). Client, family, and clinician experiences of Open Dialogue-based services. Psychological Services, 18(2), 154–163

Gordon, C., Gidugu, V., Rogers, E. S., DeRonck, J., & Ziedonis, D. (2016). Adapting Open Dialogue for Early-Onset Psychosis Into the U.S. Health Care Environment: A Feasibility Study. *Psychiatric Services,* 67(11), 1166-1168.

Granö, N., Karjalainen, M., Ranta, K., Lindgren, M., Roine, M., & Therman, S. (2016). Community-oriented family-based intervention superior to standard treatment in improving depression, hopelessness and functioning among adolescents with any psychosis-risk symptoms. P*sychiatry Research,* 237, 9-16.

Dallos, R. & Draper, R. (2010). *An introduction to family therapy: Systemic theory and practice (3r edition)*. Glasgow: Bell and Bain Ltd.

Haarakangas, K. (2002). *Mielisairaala muuttuu. Keroputaan sairaalan kokemuksia psykiatrisen hoidon kehittämisessä: avoimen dialogin hoitomalli.* Suomen Kuntaliitto.

Haarakangas, K. (1997). *The voices in treatment meeting: a dialogical analysis of the treatment meeting conversations on family-centered psychiatric treatment process in regard to the team activity.* Jyväskylä: University of Jyväskylä.

Haarakangas, K. (2014) Systeemisyys – dialogisuus – integraatio: kohti kokonaisvaltaista psykoterapiaa**.** *Perheterapia-lehti*, 4, 19-31.

Haaraniemi, T., & Kurtti, M. (2011). *Values and Leadership in nursing*. Kemi-Tornio University of Applied Sciences.

Hendy, C. & Pearson, M. (2020). Peer supported open dialogue in a UK NHS trust – a qualitative exploration of clients' and network members' experiences. *The Journal of Mental Health Traning, Education and Practice*, 15(2), 95–103.

Jäppinen, O. (2005). Terapeuttiparin yhteistyöstä ja sen hyödyistä ja haasteista. *Perheterapia-lehti*, 3, 14-41.

Karttunen, M. (2012). *Nuorisopsykiatrian poliklinikan työntekijöiden ja terveydenhoitajien välinen yhteistoiminta Länsi-Pohjan sairaanhoitopiirissä. Ylempi ammattokorkeakoulututkinto. Terveyden edistämisen koulutusohjelman opinnäytetyö.* Kemi Tornion ammattikorkeakoulu.

Permanent address of the publication: https://urn.fi/URN:NBN:fi:amk-2012061112423

Keränen, J. (1992). *Avohoitoon ja sairaalahoitoon valikoituminen perhekeskeisessä psykiatrisessa hoitojärjestelmässä*. Jyväskylä: University of Jyväskylä.

Rautkallio, A. (2018). Vakauttava perheterapia. Perheterapia 2/2018.

Seikkula, J. (1991). *The family-hospital boundary system in the social network*. Jyväskylä: University of Jyväskylä.

Seikkula, J. (1999). Reflektiivinen tiimi ja avoin dialogi – kun itse keskustelu tulee tärkeimmäksi. In J. Aaltonen & R. Rinne (ed.) *Perheterapiassa: vuoropuhelua vuosituhannen vaihtuessa* (84-94). Jyväskylä: Suomen Mielenterveysseuran Koulutuskeskus.

Seikkula, J., Aaltonen, J., Alakare, B., Haarakangas, K., Keränen, J., & Lehtinen, K. (2006). Five-year experience of first-episode nonaffective psychosis in open dialogue approach: Treatment principles, follow-up outcomes, and two case studies. *Psychotherapy Research*, 16(2), 214-218.

Seikkula, J., Alakare, B., & Aaltonen, J. (2011). The Comprehensive Open-Dialogue Approach in Western Lapland: II. Long-term stability of acute psychosis outcomes in advanced community care. *Psychosis,* 3(3), 192-204.

Seikkula, J., Alakare, B., Aaltonen, J., Holma, J. M., Rasikangas, A., & Lehtinen, V. (2003). Open Dialogue Approach: Treatment Principles and Preliminary Results of a Two-Year Follow-Up on First Episode Schizophrenia. *Ethical Human Psychology and Psychiatry*, 5(3), 163-182.

Steele, K., Boon, S. & Van der Hart, O. (2017). *Treating trauma-related dissociation: A practical, integrative approach (1st edition).* London: W. W. Norton & Company

Tuori, T., Lehtinen, V., Hakkarainen, A., Jääskeläinen, J., Kokkola,A., Ojanen, M., … Alanen, Y. O. (1998). The Finnish National Schizophrenia Project 1981-1987: 10-year evaluation of its results. *Acta Psychiatrica Scandinavica*, 97, 10-17.

Valtanen, K. (2019). The psychiatrist's role in implementing Open Dialogue. *Australian & New Zealand Journal of family therapy,* 40(3), 319-329

Van Os, J., Guloksuz, S., Vijn, T. W., Hafkenscheid, A., & Delespaul, P. (2019). The evidence-based group-level symptom-reduction model as the organizing principle for mental health care: time for change? *World Psychiatry,* 18(1), 88-96.

Vuokila-Oikkonen, P., Heikkinen, R-L., Karttunen, M., Läksy, M-L., Maikkula, S., & Wiens, V. (2011) *Psykoosin varhainen tunnistaminen ja hoidolliset interventiot nuorella – hyvän käytännön kuvaus.* B Raportteja 45 Julkaisija: Diakonia-ammattikorkeakoulu. ISBN 978-952-493-113-7.

World Health Organization. (2021). Guidance on community mental health services: promoting person-centred and rights-based approaches. License: CC BY-NC-SA 3.0 IGO.

Multi-family groups open to the broader community

Javier Sempere and Claudio Fuenzalida

Introduction

Human beings are in a constant process of dialogue with the world around them, so the individual and society are very closely interlinked, and influence one another mutually. Society provides the lens through which its members view and interpret the world, so knowledge is rooted in social interaction. We construct our own realities through language, through exchanges with others (Freedman, 1996). This means that ideas, concepts and memories arise from social exchanges and are channelled by language, and that individuals can only develop a sense of identity through continuous exchanges with others.

Since ancient times, all human matters have been addressed in public, social fora: celebrations, burials, political debates, schools, and so forth. Through these events, human beings are able to make sense of how we understand the world and how we live in it. Freud states that '*from the first, individual psychology is also social psychology*' (1913); and Pichon-Rivière (quoted in Zamanillo, 2008) says that '*all psychology, strictly speaking, is social psychology*'. According to Todorov (1995), '*living in society is not a matter of choice; we are always social beings. We wish to understand not only man's place in society, but above all, society's place in a man*'. Smith (quoted in Zamanillo, 2008) argues that '*lack of consideration*' is the worst of all evils that can befall us, and that the '*need to be regarded*' is the truth of all needs, and what drives people. Hegel (quoted in

Zamanillo, 2008) speaks of the '*desire for recognition*' as a driving force behind human actions, and says that only a social group in which we maintain relationships, and recognition, with other people can offer us security.

The multi-family group (MFG) open to the community represents the therapeutic environment that most closely approximates society, among all the possible approaches: the other families who attend the group represent the external society (Thorington, quoted in Foster, 1994). Therefore, interfamily therapy (IFT) carried out in a multi-family context that is open to the broader community could be considered the very best social therapy.

What are community MFGs?

Community MFGs are multi-family groups that are accessible and free, open not only to the patients of a particular institution and those patients' families, but to the whole of society, with no restrictions. Unlike MFGs that are run behind closed doors, whose participants meet to address specific issues, community MFGs are open to any person, of any generation and any sociocultural background, willing to share their particular philosophy of life, spirituality and personal experiences. Thus, the MFG works as an inexhaustible source of popular knowledge and shared learning, through the richest possible dialogue.

Specific features of community MFGs

The ways in which a community MFG works and is run are based on the same inter-family model as applies in any other MFG. However, there are certain peculiarities to these groups which derive from their social openness:

1. ***They are easy to access, and free to attend***

Only a space which is open, accessible and free can be representative of the community. These are MFGs that participants can choose to join spontaneously. They do not require referrals or predetermined criteria, such as attending at least a certain number of sessions, paying for the session, or being diagnosed with or suffering from a specific problem. Consequently, the MFGs are not biased – everyone has a place in the group, just like a microsociety (García Badaracco, 2000) or social microcosm (Yalom, 1995).

2. The topics addressed are universally relatable

An MFG open to the community straddles the boundary between healthcare, education and social work. In the group, all learning is valid and valued, and any of the problems citizens face in their daily lives can be addressed. In this environment, there are no diagnoses, illnesses or labels; symptoms are understood and addressed from a social perspective.

The interfamily nature of the group is crucial so that there can be a varied and balanced dialogue. The meeting must not be allowed to become either an unstructured free-for-all or a directed 'lecture'. In interfamily dialogue, there is a great deal of resonance among participants, who see their own problems and ways of interacting reflected in the others; this gives rise to continual 'corrective emotional experiences[2]'. Existential

[2] Franz Alexander (quoted in Vinagrodov & Yalom, 1996) introduced the term '*corrective emotional experience*', pointing to the fact that, for change to take place during therapy, there must be empathy experiences, at the same time as cognitive learning.

matters[3] are seen as crucially important, and become the guiding thread for the discussion. Interfamily therapy often revolves around finding meaning in our lives through accepting responsibility for our own behaviour, and having the courage to make our own decisions.

3. They offer an ideal psycho-educational setting

A community MFG is the perfect place for social learning, in light of its representativeness of society as a whole, and consequent potential to foment dialogue. The MFG is a space for interfamily psycho-education (see Chapter III), in which it is possible to review our personal narratives, and social prejudices and stereotypes, and broaden our own personal and social cognition (Baron & Byrne, 2011).

The MFG often represents the first experience of dialogue for many people who have never before had the opportunity to be heard and get answers in their family and social environments. It is also a space in which, through interfamily dialogue, distorted and monologue-base narratives are called into question: narratives which frequently get in the way of achieving a state of wellbeing. In the group, participants who are absolutely convinced that they are 'in the right' can open their minds to new possibilities. Through community dialogue, we

[3] Yalom (2000) describes what he calls 'existential psychotherapy', emphasising the need for the therapy to address issues such as the meaning of life, mortality, freedom and desires, along with other existential matters.

can finally discover and accept the *alterity of others*[4] and the *uniqueness* in ourselves.

Snapshot of group activity

Hamed is a 17-year-old man, of Maghrebi origin. He is attending the MFG alongside his mother, expressing feelings of sadness and verbalising ideas of death. He attributes his malaise to the fact that his family will not accept his homosexuality:

- Hamed: *When I told my mother I liked boys, she started insulting me, telling me homosexuality was a disease. She even slapped me several times.*
- Fátima (Hamed's mother): *I want my son to be a man like all the other men in the family, and to follow Islam*.
- Hamed: *But we're not in Morocco any more… Here in Europe, it's perfectly normal to be gay…*

Other participants in the MFG begin contributing to the dialogue:

- Adolescent 1: *How terrible it must be to have a mother who's so closed-minded. I'm bisexual, and I don't like anyone questioning my identity.*
- Mother 1: *I understand your mother, because sometimes, we want our children to be how we want them to be. But it is true, of course, that their sexuality is none of our business.*

[4] Seikkula & Arnkil (2019) refer to 'alterity' of other people as a basic principle of dialogue-based practice. It is fundamentally important that we give respect to other people, and respect that it is impossible to fully understand what another person is thinking and feeling.

- Father 1: *I think the same. And nobody deserves to be rejected.*
- Adolescent 2: *Or to be beaten*.
- Mother 2: *I'm a mother too, and I don't believe we have the right to beat our children.*
- Father 2: *My parents used to beat me, and I still feel a great deal of anger at how they treated me*.
- Fátima: *Giving him a slap isn't the same thing as beating him. I don't beat him with a belt or a cane.*
- Adolescent 1: *In my opinion, slapping somebody is still abuse*.
- Adolescent 2: *And refusing to accept someone else's sexuality, too.*
- Group leader (to Fátima): *Were you beaten as a child as well*?
- Fátima: *Yes. In lots of different ways. They used to beat seven bells out of me*.
- Mother 1: *Perhaps that's why you're now turning to violence too…*
- Mother 2 (to Fátima): *I believe your parents were wrong to treat you that way... and now you're making the same mistake too.*
- Hamed (to his mother): *You see? I've always said that to you, but you won't listen…*
- Mother 2 (to Fátima): *I think it will do you good to come to this group and learn about different ways to treat your son. I was in the same situation as you, and by coming to the group, I've come to realise that I was wrong.*

- Adolescent 3: *But here in Spain, there are parents who hit their children too…*
- Mother 1: *True. And children who hit their parents*.
- Group leader: *But as you say, it seems there is a universal right, which we shall examine together: no form of physical or verbal aggression is acceptable, because it counts as abuse. Perhaps we should all stop and think about that…*

4. Network and social support

IFT allows for the inclusion of a person's social network in an MFG, as well as providing, restructuring and extending that network. Networking processes occur in the interpersonal environment, and they are guided by the multiple macro- and microsocial processes taking place in the MFG. Being present in the lives of other participants helps build a sense of self and of others-in-relation. It also helps to reframe the past, and reshape the present and future for its members, both individually and collectively.

A community MFG is a space for collaboration and solidarity, which strengthens the feeling of belonging to the community. Communicative exchanges among the participants simultaneously offer social company, provide emotional support, serve as a cognitive template, and offer social regulation, material aid and service, and access to new social contacts.

In addition, MFGs help to create external social networks, through the connections that are interwoven among the group members. Families find support in other families going through

similar situations, and feel themselves accompanied and supported in both pleasurable and painful situations, not just within the confines of the MFG, but outside it as well: parties and social events, doctor consultations, crisis interventions, etc. This web of social connections for families who, often, have previously felt isolated is central to the process of change in the dynamics and behaviour of the group members (Sempere & Fuenzalida, 2017).

5. A therapeutic environment, and at the same time, healthcare and prevention

By virtue of its openness to everyone, a community MFG accommodates people who have a specific need for help with their problems, alongside people who simply want to learn how to improve their quality of life. Therefore, the community MFG plays a dual role, as an arena for therapeutic intervention and also healthcare and prevention.

The community MFG is not dissimilar to the '*large groups*' that Patrick de Maré defined in the 1970s, where the emphasis was on human beings' cultural context. In 'Perspectives in Group Psychotherapy' (1972), de Maré predicted that '*In the future, there will be an interest (...) in large therapeutic groups that are non-directive and aprogrammatic*'. He proposed that the group conductor should act as leader, but without setting specific topics or objectives. De Maré was a visionary who foresaw that, some day, large groups would be an established part of our culture, and would contribute to the process of humanisation of society. De Maré anticipated community MFGs and their dialogue-based practices, which realise his vision.

6. A conducive learning environment for professionals

A community MFG is a wonderful psychoeducative environment. As such, it represents the richest possible training ground for professionals wanting to treat human beings in the social, educative or healthcare setting. All participants in an MFG become teachers to trainee professionals, who have the opportunity to revise their own narratives in the group, and draw upon resources which only popular wisdom could have provided. The community MFG cures the trainee professional of arrogance, through a dialogue which questions absolute knowledge and abuses of power, and highlights his/her role as part of society, to which he/she contributes in a personal capacity. Thus, we believe it should be mandatory training, not just for the leaders of interfamily groups but for all professionals, to spend time as part of a community MFG, gaining experience.

Snapshot of clinical activity

Marta, a psychologist who has recently taken the reins of a new mental health institution, telephones the leader of the community MFG at the *Centre de Teràpia Interfamiliar* (CTI), asking for help. She says she feels overwhelmed by the responsibility of her role, and is very fearful that one of her patients could take their own life. The group leader invites her to attend the community MFG, certain that it will be of great help to her.

- Marta: *Ever since I was appointed as Head, I spend my nights thinking about my patients, over and over again, and I'm very anxious that one of them might end up taking their own life. I would like the group to help me with that…*

- Participant 1: *I must say I'm surprised to hear you say that. And at the same time, I am pleased. I had no idea that professionals could care so deeply about us patients.*
- Participant 2: *It's the same for me: I didn't think we were that important to psychologists. I didn't think you [as a group] were that sensitive… I'm also pleased to hear you say that.*
- Participant 3: *Forgive me for being indelicate, but… do you have a partner?*
- Marta: *Yes. And he gets anxious too when he sees how stressed I am…*
- Participant 3: *Well, if I were your partner, I would be very annoyed if you took your patients to bed…! (A ripple of laughter runs through the group, and the participant then continues). Or have I misunderstood? Are you not saying that you can't sleep for thinking about your patients?*
- Marta: *You're right… I do go to bed with my patients, as well as with my husband…* (she smiles)
- Participant 1: *Well, I wouldn't want you to take me anywhere... I'd be content [as your patient] for you to help me feel better.*
- Participant 2: *Exactly, exactly that… Leave your patients alone, and be with your husband* (again, there is a general laugh).
- Group leader (to Marta): *What do you feel when you hear everything they're saying?*
- Marta: *It puts me at ease, to a large extent. You're giving me a lesson in common sense. I think I'll be humbler*

from now on, and not hold onto things that aren't mine to control… I'm very grateful to all of you.

Marta also attends the next multi-family session, relaxed, and saying '*I don't go to bed with my patients any more!'* She is now able to sleep easily, and is thankful to the group for their help.

The community MFG at the Centre de Teràpia Interfamiliar (CTI) and the Asociación Salut Mental (ASM)

The CTI was founded in 2005 in Elche (Spain) as a hub for the application of, and research into, interfamily therapy. In 2007, the first community MFG was started, to serve as the backbone for the rest of the therapeutic activities carried out under the auspices of the Asociación Salut Mental (ASM – Mental Health Association). It is a group which is open to the community, held once a week and free to attend. It is frequently attended by professionals undergoing training at our centre. This MFG is built on spontaneity. The team at the CTI all take part, and any ordinary citizen is welcome to join, accompanied by whomever they please, with no need to book beforehand (Sempere & Fuenzalida, 2016; Sempere *et al.*, 2012a).

At the outset, all participants sign a non-disclosure agreement, and permission for the activity to be filmed. These recordings are used subsequently for monitoring and teaching. The fact that it is an arena open to the community helps make the composition of the group as broadly heterogeneous as possible – it is attended by people of all age groups, cultures, social classes, suffering from all sorts of problems.

The people who attend the MFG have no diagnostic labels or clinical histories. And if they introduce themselves with these

labels, they are soon diluted in the flow of a dialogue where symptoms take on a relational meaning connected to the participants' social framework. It is a group that is constantly changing, never stagnant – every week, new participants come whom the team of professionals have never seen before, which presents an element of surprise and constant stimulation. This lack of familiarity is no obstacle, given that, in order to generate dialogue, no prior information is needed. All the relevant information is present in the therapy room, and emerges spontaneously through dialogue.

As the community MFG run by the CTI is the first MFG open to the community in Spain, it is constantly being visited by professionals from various backgrounds, whose first experience of IFT comes through the CTI group. In addition, the members help organise IFT meetings that take place in Elche twice a year, and manage multiple mental-health training and teaching events in the region.

The ultimate group

The CTI's Wednesday community MFG is the ultimate group, in which everybody has a place: the local baker with his son who is smoking joints, and the said son, who explains that his father is never there; the hairdresser with her unfaithful husband, and the husband complaining about his jealous wife; the parents of a rebellious teenager, and that teenager, saying that her parents treat her like a little girl; the school guidance counsellor with a demotivated student, and the student who is hiding sadness through failure at school; the old woman who feels herself abandoned by her children, and the offspring who complain at being emotionally blackmailed by their mother; the mother whose son is suffering a full-blown psychotic break, and the son who claims that his mother is poisoning him; parents who are scolding their daughter for cutting herself, and the daughter who wants her parents to stop fighting; a solitary man, and his solitude broken by the group.

The community MFG is like a huge school, where we all learn together, with everything that happens at a school: laughter, slamming of doors, embraces, exchanging of gifts, celebrations, bursts of anger, rounds of applause, tears, and more. Yet we always rescue everybody's healthy potential, and learn and accept human beings with all of their contradictions: the disillusioned discover solidarity; the arrogant find humility; the insecure discover their power; parents finally hear their children's cries for attention; the children feel their parents' fear; the psychotic young man finds confirmation; and the victimised find their fighting spirit.

In the Wednesday MFG, everyone is seen and heard, and we have answers for everyone. The voice of every participant in the

group is valued equally, including those of the professionals. Psychoanalysts, proponents of systemic therapy, gestaltists, behaviourists and biological psychologists abandon their own monologues and find how little they actually know in comparison to the vast wealth of knowledge that lies within all of us. We all work together in a reflective dialogue, where we contribute as much as we receive, and where we ultimately become better therapists and – above all – better people. On Wednesdays, we are never, ever alone.
Javier Sempere. Co-leader of the community MFG

Other community MFGs around us

Since 2013, the team from the CTI has been working shoulder to shoulder with the Asociación Bienestar y Desarrollo (ABD[5] – Association for Wellbeing and Development) to set up community MFGs in Madrid (Piñeiro & Sánchez, 2014) and in Barcelona (Castelló & Calafat, 2014). These groups serve as both community therapeutic arenas and training environments for postgraduate students of IFT. In 2019, a similar pilot project of therapy and education was launched at the Centro de Referencia Estatal de Atención Psicosocial a personas con trastorno mental grave (CREAP – State Centre for Psychosocial Treatment of Persons with Severe Mental Illness), in Valencia.

[5] The ABD, a social organisation, runs numerous programmes aimed at vulnerable or excluded sectors of society (this includes dependents, victims of domestic violence, teenage mothers and immigrants, among others). More details on its programmes can be found on www.abd.ong.

Conclusions

Community MFGs represent ideal spaces for making the most of dialogue processes, by virtue of the fact that they include the fullest possible representation of the social universe. Any human problem can be addressed in this multifamily environment, the main distinguishing features of which are that it is open, easy to access, and free.

Community MFGs are a space that is conducive to health and the prevention of mental problems, as they function as psycho-educative spaces that are 'shaped by all', in which the participants learn to engage in dialogue and generate new forms of care. In addition, they constitute an arena for treatment and addressing of sociopsychological problems, from a stigma-free perspective.

By virtue of their universality, community MFGs are a perfect – and necessary – setting for the training of any professional interested in dealing with human problems. A professional who goes through the interfamily process has the possibility to liberate themselves from their own monologues of power and knowledge, and to discover the immense potential of social dialogue.

The first ever community MFG was run at the Centre de Terápia Interfamiliar (CTI) in Elche in 2007, supported by the Asociación Salut Mental (ASM). Since then, similar groups have emerged in other cities in Spain. It may be that, in the future, all towns and cities will have similar community spaces, in which we learn to live healthier lives.

References

Baron, R.A., Byrne, D. (2005). Psicología Social (10th Ed.). Madrid: Pearson Prentice Hall.

Castelló, N., Calafat, C. (2014). La intervención interfamiliar en contextos sociales y comunitarios. Dissertation for qualification of expertise in Multifamily Interventions, CEU Cardenal Herrera University (unpublished).

De Maré, P.B. (1974). Perspectivas en Psicoterapia de Grupo. Río de Janeiro: Imago.

Foster, L.N. (1994). It's not family therapy. It's not group therapy. It is multiple family group therapy. MFGT Resource Center Homepage. Article 6 at www.multiplefamilygroup therapy.com

Freedman, J (1996). Narrative Therapy: The Social Construction of Preferred Realities. New York: Norton.

Freud, S. (1913). La iniciación del tratamiento. *In* Freud S. Obras Completas. Tomo II. Madrid: Editorial Biblioteca Nueva. pp. 1661-74.

García Badaracco, J.E. (2000). Psicoanálisis Multifamiliar- Los otros en nosotros y el descubrimiento del sí-mismo. Buenos Aires: Editorial Paidós.

Piñeiro, L., Sánchez, L. (2014). Implantación y desarrollo de un servicio de intervención multifamiliar de ABD en Madrid. Dissertation for qualification of expertise in Multifamily Interventions, CEU Cardenal Herrera University (unpublished).

Seikkula, J., Arnkil, T.E. (2019). Diálogos abiertos y anticipaciones terapéuticas. Barcelona: Herder.

Sempere, J., Fuenzalida, C., Pérez A. et al. (2012a). Análisis del modelo de terapia grupal multifamiliar aplicado en instituciones del sureste español. Teoría y Práctica Grupoanalítica, 2 (1): 109-122.

Sempere, J., Fuenzalida, C. (2017a). Terapias Multifamiliares. El modelo Interfamiliar: la terapia hecha entre todos. Madrid: Psimática.
Sempere, J; Fuenzalida, C. (2016). Terapia interfamiliar. *In* Padres e hijos. El poder de enfermar al otro (pp. 193-224). Buenos Aires: Lugar.
Todorov, T. (1995). La vida en común. Madrid: Taurus.
Vinogradov, S., Yalom, I. (1996). Guía breve de psicoterapia de grupo. Barcelona: Paidós.
Yalom, I.D. (1995). The theory and practice of group psychotherapy. New York: Basic Books.
Yalom, I.D. (2000). Psicoterapia existencial y terapia de grupo. Barcelona: Paidós.
Zamanillo, T. (2008). Trabajo social con grupos y pedagogía ciudadana. Madrid: Síntesis.

CUPRINS

ISBN: 978-606-37-1427-6