

## Multiple family therapy: an overview

Eia Asen<sup>a</sup>

In recent years there has been increased interest in working with groups of families systemically. Multiple family therapy is applied in different settings and to a whole range of different presentations. These include work with multi-problem families; with schools, parents and pupils; with adult mentally ill individuals and their families; and with eating-disordered teenagers and their families. Principles and aims of multiple family therapy are presented, specific projects described and trends for future work outlined.

### Historical perspective

The idea of treating a number of families together was first pioneered more than four decades ago by Laqueur and his co-workers (Laqueur *et al.*, 1964). Run-down mental hospital wards, seemingly brutal medical interventions, such as insulin shock treatment, burnt-out staff and socially isolated patients presented clinicians with major challenges to bring about change. Laqueur and his group took up this challenge. They worked initially with patients with schizophrenia and invited their families on to a hospital ward as a pragmatic response to the need for improving ward management. Bringing relatives and families into the hospital milieu, involving them in the management of chronic patients, confronted some institutionalized practices. The presence of a number of families altered the context of the work, permitting different role relationships and behaviours to emerge, not only as far as the patients were concerned but also in staff. With several families being treated together in one group, it became evident that they themselves developed ideas of how to address chronically stuck issues. Laqueur and his group first aimed at improving inter- and intra-family communication, in the hope that this might help relatives to understand some of the troubled behaviours of the index patient. By focusing not only on their own ill relative, but

---

<sup>a</sup> Marlborough Family Service, 38 Marlborough Place, London NW8 0PJ, UK.

also on the symptomatic members of other families, each family member could potentially re-examine their own lives from different and new perspectives. Through the exchange of ideas and experiences with other relatives and members of other families, it seemed possible to compare notes and to learn from one another. These initial initiatives led to the setting up of more formal groups for patients with schizophrenia and their relatives (Laqueur, 1972).

From the outset, multiple family therapy was a rather peculiar blend of group therapy and family therapy, psychodynamic practices and attachment theory. One of the major systemic ideas utilized was that difficulties in relationships derived from dysfunctional feedback loops across subsystem boundaries. Combined with this idea was a psychodynamically inspired concept, namely that in normal development secondary objects of attachment gradually replace primary ones. Laqueur postulated that the presence of other families allowed a person to struggle towards increasing independence and self-differentiation by identifying with members of other families and learning by analogy (Laqueur, 1973). A further theoretical foundation was provided by Laqueur's group making use of Bateson's idea of describing problems in behaviour as restraints of redundancy and restraints of feedback (Bateson, 1973). Restraints of redundancy refers to people's restricted internal worldviews; restraints of feedback refers to the pattern of interaction between people and the circular feedback of events whereby people become restrained within the dominant story. In multiple family work, multiple perspectives are offered through double description: when there is more than one description, a second or third is introduced which can trigger the provision and reception of new information.

The early multi-family groups were appropriately described as 'sheltered workshops in family communication' (Laqueur *et al.*, 1964). By working with four or five families at the same time one could observe 'improved' communications and 'better' understanding in these families as they learned directly and indirectly from each other. Moreover, therapists seemed to feel less constrained in a group of families than when just one family was continuously the sole focus of the work.

Laqueur's early work inspired many different clinicians. McFarlane, for example, developed a multi-family therapy programme in a psychiatric hospital (McFarlane, 1982). He saw the following as the main therapeutic ingredients of this approach:

resocialization, stigma reversal, modulated disenmeshment, communication normalization and crisis management. McFarlane observed that traditional 'insight' by the family or its individual members into their problems was not essential for therapeutic change to occur. Instead, he believed that families might learn by seeing parts of themselves in others – including their own 'dysfunctions'. This process produced learning without there being a need for issues to be made explicit in psychological terms.

Anderson (1983) applied psycho-educational ideas and practices to her practice of multiple family work. In her model, meaning and understanding are thought to evolve through the dynamic social process of dialogue and conversation. The emphasis is on language as the means by which one maintains meaningful human contact and shares a reality. One hypothesis underlying this work is that if communication deviance is alleviated, more functional communication patterns can emerge. Despite a different theoretical model, the aims of Anderson's psycho-educational multi-family approach are in some respects quite similar to McFarlane's: helping the families of schizophrenics to expand their social network; to reduce stigma; to relieve the carer burden and to facilitate more tolerance as far as the family's attitude in relation to the ill person is concerned; to reduce expressed emotion (EE) in key relatives, by addressing levels of criticism, hostility and over-involvement. By offering family support within a hospital setting, a bridge is formed between families and psychiatric contexts.

In the early years of multiple family therapy it seemed that this work was most appropriate for families with limited social contacts (Leichter and Schulman, 1974; McFarlane, 1993), providing them with the opportunity to discuss common issues and to give and receive emotional support. Unlike traditional psychodynamic group therapy, families participating in multiple family therapy group work were encouraged to socialize outside the group setting. It was seen as evidence that the group and individuals had developed when families socialized outside what is traditionally seen as the 'therapeutic setting' (McFarlane, 1982).

### **The development of intensive multiple family work**

Much of the early multiple family group work in the USA took place at weekly or monthly intervals, usually in sessions lasting one or two hours at a time. The work sometimes involved the families without

the index patients and at other times the 'designated patients' were part of the multiple family groups. Multiple family therapy was given in addition to other simultaneous treatments and seen as only one of a number of ingredients in helping the patient to improve. Both frequency and intensity of multiple family work seemed appropriate for the families targeted, above all those containing a person diagnosed as suffering from schizophrenia or other forms of psychotic disorders. This relates to a well-known research finding, namely that the levels of expressed emotion displayed by key relatives (notably critical comments and over-involvement) are significantly related to the patients' recovery rates (Vaughn and Leff, 1976). In accordance with these findings, many clinicians believe that any interventions involving these families would therefore need to be of low intensity, discouraging too much proximity and aiming to disengage the index patients and relatives.

While this may be the case for families containing a patient with psychosis, it may be quite different for other families. More intensive work may be warranted if there are specific issues that are unlikely to respond to low intensity multiple family work. So-called 'multi-problem families' are one such example: here more than one member may present with psychological or psychiatric problems and symptoms, as well as with social or indeed antisocial problems, such as violence and abuse, and educational failure and brushes with the law. There is often deep chronic involvement with psychiatric and social services, police and probation. In these families it seems that there is slow or little response to change promoting interventions, and feelings of helplessness on the clients' as well as the professionals' part are abundant. It was the encounter with many seemingly 'impossible' families that generated the idea of creating an institution specializing in promoting change for multi-problem and multi-agency families, developed by Alan Cooklin and his team at the Marlborough Family Service in London (Cooklin, 1982; Asen *et al.*, 1982). The reason for designing a day unit for multiple family work was inspired by the recognition that certain families appeared to be expert at attracting increasing numbers of professionals (fifty-six in one celebrated case). At the same time it seemed that, irritatingly, these families and their individual members did not seem to make 'good' use of the various medical, psychiatric, social and educational resources and interventions offered. As a result, the families were being experienced as impossible to help, even more so since there was frequently little

coordination between the different agencies and professionals. Inviting 'chronic' families for weekly family therapy sessions seemed like a drop in the ocean. However, putting a number of these families together under one roof for prolonged periods of time appeared to be a way forward to keep alive certain rescue fantasies regarding these families which were inevitably disadvantaged if not abused by the system. Facing them with a structured daily programme which deliberately created 'controlled' crises – not dissimilar from those they encountered in their home lives – meant that families had to address daily living issues in a therapeutic context. The hope was – and still is – that this would eventually result in families identifying new forms of crisis management which no longer required the involvement of increasing numbers of professionals, thus avoiding the danger of a fragmentation of help offered. Creating an 'institution for change' (Cooklin *et al.*, 1983) meant that it was the institution with its multidisciplinary team – ranging from psychiatrists to social workers, psychologists, teachers, therapists, nurses and other professionals – which would coordinate and contain the work required. As the result of our experience of seemingly failing to deal adequately with chronic multi-problem and multi-agency families, a day unit for families was invented in the late 1970s (Asen *et al.*, 1982). When first started, this multiple family day unit was a high-intensity working setting, with up to ten families attending for eight hours a day and five days a week, often over a period of many months. Over the years it has undergone many transitions, but continues to work as a unique multi-family environment which can be flexibly adapted to the often very different needs of families (Asen *et al.*, 2001).

One, more recent innovation is the weekly reflections meeting, inspired by Tom Andersen's 'reflecting team' ideas (Andersen, 1987). This event takes place at the end of each week, when staff working with the families have a team meeting which is videotaped. In this clinical meeting the family workers exchange information and views about how each family has done during the past week. The workers are very specific about their observations and they reflect about each family's interactions and issues. This staff discussion lasts for about thirty minutes and the videotape recording is given to a systemic consultant who has not been party to the staff's reflections. This consultant then meets the parents (and at times also older children) to watch the staff's reflections. Parents may be asked to speculate about what, in their view, staff might have said in

their discussion which is about to be screened. The systemic consultant then starts the videotape and hands the remote control to one of the parents. Implied in this move is the message that it is up to the parent(s) to let the specific tape segment run for its entirety or to pause so that specific points may be taken up. Most parents opt for stopping and restarting, and are often encouraged to do so by other families and the systemic consultant. Stopping the tape allows family members to respond immediately to the staff's reflections. It is the systemic consultant's task to stimulate the families' curiosity about one another, as well as encouraging them to provide advice, criticism and support. The family workers are not in the room for the reflections meeting but some will watch it via a video-link. This is deliberate, since it makes staff temporarily unavailable for being drawn into prolonged discussions with families, feeling that they have to justify what they have said in their staff meeting. It thus allows staff to be in a reflective position, listening to the families' reflections without an opportunity to immediately put the record straight. It also permits families to reflect on how staff might digest the parents' feedback to what has been said about them.

The reflections meeting is a popular event, at times more so with families than with staff. Families like the idea that not only they themselves but also staff may be observed at work. This adds considerably to the ethos of openness and transparency prevailing in the family day unit, seeing that staff are at times struggling to make sense, that they can be quite uncertain or puzzled, and that families' involvement and feedback are crucial for the work to be successful. The post-reflections meeting is of great importance for all staff, creating yet another loop: reflecting on the families' reflections of the staff's reflections.

The Marlborough Family Day Unit in London was the first permanent multiple family day setting, specifically designed for and solely dedicated to the work with seemingly 'hopeless' families. Here the main mode of treatment was and is multiple family work, with other forms of treatment brought in if and when required, such as single family work and individual interventions. This is in marked contrast to how multiple family therapy had been practised before, with it being 'added on' to other treatments or institutional care. Over the years new multiple family units, based on the Marlborough Family Day Unit, have been created elsewhere, including The Netherlands, Germany, Scandinavia and Italy. While their work has been in part informed by the Marlborough model, the

ideas have often been creatively transformed and adapted to specific cultural and work contexts.

### **A school for multiple families**

One such adaptation took place in the Marlborough Family Service itself in the early 1980s, with the establishment of a Family School (Dawson and McHugh, 1986). The reason for creating such a project was to deal with pupils who had been excluded from their schools because of serious learning 'blocks', violence and disruptive classroom behaviour. The schools seemed to put all the blame for the pupils' problems at the family's door, whereas the family tended to blame the school entirely for the educational failure of the children. The more the family blamed the school, the more the school blamed the family. In this impasse the child was caught in the middle between the warring parties. The family refused to seek psychiatric or psychological help and the teachers no longer wanted these difficult children in their classes. To overcome this impasse a Family School was created. Here parents could witness their children's educational problems and teachers could observe the family issues that are often transferred to school (Dawson and McHugh, 1994), with the focus being not simply on the individual pupil, but on the interactions within the family, between family and school – and within the school system. The multiple family paradigm proved to be a particularly effective way of achieving change. With up to ten families attending with their son or daughter four mornings for three hours a week, there is a group of families that can reflect on one another and their relationships with the school system. In the Family School's daily meetings all children, parents and teachers are involved, providing a context for reflection, mutual support and encouragement for trying out new ways of relating and communicating. All three teachers are also trained therapists, and one of their tasks is to manage the flow of information around the group, eliciting and highlighting themes as they arise, as well as encouraging the group members to become more expert in observing their own and others' repetitive and redundant patterns of behaviour. With the opportunity for families to challenge and support each other in their struggles for change, the multi-family group is an excellent context for intensification. There is an extra feeling of immediacy and intensity that is not always easily attained in a more conventional family session. Moreover, the information raised in a

multiple family group as it relates to one family frequently has significant meaning for other families in the group. Families often say that they have thought about something which was said several days ago and that they decided to try something new as a result of what they had previously seen and heard in the group. Over time, the multiple family group gains its own momentum and becomes a context that drives the participants to expect change in themselves as well as in other group members. When people are not changing, the rest of the group wants to know why not, and asks about what needs to happen for something to shift. This dynamism can lead to spirited exchanges which are not readily available in the traditional professional/client, let alone teacher/parent/pupil relationship. It is far harder to ignore information from somebody who has first-hand knowledge of family and school issues and problems than from someone who is merely paid to know about such things (Dawson and McHugh, 2000).

### **Developing multiple family work for eating-disordered teenagers**

The first experiments of applying multiple family therapy ideas to eating-disordered teenagers in a day setting were pioneered in Dresden (Scholz and Asen, 2001) and London (Dare and Eisler, 2000). The Dresden project started in 1998 in a busy child and adolescent psychiatry service which admitted about sixty severely anorectic and bulimic teenagers per year as inpatients, invariably in rather severe physical and psychological states. Dissatisfied with the often poor treatment outcomes so common all over the world, the Dresden team started to involve parents and other family members much more centrally, right from the outset. The multiple family therapy approach seemed highly relevant, since it directly addresses the parents' sense of struggling away in isolation and having to rely heavily on the input of nurses, doctors and therapists. Connecting these parents with other parents seemed a logical step to overcome this isolation. Moreover, involving parents directly in the eating issues of their child was an important step for them to become expert themselves rather than leaving that expertise to the nursing and medical staff. Given that most parents with an anorectic child experience a complex set of feelings – including failure, guilt, fear and embarrassment – having the opportunity to meet with other families who experience similar feelings allows for these to be shared. This has strong destigmatizing effects and creates a sense of

solidarity. In a multi-family setting professional staff are in a minority and this contributes to a 'family' rather than a 'medical' atmosphere. Being in the presence of other families also has the effect of making the adolescents and their parents feel less central – they are part of a large group, and the feeling of being constantly watched and observed by staff is less intense.

The presence of other families highlights not only similarities but also differences between them, inviting comparisons. Families generally cannot help but become curious about one another – for example, how other parents handle the food refusal of their teenager – just as young people cannot help comparing their own parents' responses to those of other eating-disordered teenagers. The effect of all this is that new and different perspectives are introduced, so important since eating-disordered families tend to have distorted self-perceptions while often being very precise and intuitive about other families. Working alongside each other allows parents and teenagers to compare notes and learn from each other. Peer support and peer criticism are known to be powerful dynamics that can promote change. Many people find it easier to use feedback from fellow sufferers than from staff – it seems more 'credible' because these families all have painful direct experiences around food, repeated hospitalizations and dieting. Such feedback is generated through a whole range of different activities during the day, from joint meals, informal encounters, formal large group discussions, creative artwork or outings. The role of the therapist is that of a catalyst, enabling families to connect with one another and encouraging mutual curiosity and feedback.

Since its inception in 1998 the staff of the Dresden Eating Disorder Unit have experimented with a whole range of different lengths and frequencies of the programme (Scholz and Asen, 2001). It seems that the most appropriate package consists of an initial evening where up to eight families meet, and listen to 'graduated' ex-eating-disorder families talk about the proposed work. This is followed by an intensive week, five days and eight hours a day. One month later families attend for two whole days – and this is repeated in monthly and later in bimonthly intervals. The whole multiple family therapy package takes on average nine months.

The Dresden experiment has been carried out in parallel with a similar multiple family programme for eating-disordered teenagers, based in London at the Maudsley Hospital (Dare and Eisler, 2000). This was commenced in the spring of 1999 with a four-day block

running from 9 a.m. to 5 p.m. Families subsequently attend for whole days, approximately monthly, for up to six months. There has been plenty of communication between the Dresden and London teams, and the overall approach, as well as the programmed activities and timetable in both units, are remarkably similar. Both programmes are very structured, and require families and their individual members to constantly change context and to adapt to new demands. Such 'heat' simply cannot be created in individual family sessions. The sheer energy released in the course of such a programme provides a new 'buzz' for adolescents and parents alike, and it creates hope. Such feelings of hope may be enhanced by mixing families who have gone through a multi-family programme with others who are new to it. When 'old' families tell their story, this is frequently a considerable source of encouragement for the 'new' families, with a kind of preview of changes that might be possible for everyone. Preliminary results show that the drop-out rate is very low in both centres. In many teenagers there has been considerable somatic improvement (increased weight, return of menstruation, stabilization of eating, reduction of bingeing and vomiting, decreased laxative abuse). Family tension and dispute has been significantly reduced, and a cooperative and supportive atmosphere and working environment has been created for the young people and their families. In Dresden there has been a significant reduction in readmission rates (Scholz and Asen, 2001). More recently a team in London has adapted some of these ideas to the work with adult eating disordered-patients and their families (see Colahan and Robinson, this issue).

### **Reflections and further perspectives**

With a number of families in the same room, therapists are much less central than in other forms of systemic therapy. They need to think of themselves as catalysts, enabling re- and interactions to happen. Therapists tend to find it easier to work with multiple families if their training has exposed them to structural techniques such as 'enactment' and 'intensification' (Minuchin and Fishman, 1982). They can afford to be mobile, moving from one family to the next, thinking while on the move, in the knowledge that there are plenty of 'co-therapists' in the shape of the families and family members (Stevens *et al.*, 1983). Families are consultants to other families; they are there to help one another. In multiple family work, therapists

often act merely as catalysts, generating interactions between families who then do much of the work themselves. Therapists may frequently feel quite redundant in multiple family groups because this work carries much of its own momentum. It is possible for two therapists – one in a more active and the other in a more reflective role – to run groups comprising up to twelve families. Multiple family group work can at times create unhelpful dynamics between families, requiring staff to intervene and refocus the work. However, this tends to be a relatively rare event, usually to do with intense animosity between the parents of two families. It is generally possible to address this in the larger group context by encouraging other families to reflect aloud on what they see and what resolutions can be attempted.

The metaphor of the ‘Greek chorus’, once introduced by Papp (1980) to describe strategic manoeuvres of the therapeutic team, takes on a different meaning when looking at some of the processes in multiple family group work. An individual or the family – the protagonists – tell their story or enact their issues in front of a group of people who are asked to comment. In the classical Greek tragedies of Aischylos, the chorus was the preserver of the world order: it was through the chorus that the gods spoke to the people. The chorus amplified and intensified the action on the stage, reflecting on what went on from different perspectives and inviting the spectators to join these reflections. The protagonists in these Greek dramas became increasingly less important – their individual stories of love and hate, of ambition and defeat, were put in a larger frame: that of general human suffering and joy. Seeing things in perspective, as well as seeing things from different perspectives, are major aims and outcomes in multiple family work. Theatre and play are aspects of the work: staged games, mini role plays, sculptures, film-making, are but a few of the many dramatic techniques used (Asen *et al.*, 2001). Another concept, the ‘outsider witness group’ (White, 1997), provides an alternative frame within which to view both the processes and the therapeutic potential of multiple family work: the individuals’ and families’ stories about life, relationships and identity become enriched by listening to the group’s retellings of these stories. The outsider witness group – the other families – adds to the person’s and family’s narrative resources by sharing experiences from other lives, triggered by listening to the story of the family in focus. It permits every group member to resonate with what is being told. In doing so, the focus is shifted with nuances being introduced

bit by bit. In this way multiple family therapy generates multiple new perspectives and experiences, thereby opening up a multi-verse for new curious enquiry.

Since its infancy many decades ago, the multiple family therapy model has evolved (Strelnick, 1977) and now come of age. In the early days it was not provided as a sole therapy in its own right, but in addition to other concurrent treatments (Reiss and Costell, 1977), notably for psychotic patients and their families (Anderson, 1983; Lansky, 1981; McFarlane, 1982). In this way the multiple family paradigm has inspired more traditional therapeutic activities in general mental health services, such as relative support and carer groups, and it is now a well-established ingredient in the work with people with schizophrenia (Kuipers *et al.*, 1992). Multiple family therapy is now also practised in many other presentations and conditions (O'Shea and Phelps, 1985), including drug and alcohol abuse (Kaufman and Kaufman, 1979), chronic medical illness (Gonzalez *et al.*, 1989; Steinglass, 1998), Huntington's disease (Murburg *et al.*, 1988), child abuse (Asen *et al.*, 1989), eating-disorder patients (Dare and Eisler, 2000; Scholz and Asen, 2001; Slagerman and Yager, 1989), and more specifically bulimia nervosa (Wooley and Lewis, 1987), and a mixture of in- and outpatient children and adolescents presenting with a variety of problems (Wattie, 1994). It is likely that its cost-effectiveness in times of dwindling resources does explain in part the increasing popularity of the multiple family therapy approach. No systematic studies or random controlled trials have been conducted to date to provide a scientific evidence base for the efficacy of multiple family therapy, though there are a number of local audit projects and evaluations on a small scale (Lim, 2000; Singh, 2000; Summer, 1998) that demonstrate both the acceptability and usefulness of the approach. Another area of future research is to determine the specific ingredients in multiple family work that account for change. At the time of writing, a number of studies are on the way, particularly in the field of eating disorders, looking at outcome both in terms of symptomatic improvements as well as family interaction patterns.

## References

- Andersen, T. (1987) The reflecting team. *Family Process*, **26**: 415–428.  
Anderson, C.M. (1983) A psychoeducational program for families of patients with schizophrenia. In W-R. McFarlane (ed.) *Family Therapy in Schizophrenia*. New York: Guilford Press.

- Asen, K.E., Dawson, N. and McHugh, B. (2001) *Multiple Family Therapy. The Marlborough Model and its Wider Applications*. London and New York: Karnac.
- Asen, K.E., George, E., Piper, R. and Stevens, A. (1989) A systems approach to child abuse: management and treatment issues. *Child Abuse & Neglect*, **13**: 45–57.
- Asen, K.E., Stein, R., Stevens, A., McHugh, B., Greenwood, J. and Cooklin, A. (1982) A day unit for families. *Journal Family Therapy*, **4**: 345–358.
- Bateson, G. (1973) *Steps to an Ecology of Mind*. London and New York: Paladin.
- Cooklin, A. (1982) Change in here-and-now systems vs. systems over time. In A. Bentovim, G. Gorell-Barnes and A. Cooklin (eds) *Family Therapy: Complementary Frameworks of Theory and practice*. London: Academic Press.
- Cooklin, A., Miller, A. and McHugh, B. (1983) An institution for change: developing a family day unit. *Family Process*, **22**: 453–468.
- Dare, C. and Eisler, I. (2000) A multi-family group day treatment programme for adolescent eating disorder. *European Eating Disorders Review*, **8**: 4–18.
- Dawson, N. and McHugh, B. (1986) Families as partners. *Pastoral Care in Education*, **4**: 102–109.
- Dawson, N. and McHugh, B. (1994) Parents and children: participants in change. In E. Dowling and E. Osborne (ed.) *The Family and the School: A Joint Systems Approach to Problems with Children*. London: Routledge.
- Dawson, N. and McHugh, B. (2000) Family relationships, learning and teachers – keeping the connections. In R. Best and C. Watkins (eds) *Tomorrow's Schools*. London: Routledge.
- Gonzalez, S., Steinglass, P. and Reiss, D. (1989) Putting the illness in its place: discussion groups for families with chronic medical illnesses. *Family Process*, **28**: 69–87.
- Kaufman, E. and Kaufman, P. (1979) Multiple family therapy with drug abusers. In E. Kaufman and P. Kaufman (eds) *Family Therapy of Drug and Alcohol Abuse*. New York: Gardner Press.
- Kuipers, L., Leff, J. and Lam, D. (1992) *Family Work for Schizophrenia: A Practical Guide*. London: Gaskell.
- Lansky, M.R. (1981) Establishing a family oriented in-patient setting. In G. Berenson and H. White (eds) *Annual Review of Psychotherapy*. Vol 1. New York: Human Sciences Press.
- Laqueur, H.P. (1972) Mechanisms of change in multiple family therapy. In C.J. Sager and H.S. Kaplan (eds) *Progress in Group and Family Therapy*. New York: Bruner/Mazel.
- Laqueur, H.P. (1973) Multiple family therapy: questions and answers. In D. Bloch (ed.) *Techniques of Family Psychotherapy*. New York: Gruner & Stratton.
- Laqueur, H.P., La Burt, H.A. and Morong, E. (1964) Multiple family therapy: further developments. *International Journal Society Psychiatry*, **10**: 69–80.
- Leichter, E. and Shulman, G.L. (1974) Multiple family group therapy: a multidimensional approach. *Family Process*, **13**: 95–110.
- Lim, C. (2000) A pilot study of families' experiences of a multi-family group day treatment programme. Unpublished M.Sc. thesis, Institute of Psychiatry, London.
- McFarlane, W.R. (1982) Multiple family in the psychiatric hospital. In Harbin (ed.) *The Psychiatric Hospital and the Family*. New York: Spectrum.
- McFarlane, W.R. (ed.) (1993) Multiple family groups and the treatment of schizophrenia. In *Family Therapy in Schizophrenia*. New York: Guilford Press.
- Minuchin, S. and Fishman, C.H. (1981) *Family Therapy Techniques*. Cambridge, MA: Harvard University Press.

- Murburg, M., Price, L. and Jalali, B. (1988) Huntington's disease: therapy strategies. *Family Systems Medicine*, **6**: 290–303.
- O'Shea, M. and Phelps, R. (1985) Multiple family therapy: current status and critical appraisal. *Family Process*, **24**: 555–582.
- Papp, P. (1980) The Greek Chorus and other techniques of paradoxical therapy. *Family Process*, **19**: 45–57.
- Reiss, D. and Costell, R. (1977) The multiple family group as a small society: family regulation of interaction with nonmembers. *American Journal Psychiatry*, **134**: 21–24.
- Scholz, M. and Asen, E. (2001) Multiple family therapy with eating disordered adolescents: concepts and preliminary results. *European Eating Disorders Review*, **9**: 33–42.
- Singh, R. (2000) A retrospective clinical audit of the families who attended the family day unit between 1997–1999. Unpublished manuscript, Marlborough Family Service, BKCW Trust, London.
- Slagerman, M. and Yager, J. (1989) Multiple family group treatment for eating disorders: a short term program. *Psychiatric Medicine*, **7**: 269–283.
- Steinglass, P. (1998) Multiple family discussion groups for patients with chronic medical illness. *Families, Systems and Health*, **16**: 55–70.
- Stevens, A., Garriga, X. and Epstein, C. (1983) Proximity and distance: a technique used by family day unit workers. *Journal of Family Therapy*, **5**: 295–305.
- Strelnick, A.H.J. (1977) Multiple family group therapy: a review of the literature. *Family Process*, **16**: 307–325.
- Summer, J. (1998) Multiple family therapy. Its use in the assessment and treatment of child abuse. A pilot study. Unpublished M.Sc. thesis, Birkbeck College and Institute of Family Therapy, London.
- Vaughn, C. and Leff, J. (1976) The measurement of expressed emotion in the families of psychiatric patients. *British Journal of Social and Clinical Psychology*, **15**: 157–165.
- Wattie, M. (1994) Multiple group family therapy. *Journal of Child and Youth Care*, **9**: 31–38.
- White, M. (1997) *Narratives of Therapists' Lives*. Adelaide: Dulwich Centre Publications.
- Wooley, S.C. and Lewis, K. (1987) Multi-family therapy within an intensive treatment program for bulimia. In J. Harkaway (ed.) *Eating Disorders: The Family Therapy Collections*, **20**. Rockville: Aspen Publishing.