Received: 8 November 2020 | Accepted: 30 June 2021

DOI: 10.1111/jmft.12542

ORIGINAL ARTICLE

JMFT Journal of Marital and Family Therapy

Interfamily Therapy, a multifamily therapy model settled in infant-juvenile mental health services of Havana (Cuba): A qualitative study from participants' perspectives

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Abstract

Interfamily therapy (IFT) is a specific model for multifamily therapy (MFT) of recent expansion in Latin American and European countries. In IFT a multifamily group becomes a community of learning where professionals and family members establish collaborative relationships and participate in dialogues. This study used a qualitative phenomenological approach to explore the participants' perspective of 14 members and ex-members of two IFT groups conducted in Infant-Juvenile Mental Health Centers in Havana (Cuba). In this study IFT was well accepted and effective, and it was perceived as beneficial due to its positive influence for participants, with benefits on a personal, family and social level. In addition, participants articulated a series of therapeutic elements of IFT that were essential to promote these benefits. In conclusion, IFT seems to be a useful therapeutic model in the treatment of children, adolescents and their families in a Cuban psychiatric setting.

KEYWORDS
adolescents, children, mental health services, multifamily therapy, qualitative research

INTRODUCTION

The World Health Organization (WHO) has indicated that mental health problems account for 16% of the global burden of disease and injury in the infant-juvenile population. Failure to address these problems has consequences that extend into adulthood, affecting both physical and mental health, and limiting opportunities for a satisfying adult life (WHO, 2020). Considerable progress has been made in recent decades in developing effective therapies for children and adolescents with mental health conditions involving the family (Eisler et al., 2016).

The term multifamily therapy (MFT) refers to a range of therapeutic interventions carried out in multifamily groups, which are therapeutic environments in which both patients and their family members participate together. The first description of therapeutic use of MFT was made by Peter Laqueur (1964), who also provided a systematic description of its practical mechanisms and methodology. Subsequently, many works in the scientific literature have described MFT experiences not only in healthcare environments, either general or with a specialization in mental health (i.e., inpatient psychiatric units, mental health centers or day centers), but also in educational contexts and social services (Cook-Darzens, 2007).

There is no single model for MFT. As with other therapeutic contexts (individual, family, group therapy), MFT encapsulates a wide variety of models, depending on the theoretical basis and methodology employed. Common to all multifamily models are the theoretical principles of group and family therapy, applied in a multifamily sociocommunity setting. The following models are particularly noteworthy: systemic (Asen & Scholz, 2010), psychoanalytical (García Badaracco, 1990), psychoeducational (McFarlane, 2002) and dialogical (Sempere & Fuenzalida, 2017); the latter being the object of research in this study.

MFT groups are the therapeutic context that most closely resembles real society. An MFT group can be understood to accommodate all people, whatever their sociocultural origin or generation and their families, willing to share their private philosophy on life, spirituality, personal experiences, and model of family life with other families. MFT groups integrate all possible therapeutic contexts in a hierarchical structure of increasing complexity, ranging from the individual and the family environment to the social framework represented by the rest of the families taking part in the group. The combination stimulates simultaneous therapeutic processes for individuals, families and the group as a whole. Any human issue may be addressed through MFT groups, which help participants to understand not only their own family circle, but also the world beyond the family (Orvin, quoted in Foster, 1994). McDonnell and Dyck (2004) have highlighted the flexibility of MFT that allows its adaptation and application to a variety of infant-juvenile populations (e.g., briefer sessions if cognitively impaired children or greater peer interaction if many adolescents).

Interfamily therapy (IFT) is a specific model for MFT based on a constructionist and social approach that was developed and manualized by Javier Sempere and his team in the Interfamily Therapy Center in Spain (Sempere & Fuenzalida, 2017). It is based on the application of the principles of dialogical practices (Seikkula & Arnkil, 2006) to a multifamily group, which becomes a conversational society (or community of learning). Professionals and family members become partners or conversational companions, establishing collaborative relationships and participating in dialogues. As a consequence, IFT sessions do not have key topics; on the contrary, these sessions are open to whatever issues

participants spontaneously bring to the group. Through dialogue among all the participants, different ways of understanding and expressing their respective experiences may be found, and new meanings and understandings can be created about what has happened and is happening to the participants.

The objective when running an IFT group is not to find the absolute truth or to achieve consensus, but rather to generate a multitude of connections among participants. In contrast to conventional single-family therapy, which presents no opportunity to find useful analogies, families taking part in IFT groups can observe similar conflicts in other families, and gain insights from those examples. The families provide a cluster of relational constellations. Participants can identify and discover their own way of communicating by reflecting on the communication patterns in other families. IFT groups help families to understand their problems within a set system of interactions. The family sees how the environment affects the individual, and how the individual, in turn, affects the behavior of those around them. This is particularly important in the infant-juvenile mental health context, as parents become aware of the way they are bringing up their children and their responsibility for what happens. The participants' monological constructions are transformed and modeled. New alternative narratives are created, as a result of the reflective and polyphonic dialogue which can yield solutions to the problems addressed (Sempere & Fuenzalida, 2013).

As any other way of therapy, IFT sessions have a predefined duration for each gathering (one hour and a half or two hours), and a periodical timetable (weekly or biweekly). There is not a determined number of sessions, as in IFT, the group is open to the incorporation of new families, and each family varies in the time needed to complete each process. IFT can easily be learned and practiced by any professional when treating human beings, and it is generally accepted by the families taking part who appreciate the active role they play and the democratic nature of the process. Group heterogeneity is a key pillar of IFT, with a plurality of diagnoses and diversity of ages and roles, as neighbors, friends, other reference professionals or relatives are invited to participate in the sessions. Regarding the role of the professionals, the IFT therapists (called *facilitators*) must promote dialogue and avoid giving expert advice. Talking about oneself and from oneself and preventing advising or judging others are part of the informal communication rules of the group (Sempere & Fuenzalida, 2017).

IFT groups are expanding, and this therapy is currently performed in different Latin American and European countries (Fuenzalida & Sempere, 2017). The IFT model follows dialogical principles that are universal to all cultures; therefore, no cultural adaptation is necessary. The incorporation of IFT into Cuban clinical practice is recent, but some intrinsic strengths can be assumed. IFT is a form of community intervention par excellence, thus responding to the social and community models on which Cuban mental health care is based. In addition, in a free healthcare system such as the Cuban system, it seems important to consider that a multifamily group therapy format (treating multiple families at the same time) could be more cost-effective than individual family therapy.

There is a growing body of evidence of improvement of children/adolescents diagnosed with mood, eating, substance abuse, or behavioral disorders among others, through the use of different models of MFT (Bamberg et al., 2008; Courtney et al., 2020; Fristad et al., 2009; Lai et al., 2021; Oruche et al., 2014; Sapru et al., 2016; Steinberg et al., 2019). Nevertheless, it must be highlighted that child MFT studies are characterized by the diversity of models used, with lack of replication and few treatment manuals, which suggest that research in children is at an earlier stage of development in relation to adults and other treatments with greater empirical support (McDonell & Dyck, 2004). In addition, when investigating MFT, qualitative studies are a viable alternative, as they allow the exploration of individuals' experiences in the study of complex phenomena (Masson, 2002). However, the number of qualitative studies that focus on the participants' experiences, and include children and adolescents in different MFT models is recent and limited (Engman-Bredvik et al., 2016; Tighe et al., 2012; von der Lippe et al., 2016).

Specifically, IFT is almost an unexplored field of investigation. Until recently, in existence was a doctoral thesis that analyzed and described the application of IFT in five medical devices in Spain (four public and one private), assessing clinical changes and family atmosphere changes quantitatively, after the first year of its implementation (Sempere, 2015). In southeastern Spain. Pérez-García et al., (2020) compared treatment as usual with multifamily intervention with an interfamily approach, showing MFT greater efficacy in internalizing behavior. The experience in Cuba has recently been presented in a theoretical article (Varona Galindo et al., 2019).

There is a need to improve the understanding of the changes and mechanisms of action of MFT in general, and its different models in particular, mainly in groups aimed at the infant-juvenile population. Furthermore, the development of the different models of MFT is very scarce in the Caribbean region. The efficacy of MFT could be culturally dependent (Mehl et al., 2013), and its applicability in this sociocultural context cannot be generalized by default, based on positive experiences in other contexts.

Research purpose

This study investigated the acceptability of IFT incorporated into treatment for children/adolescents with mental health problems and their families in Cuba. Acceptability refers to the determination of whether an IFT is well received in a cultural context other than the one in which it was developed, and to what extent it can meet the participants' needs.

For that purpose, we investigated participants' subjective experiences and perceptions related to IFT groups developed in Cuba through a qualitative, phenomenological approach. Specific research questions were as follows: (a) how was IFT accepted and perceived?; (b) how, if so, did IFT benefit the participant on a personal level?; (c) how, if so, did IFT benefit the participant on a family and social level?; (d) did IFT highlight any particular therapeutic element?; and (d) is IFT likely to be useful in this cultural context (i.e., in Cuba)?

METHODS

Research design

Given our interest in exploring the perceptions and experiences of IFT among Cuban participants, we used an interpretive phenomenological analysis (IPA) for this study (Muurlink, 2018). An IPA is an approach to qualitative research with an idiographic and inductive focus that explores the meanings that individuals assign to their experiences (Smith et al., 2009). A phenomenological approach is especially convenient for investigating a phenomenon experienced by multiple subjects (Creswell & Poth, 2018). In addition, Reid et al., (2005) have suggested that an IPA is suitable for the study of unexplored fields, in which prior assumptions are avoided, and hypotheses are not tested.

Site-specific information

Mental health care in Cuba is divided into three levels. The first level corresponds to primary care, where the Mental Health Community Centers are located, in which outpatient treatment for adult and

infant-juvenile populations is differentiated. The second level corresponds to general and pediatric hospitals, where there are psychiatric services. The third level corresponds to centers specialized in addiction cessation (León González, 2002).

In 2018, there were two IFT groups in Cuba, both located in Havana province, with more than an entire year of sessions. These groups were the ones that participated in this study.

One group was composed of families from two infant-juvenile mental health centers (*Centro Habana* and *Habana Vieja* municipalities) settled at the Mental Health Community Center in *Centro Habana* municipality. This IFT group involved four infant-juvenile psychiatrists and a health psychologist.

The other group was composed of families from the Consultation-Liaison Psychiatry Department at Borrás-Marfán University Pediatric Hospital settled at Infant-Juvenile Mental Health Services Center of Borrás-Marfán in *Plaza de la Revolución* municipality. This IFT group involved three infant-juvenile psychiatrists and a clinical psychologist.

Both IFT groups targeted families with children aged from 3 to 17 years, with emotional or behavioral problems, including a variety of diagnoses (i.e., attention deficit hyperactivity disorder, major depressive disorder, or generalized anxiety disorder). The average attendance of both groups totaled 20 families at each session. Usually, two or three members of each family were present. Based on the voluntary and free participation of its members, IFT was offered to patients and their families referred to the mental health services described above, on a community assistance (outpatient) basis.

All the professionals who facilitated the two IFT groups were specialized in IFT, and received the same training by the Interfamily Therapy Center of Elche (Spain) at the same time, in the last quarter of 2016, in Havana. Sessions were held weekly, and each session lasted an hour and a half. There was no requirement of the maximum number of sessions to attend for consideration of completed treatment, and the participants could remain in the IFT group for as long as they considered (i.e., open group format).

Participants

Children/adolescents identified as patients and their families, who participated in the two IFT groups described above, were recruited into this study. We used a purposive sample, aiming at the diversity of age, sex, role in the group, education level, type of family, and the identified patient's diagnosis. Different levels of attendance (measured as months in the IFT group) were considered. Both active participants and dropouts were also included, and the reason for dropping out was inquired about.

The IPA design finds a homogeneous group for those whose research question is meaningful through intentional sampling, and not in terms of random or representative sampling (Smith & Osborn, 2007). However, the subject matter of this study defined the need for certain heterogeneity (Pietkiewicz et al., 2014), so that the sample was representative of the makeup of participants in a usual IFT group session.

Participants were required to attend a minimum of four IFT group sessions and be seven years old or older to be included in this study. The recruitment was under the control of the referral professionals of the mental health services involved. Participants received study invitations by telephone. These professionals selected participants based on if they thought they would be able, interested, and willing to share their experiences in the IFT group. One adolescent declined to participate, and it was not possible to agree on a day to interview one family (father and child).

A total of 14 individuals (aged 7–57 years) belonging to 10 families (9 parents and 5 daughters and sons) participated in this study. Table 1 shows the descriptive information of the sample. The sample size was estimated from the appropriate number indicated by the exploratory nature in qualitative

TABLE 1 Sample characterization

							Interfamily Therapy Group		
Code	**Family**	**Role**	**Age**	**Education level**	**Type of family (no. of children)**	**Diagnosis[a]**	**Attendance: no. of months**	**Status**	**Cause of dropout**
P1	1	Mother	57	Preuniversity	Co-custody (1)	ADHD	9	A	NA
P2		Son	15	Secondary			5	T	Incompatibility of school timetable
P3	2	Mother	27	Preuniversity	Extended (3)	GAD	1	T	Pregnancy
P4		Son	7	Elementary			1	T	Mother dropped out
P5	3	Mother	40	University	Single parent (3)	MDD	1.5	A	NA
P6	4	Mother	49	Preuniversity	Nuclear (3)	ADHD	10	T	Diffused reasons[b]
P7	5	Mother	55	Preuniversity	Extended (2)	Moderate intellectual disability	6	T	Diffused reasons[b]
P8	6	Father	50	University	Co-custody (1)	Substance use disorder	12	A	NA
P9	7	Father	57	Preuniversity	Extended (2)	MDD	12	A	NA
P10		Son	17	Preuniversity			10	A	NA
P11	8	Mother	46	Preuniversity	Single parent (2)	ADHD	7	T	Incompatibility of work hours
P12	9	Daughter	18	Preuniversity	Extended (1)	PTSD	2.5	T	Incompatibility of school timetable
P13	10	Step-father	40	University	Blended (4)	PCBD	2	A	NA
P14		Son	11	Elementary			2	A	NA

NOTES: ADHD, Attention Deficit Hyperactivity Disorder; GAD, Generalized Anxiety Disorder; MDD, Major Depressive; Disorder; PTSD, Posttraumatic Stress Disorder; PCBD, Persistent Complex Bereavement Disorder; A, Active; T, terminated; NA, not apply.

[a]Child's Diagnosis accord. to DSM 5.

[b]The person verbalizes a diversity of temporary obstacles (life complications, Irma hurricane, too much tasksday by day …), without defining a specific reason.

research (Turpin et al., 1997), considering the usual small samples in studies involving an IPA (e.g., Givropoulou & Tseliou, 2018). In this regard, Smith and Osborn (2007) indicated that an IPA is an idiographic mode of inquiry based on small samples to ensure in-depth examination, without generating theories generalizable to the entire population. According to this information, data saturation is not generally an objective of the IPA design; rather it aims to obtain complete and rich personal experiences from the sample studied. It has been argued that each person's experience is so individualized that true data saturation cannot be fully completed, although this issue is controversial (Pyett, 2003).

This study was approved by the reference ethics committees of the services involved: the Ethics Committee of the Municipal Health Department in *Centro Habana* municipality, and the Ethics Committee of the Scientific Council at Borrás-Marfán Pediatric Teaching Hospital. Participation was voluntary and without compensation. Participants were informed about the objectives and methodology of the study. An informed consent was collected from each participant. In the case of minors, the consent was completed by both the minor and their legal guardian. Confidentiality was protected by treating the data with a self-generated identification code, assuring participants that their personal information would not be shared with the reference institutions.

Data collection

Researchers collected the data using semi-structured, in-depth interviews. Each interviewee chose the place to carry out the interview. Thus, all the interviews were conducted at the interviewees' homes, except for two that were conducted at the reference center. The interviews lasted approximately 30 minutes per participant (approximately 15 minutes in those participants under 12 years of age).

A funneling approach (Smith & Osborn, 2007) was used to guide the interview schedule. Funneling is a related technique of an IPA that allows obtaining both participants' general opinions and their responses to more specific concerns (Smith & Osborn, 2007). The interviewer (first author) included the following questions: *how would you describe your experience in the IFT group?*, *what changes have you noticed related to your participation in the IFT group?*, *what has been the most useful and the least useful feature to you?*, *how do you think it has influenced you on a personal*, *family and social level?*, and *did you experience any negative consequences?*

The semi-structured form of the interviews allowed the interviewer to vary the order and technique of asking, as appropriate (Pietkiewicz et al., 2014). Furthermore, the vocabulary used in the questions was adapted to the interviewee's age. The questions were modified during the development of the interviews (Pietkiewicz et al., 2014) so that the themes that arose in each of them guided the development of the questions in the interview. For example, participants talked about their experience in the first sessions they attended, and how it changed. Thus, subsequent interviews specifically addressed this issue (e.g., *how did you feel in the first sessions?* and *did it remain the same after a while?*).

Data analysis

The interviewer transcribed verbatim and anonymized the audio recordings of the interviews. Analysis of the transcripts was carried out following a series of steps described by Smith and Osborn (2007) for IPA design: (a) separately, two researchers (first and second author) read the text several times, noting first reflections, associations, and preliminary interpretations; (b) independently, both researchers transformed the initial notes into themes; (c) emergent themes were connected and grouped through

a coding process, and a general group of themes was created after researchers coded and analyzed all interviews; and (d) the researchers returned to the general text to check if any aspect should be added.

Smith and Osborn (2007) indicated that the choice of themes that are selected in an IPA does not depend exclusively on their prevalence in the data. On the contrary, other factors must be considered, such as the richness of the passage in which a theme is emphasized or how the theme helps to understand possible aspects involved.

Validation methods

A double hermeneutic process is involved in an IPA. First, participants try to make sense of their world. Second, researchers try to make sense of the world provided by participants (Smith & Osborn, 2007). Consequently, an IPA is fundamentally a subjective research approach, shaped by the researcher´s belief system; therefore, validation of the researchers´ interpretation of the data in an IPA is a decisive aspect to enhance the reliability of the research process.

We used bracketing (Smith & Osborn, 2007) as an initial step before the interviews were conducted. Bracketing involves a comprehensive study of ideas and experiences of the researchers who analyzed data. To achieve this, the theoretical foundation of the different MFT models, with special attention to IFT, and the literature on the use of MFT in groups of children/adolescents and/or their relatives were reviewed. Possible presumption of the phenomenon related to their own experiences in multifamily groups was identified.

During the interviews, the interviewer (first author) checked the information and interpretations with the respondents at the very moment, using reflections of feelings, clarifications, and recapitulations, so that the participants confirmed the correct interpretation of the experiences (Lincoln & Guba, 1985). Participants' feedback also served to adapt the next interviews. At the end of each interview, the interviewer took notes, like a self-reflexive diary, with general impressions of the interview and any special issues to highlight. These ideas that emerged from the interviews were discussed with a consultant researcher (the last author). The two authors involved in the analysis held discussions with the consultant author throughout the data analysis process. This last researcher ensured that personal experiences or other biases were bracketed successfully, and performed a critical audit of the identification of categories and patterns of meaning. These three authors reformulated, revised, and agreed on the themes, using a consensus approach. None of these three authors participated in the treatment of the families in the study, were not part of the facilitators of the IFT groups, and were unrelated to the reference mental health centers.

The first author was a psychiatric-mental health nurse expert in IFT, with experience as a facilitator in IFT groups in Cuba, Peru, and Spain. The second author was also a psychiatric-mental health nurse expert in the Psychoanalytic Multifamily Model, with experience as a facilitator in psychoanalytical MFT groups in Spain. The last author was a psychiatrist and a group, family, and multi-family therapist, with extensive experience developing, training, and supervising IFT groups in European and Latin-American countries. These three authors' preferences for social epistemological constructionism, and experience as facilitators in multi-family groups, as well as their commitment to biomedical model alternatives to explain mental health disorders, inevitably molded this research.

We used *Nvivo v.12*. software to assist in organizing the data (constructing the researchers' notes by using memos and coding the data into themes).

TABLE 2 Domain and themes identified in IPA and its definitions

Domain	Main themes	Sub-themes	Definitions
Perceived benefits	Personal level	Gained insight and acceptance	Change in the perception of oneself, in relation to the importance of one's thoughts and behavior in the development of problems
		Relief of guilt, tension, and frustration	Decrease in feelings of guilt, tension, and frustration
		Increased self-confidence	Increase in trust in one's abilities and qualities, mainly related to the capacity of expressing what they feel to others
		Enhanced motivation, optimism, and hope	Increase in one's interest and guidance towards possible targets
		Helped with school functioning	Improvement in academic performance
	Family level	Got a closer relationship	Improvement in intrafamily relationships, with a decrease in conflicts
		Increased competence in parental role	Improved self-efficacy in relation to parenting
		Improved communication and understanding	Improvement in communication and family dynamics
	Social level	Increased social connection	Improvement in social interpersonal relationships
Key treatment elements	Group format	Group cohesion	Sense of belonging to a group and feeling closely connected to it; group as a safe place
		Sharing experiences and emotions	Exchange of experiences and emotions among the members of the group, as facilitators of social modeling
		Heterogeneous group composition	Plurality of problems (heterogeneity of psychiatric diagnosis) and the diversity of ages as a richness
		Informal rules	Non-implicit communication rules in the group, which require simultaneous learning in the evolution of the group
	Therapists	Therapist's role	Function attributed to facilitators (therapists) by participants
		Spontaneous therapist	Participants' collaboration as facilitators (co-therapists)
Negative aspects	Preliminary sessions	Prior treatment expectations	Participants' initial disappointment due to preconceived ideas about therapy
		First unpleasant emotional experiences	Distress experienced at the first sessions of therapy
	Targets not met	Being realistic about level of change	Persistence of some of the problems that caused participants to attend therapy

RESULTS

Table 2 shows the domains, main themes, and sub-themes generated, as well as the definitions of these sub-themes. They are described with verbatim extracts.

Domain 1. Perceived benefits

Overall, IFT was perceived positively. Interviews strongly indicated that subjects were pleased with IFT. The three main themes identified were: *personal level*, *family level*, *and social level*. Their respective sub-themes are developed below.

Gained insight and acceptance

Eight parents indicated that IFT had helped them see the negative impact of their own difficulties on the child. They became aware of how their parental pattern had influenced their children/adolescents' mental health: *"I would not let him do it because of my own fears* […] *I had not internalized or understood that I was afraid of many things"* (P1). *"Then one also has to recognize that the defects and virtues that one may have*; *what is it that clashes with that very thing that you have with them. I also learned that sometimes you don't realize it*, *but you stress out your children*, *without wanting to*; *I live and die in a hurry*, *I live and die in a hurry."* (P11). They also noted the positive impact of overcoming these difficulties on their sons and daughters. In this way, IFT gave the participants a new perspective on the child's problems, expressing a feeling of responsibility: *"I understood that the first problem I have to improve is mine*, *and by improving myself*, *I improve my son"* (P8). Regarding the difficulties mentioned, references to overprotection stood out: "*I am the one who hurts my son*; *it is ugly to say it*, *but it is a damage that I see as good because I think that I am taking care of him*, *but I am not letting him develop*, *get ahead all those things. It has helped me to realize the fear that I have*, *that I have overwhelmed him*, *that I do not leave him alone"* (P6). This sub-theme was made up only of parents.

Relief of guilt, tension, and frustration

Eight participants expressed a general sense of comfort and relief from the tension, frustration, and guilt they felt before joining IFT. It was particularly prominent in some participants: *"They have helped me to understand myself*; *they have helped me to forgive myself and they have helped me to close many open doors* […] *I feel very comforted*; *I have felt relieved after many years"* (P5).

Increased self-confidence

Eight participants spoke of an improvement in terms of the ability to express themselves, with a decrease in shyness, shame, and an increase in self-confidence: *"The most useful thing for me was learning to share with people*, *because I am a bit shy*; *sometimes*, *shyness does not let me move forward*, *and I learned to exchange ideas*, *to say more or less what I feel*, *to talk to other people"* (P3). *"I no longer have that fear of going out into the world and having the shame I had before*; *when talking to others*, *now I have more friends*, *more…I look for more solutions"* (P14).

Enhanced motivation, optimism, and hope

In five participants, there was a sensation of diminishing feelings of helplessness and hopelessness, increasing optimism and being more motivated to overcome difficulties, and have a positive change in their lives. All of this resulted in an emerging feeling of happiness: *"The group made me think that what seemed very dark to me, like a cave, well no…* [a mother] *came out of the cave and I thought that yes, it was very good, that I wish I could… Because I see them as a family now…"* (P7). *"I feel motivated, I feel very hopeful, I feel very good and I feel that I have new ideas, and I feel more creative with my things"* (P5). *"My experience has been enriching; it has given me a lot.… It has given me something like a life project to carry on with everything that has happened to me"* (P14).

Helped with school functioning

Two participants reported improvement in studies. A father verbalized greater understanding regarding his son's functioning in school: *"*[It helped me to] *be more permissive with studies… Learn when to act and when not to act and let him learn"* (P9). *"And I have done better in school, in my studies; things turn out better for me, now I get good marks in tests. The advice of all those attending therapy helped me"* (P2).

Got a closer relationship

Six participants reported an improvement in the family relationship as a result of changes in behavior and greater mutual understanding: "*My mother and I have had important changes due to therapy; we argued a lot and now we don't"* (P2). *"The relationship with my son has improved"* (P3).

Increased competence in the parental role

In relation to the previous category, six parents expressed greater confidence in their ability as parents. On one hand, they verbalized feeling greater security to establish limits when appropriate, with a more negotiating and conciliatory attitude. On the other hand, they expressed learning to give more freedom and respect. The four parents who had been attending the group the longest reported feeling like better parents: *"Before, he* [my son] *told me anything and then I… could comment on it out there because as they were children's things, I did not respect* […] *But it was his secret, his space. I never took that into account. I began to realize that in therapy"* (P1). "*In the group, I have learned to make the rules more flexible, I have learned to eliminate and I have learned to add, too"* (P11).

Improved communication and understanding

Six participants noted a greater capacity for communication and mutual understanding. Two children reported feeling more confident talking with their parents: "*Also, we had almost no communication before; I didn't have many friends, I was almost always locked up here or in the bedroom, and I didn't feel like doing anything… Now, above all I like being here, sometimes I go to my Dad's house, and I like being with my brother…"* (P12).

Increased social connection

Seven participants reported that the group helped them to overcome their shyness and function more easily socially; thus, feeling more secure with others. Three of the participants expressed a greater capacity to be confident to connect with people. Specifically, one child and one adolescent expressed having more friends: *"I spoke, although I was* [ashamed], *I spoke because… because I had to speak, because I had to speak for them to understand me, I had to speak, so that they would know what was happening to me. It helped me to play and make friends"* (P5).

Domain 2. Key treatment elements

Two main themes included the most significant therapeutic elements for participants: (a) *group format*, on the therapeutic elements of group therapy, and (b) *therapists*, referring to allusions about to the therapist's role.

Group cohesion

The feeling of not being alone was reported by 13 participants. It reduced isolation and they spoke of feeling like a big family, in which they take care of each other, and crying is not shameful: *"Arriving and crying, it seemed that you could do it in such a familiar environment, that if you did, you would not feel ashamed"* (P7). They referred to have found people to trust in and count on, and who really listen to them. The feelings of empathy and solidarity were highlighted: *"It was from people who looked at you, who helped you* […] *because before, it was always she and me"* (P7). The group was described as a space of respect, security, and confidence. Feeling the answers and reflections of others as useful and visualizing the more open attitude of his/her family allowed the person to confide: "*Something really nice because I see them unburden themselves; they freely express things that… that is, they don't talk at home and they express it there, they feel a more open environment"* (P13). *"Because over time you lose fear, the fear of speaking, and because you have a need"* (P9).

Sharing experiences and emotions

Eleven participants indicated that they became aware and developed the capacity to reflect on their own way of acting: *"There are times when you make a comment on something and it seems to you that it is normal and you perceive that what you are commenting on is abnormal"* (P7). Social modeling occurred, promoting the change of four participants who found new ways to behave within their family: *"You are making comparisons and you are drawing your own conclusions* […] *that also help you not to make the mistake the person in front of you is making"* (P9). Two participants verbalized that seeing how other people in the group struggled to solve their problems mobilized others to try it themselves with their own problems: "*And that is really exciting, to see how people struggle to achieve their happiness, to achieve their… their… improvement. I mean, then it is one thing, it is true that you have a problem that can be painful, but you are also seeing that this person… is part of… is in the group, he/she is fighting for it, and he/she is not frightened, he/she is being brave"* (P8).

Heterogeneous group composition

Nine participants felt that the diversity of the group helped them get a greater perspective, learn from others they did not expected to learn from, and resituate themselves with respect to their own relatives: "*Because my first experience, the first time I analyzed myself, came from a child. In other words, for me, even the criteria of children serve me; for me, it has been useful even what a child says, do you understand me?"* (P1). Two mothers noted that age diversity helped them to realize that their children could relate adequately in an adult context. Giving both times with shared spaces (everyone in one place), and times with separate spaces (children interacted through play in a parallel subgroup) was seen as a strength of therapy: *"Because they let me play for a little while… then they treated me… and then they talked to my mother…"* (P4). "*He is a child who adheres to this group of adults, because he is practically the youngest of those I have seen here, and he has felt good, he has felt confident, he has felt that he can play, that he can do his family activities…, he can do them within the group"* (P6). It helped to understand what things were appropriate to talk in front of children and which ones were not: *"You see yourself reflected in some experiences of other people; maybe a child, a teenager or an adult like you, even if your situation is not the same* […] *As we work with little children at times, a very personal fact in my case,* […] *that cannot be heard by minors, and at a certain moment I need to say it but I keep quiet, I limit myself for those things, I consider it as 'well, this is not the time'"* (P6).

Including people with a variety of psychiatric diagnoses helped broaden the focus of attention, delving deeper into the causes underlying symptoms than in symptoms themselves. It also facilitated the relativization and de-dramatization of own problems and the acceptance of a broader perspective: *"There were people with many more problems than me, and that gave me strength to go ahead"* (P3). Finally, learning to deal with problems shared by other families provided security for the future: *"What happens to others… is an experience that you acquire when knowing how to face it, how to get ahead, if one day it happens to us"* (P12).

Informal rules

Six interviews showed there was group learning to express oneself in the group, respecting the informal rules of communication: *"So I said: 'ah, well, then here you have to say what you feel'"* (P7). Not speaking for the other, but of oneself and from oneself, and avoiding advice were aspects identified as very useful. The teaching of listening without judging was highlighted and three participants emphasized that not feeling judged was an important basis for increasing their self-confidence, feeling respected in the group, and allowing their openness: *"To listen to people from your heart, to understand them without judging them* […] *nobody refuses anything, and that gives you a lot of confidence when speaking, because sometimes it happens that people are shy about speaking because someone can tell them, someone can refute him or send him to silence or… and that doesn't, it doesn't happen in the group"* (P8).

Therapist's role

References to therapists were higher in two participants who left the group with a diffused reason, and in participants with fewer months of attendance of the IFT group. These participants gave the therapists a leading role in therapy as experts. This role gradually declined as participants gained more experience in the IFT group. The three participants with the longest experience attending the IFT group, who had a

good attendance record, placed the therapeutic power of the group in the process of shared experiences, and in the person as a protagonist of his/her own therapeutic process. Thus, these participants saw in the therapist a figure that made it easier for people to express themselves and interact with each other: *"When we go to see a doctor, what we want is for the doctor to take out the trash. But the garbage is ours; you sweep and clean"* (P1). *"In a consultation* […] *the doctor sits there* […] *But he/she is a person and it may happen that you do not have faith in that doctor, or you notice that he/she is in a hurry* […] *But when there is a large group, I see that the exchange flows more* […] *Well, the psychologists are not alone there, the patients are also there* […] *sometimes the doctor says 'oh, I see your face, you want to say something'… because you already have it on the tip of your tongue, you have the need to say it"* (P9).

Spontaneous therapist

Five parents pointed out the beneficial effect on their ability to help other participants from their own experiences, thus giving a new meaning to the phrase "suffering lived and overcome": *"I can* [help] *because I was helped, do you understand? So as a reward I have to do the same with people, and it seems to me that I continue to receive* […] *I feel the need to help the person who was like me in a day, because I want him/her to feel the way I feel now*" (P1). *"That is to say, I think and it comforts me to give an idea and also help, even if I am not a doctor"* (P9).

Domain 3. Negative aspects

Negative or limited aspects of the IFT confirmed two main themes: (a) aspects given in the *preliminary sessions* and (b) *targets not met* (unsolved issues after months in the group).

Prior treatment expectations

Five parents felt that the group could not help them since there were people with problems other than their own: *"The only thing* […] *that it lacks is space* [time]; *it is little space and there are people who take practically the entire space*, […] *and what remains is reduced for the rest"* (P13). Feelings such as frustration or anger emerged when automatic response and professional advice were not found: "*In the first session* […] *we thought 'oh, what am I doing here'; there were suicide problems, beatings problems, abuse and that. And mine was not that"* (P9). *"I initially went with my son, because of my son's fears, not because of me"* (P1).

However, other feelings, such as curiosity or despair, led them to continue with the group. The disappointment was diluted with the evolution of the IFT, as seen in interviews with participants with extended experience in the IFT group. Two of them said they felt the specific moment in which this change of perspective occurred: *"Because if you go to therapy only twice, you don't go any more, because it seems that that doesn't… that* […] *you don't solve anything* […] *About the fourth time* [we went] *was when we realized that it was a place to go"* (P7).

First unpleasant emotional experiences

Three participants verbalized that the first sessions were hard or intense due to a great emotional burden they had or perceived in the group, or because they were not prepared to accept their difficulties:

"Because I was not ready to start accepting my character defects, *to start listening to that… and on those days that you become more relaxed*, *then I started*, *about a month and a half of therapy*, *when I started to accept that"* (P1). Two participants spoke about their shyness and fear of being surrounded by so many people to share their personal experiences. A child expressed boredom: *"The bad thing about therapy is that I was sometimes bored"* (P4). Furthermore, two interviewees with the most distressing narrations, who focused on their life histories rather than the interview questions, were participants recently incorporated into therapy. In addition, two drop-outs due to diffused reasons gave the longest interviews with very high expressed emotion. In relation to this, a participant showed special concern for people who attended only a few initial sessions, leaving quickly: *"The weak part that I have seen* […] *being a therapy where people go and publicly strip their feelings*; *there are many people who go and do not speak and do not go anymore* […] *because perhaps they are not prepared* […] *I've seen people who go two or three sessions and don't go any more*, *but then they show up and come back* […] *In other words*, *realizing that the initial problem is you*, *it is not a problem of one session or two"* (P8).

Being realistic about the level of change

Nine participants referred to unsolved or partially solved problems. Three levels were established: (a) problems detected as unsolvable, being a matter of learning to live with them; (b) problems that took more time to be solved; and (c) problems that remained, with less intensity or frequency. Participants expressed: "*In my case too*, *because I had things that… and I still have things that… we are not perfect"* (P9). *"Relationship in the family has improved*, *although the problems are still there*; *believe you me*, *I am honest* […] *They still persist*, *not to the high degree they were*, *they have decreased*, *but they are* […] *because that is precisely part of these characteristics"* (P11). "*Personally…. I'm the same…It hasn't helped me with my problem* [he refers to the fact that he maintains the same psychiatric diagnosis]; *mine remains the same. But nothing bad has happened"* (P10).

DISCUSSION

Prior studies on the impact of different MFT models have documented benefits on the health and well-being of children/adolescents and their families. Nevertheless, this was the first study to qualitatively explore the IFT model, based on the experiences and perceptions in a Cuban sample. In this study, IFT was well accepted. IFT was perceived as beneficial due to its positive influence on the participants, with benefits on a personal level (gained insight and acceptance; relief of guilt, tension, and frustration; increased self-confidence; enhanced motivation, optimism, and hope; helped with school functioning), on a family level (resulted in closer relationships; increased competence in the parental role; improved communication and understanding) and on a social level (increased social connection). Participants in this study articulated a series of therapeutic elements of IFT that were essential to promote these benefits. These key elements were related to group format (group cohesion; sharing experiences and emotions; heterogeneous group composition; informal rules) and therapists (therapists' roles and spontaneous therapists). However, the participants noted a few negative aspects, mainly related to their first sessions (prior treatment expectations and first unpleasant emotional experiences), and about target not met (being realistic about the level of change).

Regarding the indicated personal benefits, one key aspect must be highlighted. In this study, when participants spoke about gained insight and acceptance, they referred to the influence of

their actions and behaviors on themselves and others. Nonetheless, in other studies addressing the psychoeducational approach of MFT, participants expressed greater insight and acceptance related to the diagnosis of the identified patient (Nilsen et al., 2016; Voriadaki et al., 2015). In this respect, our findings resonate with multisystemic therapy by emphasizing parental change as precursors to children's improvements (Henggeler et al., 2009). According to this finding, in this study, participants (mainly the parents) focused discourse mostly on their own therapeutic process. This is in contrast with studies on other MFT models, in which participants' discourse on improvement was focused on the symptoms related to the children/adolescents' diagnoses (identified patient) and only secondarily were other aspects, such as caregiver's burden, evaluated (Dennhag et al., 2019; Engman-Bredvik et al., 2016; Stewart et al., 2019). In that regard, in IFT, the facilitators do not make a distinction between "identified patients" and "family members"; all participants are submitted as active subjects in therapy, and they participate in therapeutic mechanisms the same way (Sempere & Fuenzalida, 2017). The creation of peer relationships and affective bonds that are generated allowed the activation of corrective emotional experiences, which is particularly relevant for participants' recovery (not just in identified patients, but to a greater extent, in family members).

Regarding family benefits, although an increase in communication and understanding and a reduction in conflicts were emphasized, it is necessary to clarify one aspect. Improvement of family climate requires some time to occur since the beginning of therapy involves a questioning of relational models, and therapeutic crises may arise in the form of differentiation of movements experienced as difficulties by families. For this reason, the newly incorporated families could focus their discourse more on the relief of being able to express themselves and share experiences, than on the improvements in family dynamics.

Participants highlighted a series of significant therapeutic elements of IFT. On one hand, some of them were general aspects of MFT, such as the importance of group cohesion as a promoter of change, emphasized in previous studies of other MFT models (Engman-Bredvik et al., 2016; Huestis et al., 2017), and the impact of sharing perspectives and experiences as a key to the positive changes generated (Huestis et al., 2017; Voriadaki et al., 2015). As Bishop et al., (2002) documented, sharing personal experiences facilitates contextualization of the ways families do things, and the new relationships developed in this new system echo the original family process in the development of mental health problems. Family members can negotiate and manage in a different way using this new context, through learning by analogy and the dilution of affections.

Other therapeutic elements are not common to all MFT models. Thus, groups are mostly homogeneous, in age (von der Lippe et al., 2016) or diagnosis (Engman-Bredvik et al., 2016). Although the importance of sharing experiences in families with a similar situation has been evaluated (Voriadaki et al., 2015), this study would be consistent with the findings of Goll-Kopka (2009), who indicated that the differences between individual psychiatric diagnoses were not essential for the group participants, and families could connect with the different problems that arose in those with other diagnoses. That is, the same type of suffering does not entail the same diagnosis. In addition, in reference to informal communication rules of the group, this study emphasized non-judgment as a global characteristic of the group. Nevertheless, in the study by Tighe et al., (2012), non-judgment is noted as a quality that only the therapist must have.

The role of the therapist and spontaneous therapist could possibly be the key treatment that most differentiates the IFT from other MFT models (psychoanalytical, systemic, psychoeducational). Traditionally, the therapist has been seen as an expert in dealing with emotional problems, drawing himself/herself as a key element due to his/her contributions and orientations, with allusions to the importance of his/her competence and characteristics, such as warmth, flexibility or respect (van Ee,

2018; Tighe et al., 2012). In this study, although the therapist's importance is recognized, the relevance of the contributions, competences, and qualities appeared to be referred to the group in general and not to the therapist in particular. The participants highlighted the work of the therapists to facilitate communication. In fact, the therapists at IFT are called *facilitators*. Additionally, the references to the participants as spontaneous therapists and the personal benefit of helping others were not reflected in other similar studies analyzed, although Bishop (2002) indicated that the MFT group was more effective when the sense of joint ownership was maximized. Interestingly enough, the IFT model was developed when there was a growing interest, mainly in the United States and United Kingdom, in creating "expert patients" and the consensus seemed to be that MFT created expert careers (Schmidt & Asen, 2005). As Sempere and Fuenzalida (2017) mentioned, IFT would be a revolution in current therapeutic interventions, since it places participants (identified patients and relatives equally) at the core of the intervention, and turns them into active agents of the therapeutic action. In this way, IFT could be considered a "democratic" model of therapy that can be summarized as "the therapy done together."

We propose to interpret some findings related to the participants' roles as a three-step process: (a) initial uncertainty and disappointment, with two traditional roles (i.e., patient and familiar); (b) resignification of the child/adolescent´s problems, with redistribution of roles (i.e., all participants); and (c) being an experience and instrument of change for other families, with a new role (i.e., spontaneous co-therapist). These claims would be supported by the following aspects: the frustrations of parents regarding what they expected at their initial sessions in IFT group (*Prior treatment expectations* theme), the realization of the impact of their parenting patterns on their sons' and daughters' mental health (*Gained insight and acceptance* theme), the indication that the IFT group was therapeutic for them (*Increased self-confidence* theme) and the experiences helping others (S*pontaneous therapist* theme).

In regard to the specific cultural context, benefits pointed out in MFT studies, such as feelings of relief from guilt and tension (Engman-Bredvik et al., 2016; Tighe et al., 2012), a greater feeling of optimism, hope, and motivation (Engman-Bredvik et al., 2016; Huestis et al., 2017; Voriadaki et al., 2015), improvement in parental competence (van Ee, 2018; Engman-Bredvik et al., 2016) or an increase in socialization (Huestis et al., 2017; Tighe et al., 2012), have been carried out in other cultural contexts, and have also been reported in our study. The unfulfilled objectives, indicated as a negative aspect, were common to other similar studies (van Ee, 2018; Tighe et al., 2012). These findings suggest Cuba as suitable to implement IFT without requiring a cultural adaptation. Although the way of expression, emotional inhibition, and concrete problems may be culturally different, the underlying interpersonal conflicts seem universal.

Limitations and implications for research

This study has a number of limitations. Firstly, qualitative research based on IPA has been used, and this must be considered, although a series of measures were indicated to minimize the effect of subjective bias. Despite efforts to limit participation biases (i.e., clear description of confidentiality, individual interviews by personnel outside the IFT groups and reference institutions, the inclusion of drop-outs), it is unknown whether a social desirability bias regarding the perceived benefits occurred. Presumably, people who agreed to take part in this study were more motivated than the group average. The potential recall bias associated with retrospective information must also be added as a limitation. Lastly, the ratio of relatives to children/adolescents was not balanced, although a greater number of mothers (instead of fathers) was consistent within the groups.

There remains a lack of robust evidence for MFT, compared to other standard family treatments or usual treatments. Continuing to study the users' perspectives of the therapeutic process, in isolation or by comparing them with the professionals' perspectives, would give an additional dimension to the findings presented here. In future research, it would be interesting to include physical health, and educational and social contexts, since these are the diverse contexts on which an IFT model is based. Evaluating the analysis of the recordings of the sessions could be a useful way to assess the process as it occurs, as a complement to the *post hoc* accounts of the experiences. It would also be of interest to analyze the change in the therapeutic relationship that could occur through the common experience of the IFT groups. It should be noted that there is a lack of training in the Cuban IFT facilitators compared to the training in Spain. In future research, it would be of interest to make a comparison of IFT in different countries, analyzing if there are differences related to the extent of facilitators' training.

Some aspects must be highlighted. First, there are shared opinions among people with more experience with IFT that are not shared with those with less experience in IFT; for instance, the role attributed to professionals in the group or their sense of personal growth. Moreover, people with more experience clearly pointed out the key treatments of IFT. Second, the children/adolescents' references were much lower than those of the parents. One possible reason may be that IFT helped parents more than children, at least initially, which is consistent with the study carried out in Spain (Sempere, 2015). Thirdly, contrary to what might seem intuitive, the two participants that dropped out due to diffused reasons contributed a significant amount of data. These assessments indicate the interest of carrying out a comparative study in future research, by comparing opinions from different groups of interest that were deduced from this study: identified patients versus relatives; expert participants versus naïve participants; active participants versus drop-outs; drop-outs due to a specific reason versus drop-outs due to a diffuse reason. Finally, it would also be relevant to conduct studies comparing the different models of MFT. Using a mixed approach of combining quantitative and qualitative measures would facilitate comparisons between the models, helping to clarify common and unique characteristics.

Conclusion

This study contributes to the current literature, helping to reach a phenomenological understanding of participants' experiences in IFT groups. Previous research has shown the effectiveness of MFT, but the IFT model is still poorly understood. In order to achieve a greater understanding of IFT, the experience of 14 participants was rigorously and systematically explored. The acceptability of this intervention, applied for the first time to a Cuban sample, was preliminarily confirmed in this pilot study. IFT appears to be a promising intervention, formed as a space in which several families meet and share their own experiences, and allowing them to move from particular understanding to common understanding, and become agents of positive change for themselves and others. The therapeutic factors reported in this study help to gain understanding of the processes of change in family dynamics. IFT seems to adapt well to different cultural perspectives since the therapeutic process is mainly carried out by those who participate in it.

ACKNOWLEDGMENTS

The authors thank all the children, adolescents and adults who participated in this study. We also thank all professionals in the infant-juvenile units of Mental Health Department at *Borrás-Marfán* Pediatric Teaching Hospital and Mental Health Community Center at Cento Habana and Habana Vieja municipalities for facilitating this investigation.

CONFLICT OF INTEREST

The author declares no sources of support or conflict of interest.

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How to cite this article: Ruiz-Íñiguez, R., Carralero-Montero, A., Martínez-González, A., Méndez-Parra, E., Valdés-Díaz, Y., & Sempere, J. (2021). Interfamily Therapy, a multifamily therapy model settled in infant-juvenile mental health services of Havana (Cuba): A qualitative study from participants' perspectives. *Journal of Marital and Family Therapy*, 00, 1–21. https://doi.org/10.1111/jmft.12542