CONTEMPORARY FAMILIES: THERAPEUTIC SUPPORT FOR NEW CHALLENGES

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CONTEMPORARY FAMILIES: THERAPEUTIC SUPPORT FOR NEW CHALLENGES

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EDITORIAL
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Editorial: Contemporary Families: Therapeutic Support for New Challenges

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Keywords: family relations, social adaptation, psychological outcomes, contemporary family, adoption, same-sex parenting, innovative mental health care

Editorial on the Research Topic

Contemporary Families: Therapeutic Support for New Challenges

In the contemporary context, families are built and evolve in multiple, changing and more and more complex configurations. Women and men become parents in homosexual relationships, through international adoption, or across boundaries, in transnational spaces.

Children and adolescents grow up confronted with filiation, identity, or gender questions. Their family history can be multiple, rooted in different filiations and countries. When displacement and/or migration is part of their history, they sometimes have to cope with a difficult and painful past, on an individual but sometimes also collective level.

At the same time, new information and communication technologies and especially social media enter the families' homes, blurring boundaries between the outside world and the domestic sphere as well as possibly disrupting subjective development trajectories.

This Research Topic addresses the specificities of these evolutions in family life and their meaning for and impact on the psychological development of family members and their relations.

Same sex parent families were the focus of a review of qualitative and quantitative studies conducted by Siegel et al. They explored the psychological consequences of living in an ambiguous or hostile legal climate for children and parents, and how this may influence their family functioning.

Rabain explored relations in families with transgender adolescents, through the presentation of an innovative therapeutic approach, gathering parents, adolescents, as well as whole families together in different settings.

Another specific family configuration was studied by Skandrani, Moro et al. through their analysis of adoptive family relations when facing new forms of contacts with birth families, initiated by the latter through social media.

New information and communication technologies were also studied by Duriez, since they enter and revolutionize family relationships and organization. The author developed an Emotion Regulation Focused Family Therapy to face these new challenges.

Other studies published in this Research Topic questioned the contemporary social framework as well as the historical context in which these families evolve and change. They highlighted the impact of these contexts on the individual development as well as on family relations and their outcomes.

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Feldman and Mansouri studied the consequences of breakdowns in filiation for children traumatically separated from their families in the Reunion Island and sent to foster families, adoptive families, and/or children's homes to mainland France in a specific public political context.

The specificities of the historical and transnational contexts were also studied by Grupp et al. with asylum seekers living in Germany and undocumented migrants and failed asylum seekers living in France. Family and transgenerational ties linked to spirituality appeared to be central in their understanding of their post-traumatic stress symptoms.

The new challenges families are confronted with have led mental health professionals to set up innovative therapeutic support and clinical settings, including group therapy, adoption therapy, multi-family therapy and transcultural therapy. The exploration of these new mental health care settings can promote the psychological, social and family outcomes in case of psychological suffering or difficulties in family relationships.

Two qualitative studies focused on an innovative mental health care setting, i.e., multi-family therapy, to address specific mental disorders families are confronted with. Baumas et al. explored the changes observed by adolescents with anorexia nervosa and their parents after a multi-family therapy, in terms of symptoms and family interactions, in focus groups. Roué et al. used semi-structured interviews to assess the benefits of multi-family therapy for adolescents with school refusal and their parents.

In order to promote mental health and prevent mental disorders or disruptions of family relations, an increasing number of clinical settings are provided for patient's family members. The contributions to this topic propose support groups for siblings of anorexia nervosa patients (Persico et al.), social support for donor families (Luo et al.), as well as couple therapy for partners of patients with chronic kidney disease (Riazuelo). These different mental health care settings promote the psychological, social, and family wellbeing in case of psychological suffering or difficulties in family relationships, and ultimately activate the families' resources.

AUTHOR CONTRIBUTIONS

All authors listed have made a substantial, direct, and intellectual contribution to the work and approved it for publication.

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ORIGINAL RESEARCH
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Why Multi-Family Groups for Transgender Adolescents and Their Parents?

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The author presents a therapeutic approach for contemporary families carried out in an innovative mental health care setting. This approach involves receiving both transgender adolescents and their parents. Initially, the adolescents are brought together in a discussion group. Then, the parents of these adolescents are gathered without their children in order to reflect on family relations and social adaptation and to receive support when needed. Both groups are gathered together a couple of times a year in a multi-family meeting. Using a dynamic based on the principle of free association and the interplay of identifications among participants, the author points out how these groups and multi-family gatherings promote mental health and prevent mental disorders and the disruption of family relations.

Keywords: multi-family groups, contemporary families, innovating mental health care, trans identity, family relation, social adapation, same-sex parenting, psychological outcomes

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INTRODUCTION

In the context of contemporary family configurations such as same-sex parenting or single parenting, clinicians have been developing new and innovative approaches for providing therapeutic support in mental health care. Some are based on working with patients individually, while others favor a group approach, using focus groups, discussion groups or multi-family groups in which people accompanied by their children or their parents. The innovative mental health care setting we will present in this paper is meant for both transgender adolescents and their parents. Initially, the adolescents are brought together in a discussion group whose dynamic is based on the principle of free association. Then, their parents are received without their child in order to foster reflection regarding family relations and social adaptation as well as to receive support when needed. Both groups meet for a multi-family session two or three times a year in order to both promote therapeutic outcomes in case of psychological suffering or difficulties in family relationships, and prevent the disruption of family relations. In other words, this three-step approach aims at fostering a discussion about the challenges encountered by transgender adolescents and their parents regarding their family relations and social adaptation, and more particularly the difficulties faced in experiences of discrimination and rejection.

Who are our groups for and how do they function? How do they promote mental health? How do they prevent mental disorders?

MATERIALS AND METHODS

Ethical review and approval were not required for this study on human participants in accordance with the local legislation and international requirements. The participants provided their written informed consent before participating in this study.

In 2013, Professor David Cohen set up a Sexual Identity Consultation Service in his Child and Adolescent Psychiatry Department (La Salpêtrière Hospital, Paris). These types of consultations first emerged in the United States and Canada in the 1970s and eventually reached Europe through the Netherlands and the United Kingdom. In 2013, three pioneering consultation services were set up in France, including our own. Their common goal was to welcome people who presented "gender dysphoria". Despite having a large cohort compared to other French hospitals, a statistic analysis remains impossible for the moment: in six years, our Sexual Identity Consultation only received about 150 transgender children and adolescents – which is definitely not enough for a statistic analysis. These figures demonstrate the lack of resources deployed across the country to support transgender minors (Condat et al., 2016; Mendès et al., 2016).

In our Child and Adolescent Psychiatry Department, most transgender teenagers seek our help in order to be guided through their transition. The initial request is often made with regard to the medical aspects of this process. Each month within La Salpêtrière Hospital, Multidisciplinary Concertation Meetings (MCM) bring together various professions: child psychiatrists, psychologists, pediatricians, psychomotor therapists, endocrinologists, reproductive biologists, ethicists and jurists. In this setting, they share their respective points of view and work out the handling of the most complex cases together. For instance, they can evaluate and question the relevance of prescribing a hormone therapy or a puberty blocker. They can also determine which treatment is likely to work best for which patient. In these meetings, decisions are made on a case-by-case basis.

In 2017, Professor David Cohen proposed me to create a new mental health care setting with Dr. Julie Brunelle in his Sexual Identity Consultation Service. Dr. Julie Brunelle had been working with transgender minors for several years whereas I was invited to participate as a therapeutic group specialist. As a matter of fact, I had introduced two years before a pioneer multi-family analytical group in *La Salpêtrière* Hospital for the attention of addicted teenagers. The setting-up of that group was based on my clinical background in the *Dr. Ricardo Gutiérrez* Hospital for Children in Buenos Aires. Argentina is the country where multi-family psychoanalysis was created in the 1960s by García Badaracco (1989) and García Badaracco (2000). This new setting was initially for the attention of schizophrenic patients but its indications have become more and more diverse. Nowadays, it can be indicated for young patients who have so far been resistant to traditional therapies. They usually suffer from behavioral disorders, eating disorders, addictions, narcissistic issues, an anxio-depressive syndrome or separation anxiety (Rabain and Bourvis, 2016). Multi-family groups bring together *"between two and twenty families to exchange their stories, experiences and emotions. The sessions can last between 1 h and two and a half hours, depending on the number of participants, the types of pathology and the institutional framework. Communication is coordinated by a group of co-therapists who have been trained in individual, group and family psychotherapy techniques* [...]".

That's how Dr. Julie Brunelle and I started bringing together in a group about 10 adolescents aged 13–19 who had questions regarding trans identity. At that time, we were one of the only Child and Adolescent Psychiatry Departments to offer group outpatient care to transgender minors in France. That group still operates today. Each session consists of two parts: first the reception of the ten or so transgender teenagers and then, separately, the reception of their parents. Both subgroups are "open," which means that newcomers can be included along the way, and both are gathered together a couple of times a year in a multi-family meeting. We would like to point out that all participants are extremely regular, regardless of whether or not they come from Paris and its suburbs. In fact, some of them live in the country-side, in other cities, or in small villages and travel each month across the country to reach Paris, just because they do not want to miss a single group session! 50% percent of our patients come from outside of Paris area. Furthermore, we receive both families with privileged backgrounds as well as socially disadvantaged families.

From the very first meeting, we make it clear that our objective is to accompany the adolescents in the process of constructing their gender identity and to encourage the unfolding of their subjectivity in a context removed from gender stereotypes. Our objective with the parents is to reflect on family relations and dealing with all kinds of experiences of discrimination. Our group's framework is founded on several rules: as soon as a new transgender teenager is included, everyone introduces themselves with their new name, their age, sometimes their class, musical tastes and extracurricular activities, just as they would in any other group of teenagers. They also ask if that new person wants to be referred to as "he" or "she". Then, three fundamental rules are formulated at the outset. Firstly, *"Everything that is said in the group must remain there."* This rule of *confidentiality* is extremely important. Secondly, *"Do not judge any member of the group!"* We call this the rule of *respect*. And finally, *"Ask for the floor when you feel the need or desire to speak... And speak up as much as you can!"*. Indeed, each person is invited to formulate what they want, what they feel, and what they need to say or question so that their words resonate with the others. This is the rule of *free association*. In other words, we do not work with a selection of topics prepared in advance.

As with the adolescents, the parent group works with the same rules (*confidentiality, respect* and *free association*). When a new mother or father is included, everyone also introduces themselves with their own name and their child's. Moreover, the co-therapists comments aim to relaunch the associativity of the participants and do not consist in a direct interpretation such as in a psychoanalytic group. However, like any therapeutic framework, the group of transgender adolescents and that of their parents respond to the five criteria of Racamier (2002): 1) a fixed *place* of the institution; 2) a fixed *period of time* (in this case, 1 h with the teenagers followed by 1 h with their parents) and a *frequency* (monthly meetings); the multi-family sessions are scheduled twice or thrice a year, last 1 h and a half with everyone together; 3) a substantial *number of families* under the guidance of two co-therapists and a secretary; 4) the three fundamental *rules* we mentioned above concerning all participants; 5) and, last but not least, paying attention to *border effects*, in other words the boundaries between the inside and the outside of the group, or even those intermediate moments when the session starts or ends.

After each session, both co-therapists and secretary have a half-an-hour discussion in order to talk about the group dynamics and the therapeutic process of each patient. That work of elaboration is based not only on the topics discussed by the patients and their emotions but also on our countertransference reactions. Moreover, every 2 months, we have a supervision with a private clinical psychologist in order to go on elaborating our movements of countertransference, from the notes taken by the secretary during the sessions and from what we remember. Once again, the dynamic is based on the principle of free association. In short, we are two co-therapists and one secretary presenting the clinical material from different perspectives to a psychologist who doesn't work in our hospital but who has a significant experience of therapeutic groups.

RESULTS

During the first sessions, the most recurrent question usually concerns the hostility of the adolescent's environment, in particular the school environment and the neighborhood, or even hostility from relatives – frequently relatives outside the nuclear family. Most of the time, this phenomenon of rejection constitutes an impediment to the transition process. Nevertheless, this theme is unifying for the transgender teenagers as it allows them to temporarily set aside their differences: *"The other day, transphobes showed up in front of my school. They brought baseball bats!"*, says Jenifer. The place most often mentioned for being threatened or molested is school. David is indignant*: "In my college, the cisgenders sometimes dare to ask us what's between our legs... We would never allow ourselves to ask them such intimate questions!"*. When speaking about cisgenders, intimacy is a theme that returns regularly as does the gaze of cisgender people: *"Some 'cis-'people want to essentialize us; sometimes they try to sleep with us, just for one night, just to see, as though we were circus freaks!"*. Another unifying theme is sports, in particular the changing rooms, the swimming pool and summers at the beach: "*What if my binder shows under my T-shirt? What if I run into someone who knows my old identity. . .?*". In short, recurrent themes in the adolescent group are hostility of the adolescent's environment, intimacy and their involvement in an activist movement. Thanks to those common topics, the envelopes of the group are gradually being consolidated and the teenagers start to speak up: "*I was really scared before I came out; and I was a bit relieved afterwards; but as a matter of fact, I can only say this kind of thing here, in this group,* because I trust you guys!".

In our experience, after about one year, opinions start to differ. At the same time, there is a reinforcement of the associative capacities of the participants and their capacity for contradiction. The following is an example of participants speaking up when they disagree: *"Should one say or hide one's trans identity?"* For some, not everyone has to know: *"I don't want to be a trans boy: I just want to be a boy!"*. Moreover, there is no need to inform people they meet after the transition. For others, the announcement makes it possible to sort out the people one trusts and those one will have to get rid of. There are also other differences: should one be an activist or not? Some reject the radical and sometimes caricatural style of LGBT activists: *"Only sectarian people expose themselves during the Gay Pride march. . . It hurts the cause! I won't participate this year!"*. Others consider Gay Pride as ". . .*the only day of the year when we are not afraid, because we feel surrounded by our 'new family'!*".

Very often, transgender adolescents temporarily become the teachers of their own parents. The latter have not only subjective knowledge that inhabits their bodies, but also information gathered from social networks and blogs by transgender teens. The collective discourse is based on a lexical field of neologisms that they have to transmit to their parents. Transgender adolescents are also better informed than the vast majority of health professionals about the multidisciplinary care that should be considered in the context of their transition. What about their parents, once they are gathered in a group?

Whereas the tone of the adolescent group is most often one of humor, laughter and self-mockery, even when discussing painful situations, the parent group is less in harmony: while some trivialize their family situation, others evoke their anxieties. They sometimes burst into tears, something that has yet to happen in the adolescent group.

No parent is at the same stage. The most refractory ones have left the group after a few sessions while others have stayed until today. The range of parental positions is quite broad. Some support their child unconditionally: *"I've been behind my daughter since I realized that her transition was vital for her."*; "*I've done everything I can to speed up the process of changing civil status*", says Billie's mother before adding that *"The first testosterone injection was a happy moment shared with family and friends."* Tatiana's mother: *"In France, it takes years to undergo surgery. And so, I'm accompanying my daughter abroad for her 18th birthday. I can't wait for the surgery so that her "dysphoria" can be alleviated!"* Other parents will object to any form of transition: *"I won't use her new name! My daughter will always remain a girl!"* Between these two extremes, all intermediaries are possible.

Concerns about their child's body are recurrent: what are the post-operative side effects? How does one assess the risk of failure? *"What if he wants to reverse the operation?"* Reassignment surgeries transform from one day to the next and are irreversible. Hormone therapies, whose results appear gradually, generate equally perceptible anxiety: *"Do we have enough insight into the undesirable effects of puberty blockers or hormones on the bones?"*

Further away from the soma, the topic of "mourning the child as imagined by his parents" comes up frequently, and often with the same stages: *"First, she cut her hair. Then her birth name disappeared from the family record book. Then* he *started testosterone, and soon it will be a mastectomy. I thought I had mourned my daughter. But now, since he doesn't want to preserve his eggs, I'm at a loss. I will never be a grandmother!"*, says Michael's mother before she breaks down in tears. Michael's mom has been a single parent since her son was 3 years old. She is doing her best but sometimes loses self-assurance. In order to comfort her, Daniel's father answers: *"You might be right… However, at least, you won't lose your son. Mine was on his fourth suicide attempt. Since he became a man, he has been living again!"*. Supporting the transition of one's child can significantly reduce the risk of suicide (Toomey and Syvertsen, 2018).

Another recurring question for the parents of the group concerns their own personal experience since their children's coming-out: *"For me, the news was like an atomic bomb; but in the end, it was nothing compared to our fear of suicide attempts."* Another father: *"Christopher didn't like dresses. I thought she would become homosexual, but not transgender. And by the way, I didn't even know what it was at the time!"*.

For Steve's mother – who is a single parent for her adopted child – the detonator was her encounter with a mother and her transgender daughter in the waiting room that made the difference: *"The kid looked happy and fulfilled. I found out by chance that she was transgender, despite her totally ordinary appearance,"* she recalls. *"Then I talked about trans identity with her mother, a gentle woman who was more advanced than I was, and it soothed me. It changed my mind, and I started supporting my son, especially against bullying!"*. Indeed, Steve's mother had to go to the high school several times before coming to an agreement with the director for a "social transition" (for her son to be called by his boy's name and to be treated as a boy). However, the school doctor decided that this would not be possible and made an announcement to all the teachers and students of the establishment reminding them that Steve was *"born a girl,"* had lied, and should henceforth be called by his female name. This situation inevitably led to Steve suddenly dropping out from school. Steve never returned to that high school again.

After about a year, the exchanges between the parents have ended up becoming more decentralized: recently, trans identity issues have given way to problems classically found in adolescence: *"If my daughter is looking for her place so much, it's because she is going through some classic teenage rebellion!"*. After a while though, people do zoom out and are able to see the whole picture.

When the transgender teens and their parents meet for a multi-family session, nobody cuts anybody off. The parents generally have an attentive attitude and some of them are impressed and moved to watch their own child inside of a consolidated group made up of other transgender teenagers. The co-therapists try to promote therapeutic outcomes in case of psychological suffering or difficulties in family relationships by inviting the members of the group to talk about anything that comes to their mind, *"even if it's not easy"*: *"My mother and I have been rejected from her family in Marseille. She is a lesbian and I'm trans… but we don't really care because they are all mafiosos over-there!* (laughs). *In the beginning, my mom' and I disagreed a lot… but now we've moved from Marseille to Paris, and we are just fine!"* Paradoxically, it's often easier to talk about difficult issues during a multi-family group because the participants who are witnessing the verbal exchanges also constitute a very solid support (Rabain, 2018).

But why and how do multi-family sessions make it possible to discuss the challenges encountered by transgender adolescents and their parents regarding their social adaptation? How do they promote therapeutic outcomes in case of psychological suffering or difficulties in family relationships? How do they sometimes even prevent the disruption of family relations?

DISCUSSION

Movements of Transference and Countertransference

The multi-family group modifies the transference movements by dispersing the projections on different members of the group. Gathering several families with co-therapists and a secretary generates "multiple transfers". This particular transference dynamic allows the participants to avoid the negative effects of a massive dual transference. More specifically, the psychoanalytic multi-family setting generates transference elements that can be categorized in three ways. The transference can first be "radial" 1), that is, directed to the co-therapists. Then, the transference can be "horizontal" 2) when targeting other members of the group. That type of transference reinforces along the sessions thanks to the resonance effects between participants facing common issues. Some crossed identifications which consist in investing other parents of the group can be very helpful for some teenagers whose parents have narcissistic weaknesses. Indeed, multi-family groups consolidate identity and reinforce narcissistic stability. In other words, the identification games promoted by this setting supports adolescents as well as their parents when they have narcissistic weaknesses. And finally, the transference can aim the group "as a total object" 3) (Rabain and Bourvis, 2016, 320).

According to J. García Badaracco: "*The participation of a patient in a* [psychoanalytic multi-family] *group* […] *increases the work of elaboration. This work pushes the members of the family to relax their defenses.*" (2000, 66, personal translation). Whereas the transference issues are qualified as "multiple" – or "diffracted," according to the translation – the countertransference movements in such a setting are "protean" as far as the co-therapists identify with both adolescents and their parents. Another reason why our supervision sessions have been really helpful.

Promoting Mental Health

Our innovative mental health care approach made it possible for both the adolescents and their parents to break out of a certain form of isolation. In the adolescents' group, regardless of the singularity of their experiences, everyone, without exception, has experienced transphobia, being rejected and ostracized, which is very common (Simons and Schrager, 2013, 791). During the first year of the discussion group, manifestations of respect and attentiveness to other group members brings to mind the phenomenon of "group illusion" as defined by Anzieu (1991), (362–363): non-conflictuality and a feeling of self-sufficiency coexist, as though all necessary models were to be found through the diversity of material supplied by the participants. As the group envelope was formed, a boundary between a good interior and a hostile exterior materialized. The cleavage between good and bad was therefore not within the group, but between the group and the exterior (Anzieu, 1975; Anzieu, 1985).

The gaze of cisgender people can sometimes be experienced as rejecting and scornful, or even curious, in a voyeuristic way (Bufnoir, 2016). To be included in a discussion group which gathers transgender adolescents is therefore a way to reinforce one's own narcissism. It also promotes mental health by informing the members of the group of the different possibilities of attention they can receive either in the hospital or in a number of associations: transgender associations such as OUTrans[1], associations against transphobia, LGBTIQA+ associations, etc.

In the same way, the parents also question very important themes such as suicide and survival of their child. For example, a recurring and difficult issue for the parents of the group is the "mourning of the child they had dreamed of" (Lebovici and Stoléru, 1983; Lebovici, 1998). Being together, trying to elaborate together helps not only with treating their own anxiety but also makes it possible to better position themselves in front of their child, which is essential for supporting them (Menvielle and Rodan, 2011). From a psychiatric standpoint, there is a recrudescence of signs of anxiety and depression among transgender teenagers. For these reasons, our groups can be considered as a preventative approach, although they are not limited to prevention.

Prevention of Mental Disorders

The anxiety and depression found in transgender teenagers are linked to specific aspects of their environment (Bernard and Wathelet, 2019, 111–123). Risk factors include bullying at school or in the neighborhood and the transphobia of family members. Indeed, gender-related stigmatization increases the risk of developing a depressive syndrome fivefold compared to the general adolescent population (Kaltiala-Heino and Bergman, 2018, 31–41). Hence the importance of providing medical and psychological support to transgender minors and their parents.

Among the teenagers of our Sexual Identity Consultation, approximately 70% have anxiety issues, and more particularly an "anxiety-depressive disorder" according to the annual statistical report on the activities of our Adolescent Psychiatry Department (2019). There are also phobic reactions, in particular school phobia which is very common among transgender adolescents, leading to subjects totally dropping out of school. This phenomenon is more frequent with this group compared to the general population of our Department: the dropout rate is 38%. Faced with this data, we are discussing the possibility of a new study, with the help of other Adolescent Psychiatry Departments, in order to compare the rate of anxiety-depressive syndrome in subjects who have benefited from our mental health care approach against a control group of subjects who have not received any group support.

As soon as the group envelopes were strong enough, the first movements of differentiation could finally appear: some of them want to be considered as transgender teenagers whereas other ones just want to be considered as a boy or as a girl; that is, if one is to live happily, one must live in hiding. While other members argued that to defend themselves effectively, it was necessary to be firm. In the same way, where some were horrified by the Pride march, others said that they adored Gay Pride.

While the community environment and social networks offer a wide variety of identificatory figures to transgender teenagers, the adolescent group reinforces the identification game *in situ*. In addition to fighting against a tendency towards deadly isolation, the sessions allow for identifications and counter-identifications with binary or non-binary participants, which revive their psychic associativity. Thus, the "gender-fluid generation" – referring to the new generation of adolescents and adults in which some people feel that they are neither quite man nor quite woman – remains undeniably more flexible than the previous one, especially with regard to gender identity and the question of sexual orientation. In this group, almost every participant was involved in a romantic relationship from the beginning. However, no one would talk about it spontaneously. No one knew who was with a boy or a girl; with a cisgender or a transgender partner. After one year, the teenagers became less evasive and started to talk about their love affair. In other words, this group approach reinforces the ability to associate and redeploy libido onto objects of substitution (Rabain, 2017; Rabain, 2018). Another main goal of this group is « *to strengthen the personality – process of subjectivation – and to promote a better emotional stability with a greater capacity to face and endure traumatic events* ». (García Badaracco, 2000, (235, personal translation).

Prevention of Disruptions of Family Relations

At first, the parents' group was characterized by an initial distrust. Some of them thought that we were trying to convince their child to go through the transition. However, the sessions quickly led to better cooperation. While a certain ambivalence was evident during the first sessions, it progressively faded away in favor of a more secure space for discussion. The parents did not remain focused on issues limited to trans identity: they finally zoomed out, probably thanks to our support group, among other things. It is essential to work with parents for the sake of their child because the position of the parents has an obvious influence on the transition path of transgender teenagers. Helping parents to articulate their own point of view and move away from a monolithic and often normative stereotypical view of transgender issues

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[1] www.outrans.org.

constitutes a significant benefit for their child (Menvielle and Rodnan, 2011; Simons and Schrager, 2013). Working through parental fears and taking into account the principle of reality – for example, by not denying the many risks faced by trans people – leads them to be better able to protect their child. This preliminary work leads to an increased mutual understanding during multi-family gatherings.

Another important point: there is a logical time lag between the experience of the transgender adolescents and that of their parents. At the moment when teenagers are about to come out, they have been usually been working on it for a long time. However, by the time they finally say it, they are likely to expect their parents to react immediately. For instance, when they come out as a transgender teen, most of them already know that they want to get hormones. They have already decided to make this request since the idea has generally been there for a couple of years. Parents, on the other hand, have often not thought about such things before. They therefore cannot take a position as quickly as their child would for like them to. In this situation, the welcoming of new participants by the veteran ones can be really helpful. Beyond the mutual narcissistic revalorization generated by this activity, it would seem that the veteran parents in the group identify in the new members the distress they once experienced and, as a result, how far they have come since then. In return, the new participants have more identificatory models to rely on. This valuable relief reduces tensions within the family and helps to prevent the disruption of family relations.

Moreover, in these intergenerational multi-family groups, the narration of the parents' point of view invites every adolescent to take an interest in their own family values and encourages the emergence or reinforcement of their own capacity for speaking up. This gives new energy to the process of subjectivation, which requires an unavoidable "clash of arms" between adolescents and their parents (Winnicott, 1971, 200). Let us make it clear here that this "confrontation between generations" (Kancyper, 2018) is a necessary although not sufficient condition for subjectivation. Indeed, any conflict, however painful it may be, does not always lead to fruitful changes. Our group approach to mental health increases the chances that confrontation between adolescents and their parents may reinforce the process of subjectivation.

CONCLUSION

In this article, we discussed why we have to take care of adolescents who question their gender identity with their parents in a multi-family-oriented approach. We also question how to support their parents, who are often destabilized at the sight of a pubertal process different from the one they experienced at the same age. The group generated a dynamic that allowed its members to put their questions into perspective in the face of the experiences of other families. This resulted in a new impetus and the readjustment of certain positions hostile to transgender people.

According to the French *Trans identity Observatory*[2], there are more attacks against transgender women than transgender men. These usually involve serious assaults and crimes, which is particularly stressful for parents. Anxiety is often aroused by the inability to think about and talk about these questions of trans identity. In our approach, one of our main goals consists in co-constructing a whole panel of representations and signifiers that the transgender teens and their parents will be able to use to build their own representations. In other words, all roads leading to a greater number of representations will constitute a victory against the progression and permanent installation of mental health disorders.

In the future, why not add the brief intervention of transgender associations? They would likely be a great help in the work of putting into words what people feel before, during and after the transition process. Talking with transgender adults who are doing well and who are the authors of their own lives could eventually result in a significant aid for the project of destigmatizing trans identity.

DATA AVAILABILITY STATEMENT

The original contributions presented in the study are included in the article/Supplementary Material, further inquiries can be directed to the corresponding author.

ETHICS STATEMENT

Ethical review and approval was not required for the study on human participants in accordance with the local legislation and institutional requirements. Written informed consent to participate in this study was provided by the participants' legal guardian/next of kin.

AUTHOR CONTRIBUTIONS

The author confirms being the sole contributor of this work and has approved it for publication.

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ORIGINAL RESEARCH
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Patients and Parents' Experience of Multi-Family Therapy for Anorexia Nervosa: A Pilot Study

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Background: Family therapy is considered as the gold standard in treatment of adolescents with anorexia nervosa (AN). Among the different types of family therapy, multi-family therapy (MFT) is increasingly used for treating AN, and shows promising results. In this article, our focus relied on the patients' and their parents' perceptions of the effectiveness and the underlying mechanisms of the MFT. Methods: The present pilot exploratory qualitative study included two focus groups conducted using a semi-structured approach: one with the adolescents ($n = 3$), and another with one or two of their parents ($n = 4$ mothers; $n = 2$ fathers). The subjects discussed were the changes observed in both AN symptoms and family interactions following therapy, and the mechanisms underlying these changes. We crossed the perspectives of the adolescents and of the parents on these two points. Results: Qualitative analysis revealed that while both adolescents and parents had difficulties relating the changes they observed in the last year to MFT, they were able to say that the group cohesion had several positive effects and that their family dynamics had improved. In the light of analysis the adolescents perceived more improvements related eating disorders symptoms than their parents did, while parents were concerned about a negative effect of MFT on their children. Discussion: While both patients and parents perceived improvements in both AN symptoms and family interactions in the past year, it was not clear if they considered MFT to have led to these improvements. FG also explored the MFT mechanisms underlying changes. Both adolescents and their parents stressed the beneficial effects of identification to others members of the group and shared experience to overcome social isolation. Parents also mentioned the sympathy they felt for each other. The idea that they give a central place to families in the therapy was also described by the families.

Keywords: multi-family therapy, anorexia nervosa, patients' experience, parents' experience, focus group

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INTRODUCTION

Anorexia nervosa (AN) is a psychiatric disorder affecting 0.3% of men, and 0.5 to 2.2% of women, with the highest prevalence among 15–18 year-old girls (Roux et al., 2013). AN is characterized by restriction of intake leading to significantly low body weight, persistent behavior to prevent weight gain, disturbed perception and experience of one's own body, weight and shape, and the excessive fear of gaining weight or becoming fat (American Psychiatric Association et al., 2015). The multiplicity of AN's consequences requires multidisciplinary care, amongst which family therapy is strongly recommended by practice guidelines, especially for children and adolescents (Haute Autorité de Santé, 2010).

Among the different forms of family therapy, multi-family therapy (MFT) is increasingly used in the treatment of eating disorders (ED). While literature is still scarce, results of Gelin et al. (2018)'s literature review regarding MFT efficacy in treating ED are promising: all nine studies (both prospective and retrospective) showed an improvement of ED symptoms, quality of life, self-esteem and mood for both patients and their parents. Moreover, the parents' sense of efficacy and of parenting competence were enhanced. Those studies also highlighted a strong satisfaction of the families regarding MFT and a low rate of therapy drop out. At last, frequency and duration of patients' hospitalizations were reduced than usual. Considering that around 10% of families do not adhere to single-family therapy, or even refuse this approach, MFT offers a valuable alternative (Asen, 2002; Cook-Darzens et al., 2005).

Multi-family therapy is a form of therapy that brings together several families (usually four to seven) affected by the same pathology. Initially used in the treatment of schizophrenia, MFT was initiated by Laqueur and his collaborators in the 1960's (Le Grange and Eisler, 2009). MFT focuses its therapeutic effect on the whole family system and not only on the designated patient. The entire family is therefore involved in the treatment and becomes an active agent of change (Gelin et al., 2015). In the treatment of ED, MFT is inspired by different models including psychoeducational, systemic, psychodynamic, and attachment theories (Gelin et al., 2015). The main objective of MFT is to reduce AN symptomatology, in particular by directly involving parents in the management of their child's eating behavior (Asen, 2002). MFT also aims to improve intra-family relationships and to reduce conflicts, particularly those related to eating (Le Grange and Eisler, 2009). The success of MFT mainly relies on the establishment of a group cohesion, which permits a feeling of understanding and mutual identification within the group. This process reduces families' social isolation. Asen and Scholz (2010) described the following processes underlying MFT:

- Create solidarity. This is a source of support and it creates resources for families.
- Overcome stigma and social isolation. Families come out of isolation by sharing their experiences. Sharing allows them to identify with each other and reduces loneliness.
- Stimulate new perspectives by comparing themselves to other families through their similarities, but also their differences. Questioning a family on how they manage situations can, for example, induce a new perspective on their way of seeing things.
- Learn from each other, in particular through sharing experiences, mutual support and identification with other families.
- Mutual support and feedback promotes mutual learning.
- See the others as a mirror. Identifying with other families reduce isolation.
- Positive use of group pressure. Criticism and support from other group members promotes change.
- Discover and build on their skills, in particular by helping members of other families, but also by opening their feelings up to the group.
- Sharing and exchanging with several host families promotes learning by analogy and mutual support.
- Increase hope, in particular by bringing in families who have previously participated in a MFT and by planning for the future.
- Intensifying interactions and experiences makes it possible to understand some behaviors, but also to increase the possibility of comparing and identifying with others.
- Develop new behaviors in a safe space. The secure space of the MFT sometimes allows patients to experiment with new behaviors.
- Strengthen introspection through mutual learning, solidarity and the exercises suggested during MFT. These will facilitate the expression of participants' emotions and will allow them to better observe and analyze them.

In England, the Maudsley Hospital team assessed the experiences of six families involved in a 4-day MFT group and identified the processes of change that takes place in MFT (Voriadaki et al., 2015). In addition to rating scales and filling a daily journal, they set up focus groups (FG). Adolescents and their parents took part in separate FG. Both adolescents' and parents' FG highlighted that sharing similar experiences and mutual identifications was a key aspect in fostering changes. The adolescents' FG showed that the presence of others specifically helped generate new perspectives. The parents' FG highlighted a reduction of their feelings of isolation and powerlessness following the MFT. Both adolescents' and parents' FG also showed that role-playing increased empathy, motivation and mobilization of family resources. Finally, participants identified the benefits of expressing emotions within their family. FG highlighted the presence of different processes identified by Asen and Scholz (2010) such as learning and mutual support, the creation of solidarity and the development of an external perspective of reflection. Offord et al. (2006) also conducted a qualitative study that explored AN patients' experiences of their treatment's. They interviewed seven young adults treated for AN using semi-structured interviews. The analysis of their speeches has allowed the emergence of four main themes: (i) "Removal from normality versus connecting with the outside world," (ii) "Treated as another anorexic versus a unique individual in distress," (iii) "Control and collaboration," and (iv) "The importance of peer relationships." The Interpretative Phenomenological Analysis revealed a strong sense of isolation during hospitalizations, a feeling of powerless and of being view simply as another anorexic. Some aspects of the treatment were therefore perceived as aggravating factors by the participants.

In this article are presented the results of two pilot focus-groups aiming to explore the experience of families focusing on the changes following a new 10-session MFT program in addition to the global therapeutic program, and the mechanisms underlying these changes according to these families. This ongoing study is an ancillary study of a multicenter randomized controlled trial comparing MFT to single-family therapy in adolescents with AN (Carrot et al., 2019).

MATERIALS AND METHODS

Design

The present exploratory qualitative study included two focus groups. FG are a data collection procedure regrouping individuals around a predefined subject to focus on it (Kitzinger et al., 2004). Rarely used in clinical psychology, this procedure is yet an effective means of collecting participant's personal opinions. FG usually brings together a dozen people for about an hour and a half around a pre-defined theme (Onwuegbuzie et al., 2009). Participants share common characteristics which allow them to form a homogeneous group. This homogeneity helps them sharing life experiences and feelings (Krueger and Casey, 2014). In addition, the interviewer's non-directive conduct allows participants to develop and co-construct their ideas (Kalampalikis, 2004). FG can help completing quantitative data, which does not give access to in-depth and complete information and does not allow this co-construction of ideas. The communication space given by FG allows participants to build and structure an idea together and discuss around a theme.

Participants

Participants were recruited from a larger RCT study (for a detailed protocol of the THERAFAMBEST study; see Carrot et al., 2019). In this study we used purposive sampling as we focused on one particular subgroup of the THERAFAMBEST study. Indeed, all participants attended the same MFT group. All four families who participated in the group were proposed to participate to the study. Two fathers refused to participate due to professional reasons. The parents of one adolescent did not give their consent for her to participate in the study. All three patients recruited (two girls and a boy) were aged 14 to 19 years and treated in outpatient care or hospitalized for AN in one of the four THERAFAMBEST study sites (Maison des Adolescents, Cochin Hospital, Paris, France). All four families were intact.

Treatment

THERAFAMBEST's MFT combines elements of the integrative model practiced by Cook-Darzens (2007) and elements of the Maudsley approach (Eisler, 2005). Four main themes are addressed in the program: (i) understanding and managing AN, (ii) family relations and family identity, (iii) overcoming social isolation, (iv) values, beliefs, and perceptions.

While some of the objectives are naturally achieved by the structure and dynamics of the group, other objectives are encouraged by specific interventions and therapeutic strategies and techniques. Tools used in sessions are based on several concepts and practices: cognitive behavioral approaches (psychoeducation, learning by analogy), medical family therapy (adaptation to processes of illness), psychodynamics (differentiation process through identification with other families), and systemic group approach and family therapy.

Multi-family therapy comprises 10 sessions over a year. Each session lasts three hours and involves initially five to seven families including the patients, their parents and non-systematically their siblings (but sometimes some family drop). Siblings attend to all sessions but three focus on parenting competences to cope with ED symptoms. The staff includes two lead co-therapists and several assistants (their number will depend on the size of the group). Assistants help families during the activities, providing further explanations and/or support if needed.

Procedure and Materials

This study was approved by the French National Agency for Health and Medical Drugs (ANSM) and by the local Independent Ethics Committee ("Comité de Protection des Personnes" – Ile de France III; CPP: 2016-A00818-43). Information about the present study and the goals of the FG was verbally explained at the last session of the MFT group. The recruitment of FG is still undergoing as the saturation point is not yet reached. The data gathered were confidential and identifying information have been anonymized.

Focus Groups

Multi-family therapy is a group experience so we choose to use FG to explore interaction and group dimension. In order to cross the perspectives of parents and adolescents, two FG discussions were conducted: one with the adolescents (FG-A) and one with their parents (FG-P). This choice was made in order to encourage the participants' free expression. Furthermore, a previous study showed that parents and adolescents may have different opinions on MFT (Voriadaki et al., 2015). The FG were carried out the same day one month after the end of the last MFT session by four women. RZ and NR are university lecturers in charge of the present ancillary study. LM is a researcher (PhD in psychology) in charge of the THERAFAMBEST participants' evaluations, and therefore met with the participants beforehand. VB is a master student in psychology doing an internship on the THERAFAMBEST study. During the last MFT session, NR was the one proposing to the families to participate to the focus group. Both focus groups took place in the Institut Mutualiste Montsouris' psychiatric unit and not in the patients' usual hospital.

The aim of the FG was to identify the various changes perceived as a result of the treatment, but also the factors that lead to these changes according to the families. During the FG, the moderators asked questions in line with the interview guide presented in **Table 1**. The interview guide was informed by a rigorous review of the literature on AN, which identified themes and sub-themes related to changes and factor of changes. The highlighting of these themes and sub themes were expected during the FG. Each discussion lasted approximately an hour and a half. In order to analyze their content, they were audio-recorded and transcribed with the participants' consent but it was not sent back to the participants to check or make corrections of the content. Thanks to the recording, an exact transcription of the

TABLE 1 | Grid interview.

Changes	
AN symptoms	- Did you observe any change in the AN symptoms following the MFT? - Following the MFT, did you observe any change in your child's concerns about his/her weight/your concerns about your weight?* - Following the MFT, did you observe any change in your child's concerns about food/your concerns about food?* - Following the MFT, did you observe any change in your child's concerns about his/her body shape/your concerns about your body shape?* - Following the MFT, did you notice any change in your child's food rituals (such as sorting or cutting food in small pieces, or taking with small bites for examples)/your food rituals (such as sorting or cutting food in small pieces, or taking with small bites for examples)?* - Following the MFT, did you notice any change in your child's hyperactivity/your hyperactivity?*
Family interactions	- Did you observe any change in your family relationships following the MFT? - Following the MFT, did you notice any change in the quality of the interactions within your family?* - Following the MFT, did your family do more fun activities?* - Following the MFT, did emotions were more shared within your family?* - In your opinion, has the MFT changed your family's vision of the future?* - Following the MFT, did you observe any change in the way you behave with your child during meals/in the way your parents behave with you during meals?* - In your opinion, did MFT promote or improve your feelings of parental competence?* - Following the MFT, did you notice any change in your children relationship/in your relation with your brothers and/or sisters?*
Agents of change	
Group cohesion	- In your opinion, what allowed the changes we just discussed? - In your opinion, does the group dimension of the MFT could have facilitated changes we previously discussed?* - In your opinion, did the MFT allow mutual understanding and empathy within the group?*
Therapeutic alliance	- Will you consider that you had a trustful relationship with the therapists? - In your opinion, did the relation with the therapists allowed any changes we discussed?

**These additional questions were asked if the adolescents or their parents did not discuss these topics by themselves.*

participants' discourse was made, which also justifies the absence of note-taking during the FG.

Data Analysis

The two FG's audiotapes were anonymously transcribed, and a thematic interpretation, which is an inductive analytic approach, was chosen to explore their content. This analysis strategy was designed to understand the complex system of meanings attached to a unique and subjective phenomenon. A standardized procedure guarantees the methodology rigor (Vaismoradi et al., 2013). First, each interview was read and the main themes were double-blind coded by two pairs of authors (RZ and LM; SJS and NR). Then, most frequent themes were identified and discussed by the four authors. In this study, we respected the criteria of scientific rigor established by the qualitative analysis (Fossey et al., 2002).

RESULTS

Participants

Demographic and clinical characteristics of the patients included in the FG-A are presented in **Table 2**. FG-A included 2 girls and 1 boy aged 14 to 19 years old. While duration of the disease was similar between the three adolescents (2 to 3 years), age of first symptoms differed (12 to 16 years). When the MFT began, the two females were hospitalized and one male was treated in outpatient care. After the MFT, they all were outpatients. All patients' BMI increased during MFT and only one of the girls has been hospitalized twice. The FG-P included six parents: four mothers, including one of an adolescent who did participate to the MFT but not to the FG, and two fathers.

Major Themes Found in Both of the FG-A and -P

Difficulty Linking Patients' Evolutions and MFT

Both parents and adolescents could not establish a clear link between the changes they observed during the past year and the MFT.

> *Mother 1: "MFT is one of many factors that have contributed to an evolution, but we are unable to say in which proportion it contributed. I think it has not been useless but I will be unable to tell you how useful it has been for me."*

Being in a Group Has Several Positive Effects

Both parents and adolescents argued that the group was a source of support and hope, as they could exchange with people living similar difficulties. Discussions within the group highlighted resources of each participant. It also broke isolation and reduced the parents' feeling of guilt.

TABLE 2 | Demographic and clinical characteristics of the adolescents included in the FG-A.

	Adolescent 1 (A1)	**Adolescent 2 (A2)**	**Adolescent 3 (A3)**
Gender	Female	Female	Male
Age	16	14	19
Duration of AN (years)	2	2	3
Number of past hospitalizations (total duration in weeks)	3 (35)	3 (13)	5 (57)
Care before MFT	Inpatient	Inpatient	Outpatient
Care after MFT	Outpatient	Outpatient	Outpatient
Number of hospitalizations during MFT (total duration in weeks)	0	2 (40)	0
Body Mass Index (BMI) before MFT	19.23	14.81	19.84
BMI after MFT	20.83	16.43	20.28

> *Father 1: "Overall, we come out of it more positive; I found the group effect to encourage us to be more optimistic. That is pretty good. So, it gives a bit of hope. Each time, after a session of this family therapy, I was more positive than when I went there."*
> *Adolescent 2: "Seeing other people who were in the same situation as I was, it helped me. It helped me to talk with them."*

The presence of the siblings was more controversial between the two groups. Adolescents perceived it as beneficial for their siblings while parents though that could have censored their children's participation in the discussions.

> *Adolescent 3 (talking about his sibling): "I mainly noticed that during therapy's sessions, they spoke to me more freely, and they identified themselves a lot with others. It was cool. Not necessarily in terms of how they behaved afterwards, but during the sessions they were involved".*
> *Mother 2 (talking about sibling's support groups): "As they are amongst sibling, they can complain about their sick sister or brother. Because, it is not easy, they do not dare to do it in front of us, in front of other parents. Even less in front of their brother or sister. Well, I am saying that but I do not know what they told you."*

It should be noted that all participants mentioned the fact that they knew each other prior the MFT (patients met during previous hospitalizations and parents in a parents' group) was probably facilitating the group cohesion.

MFT Improved the Family Dynamics

Participants noted an improvement in communication within the family as they understand each other better. They also mentioned a better understanding of the disease by the parents.

> *Mother 3: "I also felt very strongly that I was very touched by what the other adolescents could say. As a result, it helped me detach myself and I felt things that might have annoyed me if it came from my child, I would not have understood. I understood better through the words of another young person."*
> *Adolescent 1: "I guess that when I was sick they used to be extremely careful talking to me, now they say things freely."*
> *Adolescent 1: "I understood that it must be hell to have a child who does not eat anymore."*

Criticism of the Disparity in the Stages of the Disease Among the Patients

Parents and adolescents argued that the heterogeneity of the group in terms of stages of the disease was a limitation for two mean reasons: (i) it involves different needs and priorities for the families and (ii) it is challenging for the patients as it might leads to comparison.

> *Mother 1: "We are not at the same stage, thus we do not all have the same priorities"*
> *Adolescent 1: "At one point, when I was finally getting out of it, and there was a therapy session, and there were other people who said they wanted to stop eating carbohydrate, I felt bad. [. . .] Finally, I got out of it, and I think that it made it stronger, because there were comments like that. But it hurt me a little bit at the time to see people who were not at the same stage as I was."*

Frustration That Family Issues Could Not Be Discussed in the Group

Parents and adolescents expressed frustration regarding their families' specific issues that could not be address within the group in a satisfying depth. They wished they could address more personal issues in a uni-familial therapy.

> *Father 1: "The family has never been put in the center, and it is normal. We are not going to expose all our problems in the group. But, there is a point where we have to address these issues."*
> *Adolescent 1: "Sometimes it was a bit frustrating because we could start to speak about an issue that we wanted to talk through, or we really wanted to get into more family centered issues. But as we were in a group and we were not there to talk about ourselves, well, we cut it short."*

Major Themes Specific to the FG-A

Improvements Over the Last Year

Adolescents mentioned the improvements they observed over the past year in terms of ED symptoms: decreased preoccupation about weight, decreased guilt about eating, decreased compulsive eating, decreased perfectionism, and openness to other concerns than ED-related ones (notably seduction and romantic relationships). At last, concerning hyperactivity, adolescents noted a variable evolution: sometimes it improves, and sometimes there is a resurgence of symptoms. They also reported being more self-confident and an improvement in their mood.

> *Adolescent 1: "Now I am able to focus on something other than weight, sport, and food."*
> *Adolescent 1: "A year ago I was shy. In the eyes of others I had to be perfect, I controlled everything I said, I could not cross any line, now I do not care. I can party, I can dance, I can let loose with my friends, there is no more problem. Even with people I do not know."*
> *Adolescent 2: "I feel much better, I am less sad, I cry less, I see life in a less negative way. In the last year, there have been many changes."*

Changes in the Family Emotional Tone

Adolescents specifically mentioned changes in emotional expression and tone within their families: they reported more affection and humor.

> *Adolescent 1: "With my sister we laugh all the time, we have regained the complicity we had before, that is nice."*
> *Adolescent 3: "We are more affectionate. But not only in the words, well, in the words too. We have never been the type of people to say things to each other."*
> *Improvement of their parents' well-being*

Adolescents observed improvement in their parents' well-being during the last year.

> *Adolescent 1: "My mother, she has not really changed her behavior except that she is more relaxed, she is not scared all the time anymore. [. . .] My father is also more relaxed. He thinks about other things than me. They are no longer just the parents of a sick child."*

Major Themes Specific to the FG-P

Parents' Concerns About the Short-Term Deleterious Effect of MFT on Their Children

Parents expressed concerns about a possible short-term deleterious effect of the topics discussed in MFT on both their children suffering from AN and the siblings.

> *Mother 2: "However, I know that my daughter sometimes came out of the session worse than when she came in. In fact, it could have been a bit of a drag. Us parents, we were happy to come, but for them it was harder."*
> *Mother 2: "It was violent for the little ones, at least for the younger ones. I wish my youngest daughter had not been there."*
> *Difficulties coming to therapy encountered by the parents.*

Parents mentioned the burden of the investment required for the medical care of their children and their difficulties in reconciling work and attending MFT.

> *Mother 1: "I was thinking: "We are going to spend another half day in MFT". We have busy jobs. You cannot imagine how many half-days we had to free to go to medical appointments and therapies' sessions here and there. It is hard to manage, we still have a job to do, and we have to get paid at the end of the month".*

Difficulties to Cope With the Topics Discussed in Therapy

Parents talked about their own difficulties in coping with the topics discussed in therapy, in parallel to those their children might have encountered.

> *Mother 3: "We are fine. In fact, I think we are holding up. But, maybe they had fewer defenses to cope with what they heard in there. And even for us, eh, it was upsetting."*

Comparison of MFT With Single-Family Therapy

Parents compared MFT to single-family therapy. According to them, MFT would allow a better adherence of ones being reluctant to single-family therapy. While single-family therapy would allow for more cohesion within the family. Parents concluded that these two kinds of family therapies are complementary.

> *Mother 4: "I think that if there had been single-family therapy, I think that it would not have worked, it would have been too hard to be face-to-face."*
> *Mother 3: "For the single-family therapy we had to drag the children, they did not want to go. But, each time, it created something strong and we were quite united for two or three hours. It did not do that after MFT. Each time we would say "well, let's do something afterwards," but each time everyone went about their business. MFT has not the same effects afterwards."*
> *Mother 3: "I think it takes both, in fact. We need spaces like this one where we actually highlight the resources we have. The disease has an effect on the family and our family and other families are the same; families are actually hurt by the disease. And then, sometimes, we also need other spaces where we can talk about what is difficult in a particular family. Because it might not be the same thing in our family and in another one, because I do not think that there is a typical anorexic child's family."*

DISCUSSION

The objective of this research was to explore the experience of families following a 10-session MFT included a global treatment program for AN. Specifically, changes observed by families in both AN symptoms and family interactions following therapy, and the mechanisms underlying these changes were discussed in FG, were screened. Underlying mechanisms did not appear in the discussion because participants failed to rely improvements they observed and MFT therapeutic processes, except group cohesion. On the other hand, changes in symptomatology and in family dynamics were discussed. Finally, MFT-related issues appeared that was not anticipated.

Improvements in AN symptomatology did not appeared in the parents' speech, but they were pointed out by the adolescents. Patients mentioned a decrease of their food rituals and preoccupations about body shape, weight and/or meals following MFT. Decrease of body-related concerns following MFT has been described in literature (Gelin et al., 2015). Results concerning problematic physical activity are mixed, as this symptom seems to fluctuate. However, adolescents did not seem to be able to explain this variation in relation to the therapy.

Both adolescents and their parents perceived improvements in their family relationships. Adolescents stressed the increase of closeness, humor, frankness and affection between each other, while parents focused on the increase of communication within the family. Furthermore, both parents and adolescents reported an improvement of their interactions during meal, which can be a challenging moment for families with AN adolescent. This is in accordance with Scholz et al. (2005)'s results that showed a decrease in conflicts and tension within families following MFT. Furthermore, this result is also important because the MFT in the THERAFAMBEST project was conceived with the aim, among others, of offering an eating-focused care to assist parents in their mission to feed their child (Carrot et al., 2019). Finally, families reported an increase of hope for the future following the MFT. This result thus confirms the idea that the increase in hope is promoted by the intervention of families in MFT (Asen and Scholz, 2010).

The positive effects provided by the group emerged from both focus groups. As it has been stressed by Voriadaki et al. (2015), the group cohesion is a key agent of change in MFT. Our results are in line with Asen and Scholz (2010)'s assumption that group cohesion is made possible by mutual identification, feelings of understanding and empathy (Asen and Scholz, 2010). Both adolescents of the present study and their parents stressed the beneficial effects of identification to others members of the group and shared experience to overcome social isolation. Parents also mentioned the sympathy they felt for each other. Parents of this MFT group were indeed very close: they frequently communicated and seen each other outside of the MFT group. During the FG, they shared their desire to stay in touch in the future. However, all participants mentioned some frustration associated to the fact that MFT is not focusing on one particular family's issues. To give a central place to the notion of family in the therapy has been stressed as primordial in MFT (Cook-Darzens, 2007). It might be useful to orient them to single-family therapy in order to address issues that cannot be addressed in MFT. The two kinds of family therapy (single- versus multi-) could prove to have complementary effects. The results of Eisler et al. (2016)'s study indeed showed that the addition of MFT and single-family therapy allows for faster improvements (in terms of weight, presence of menstruation and absence of bulimic symptoms) than single-family therapy alone.

Various issues that were not anticipated emerged from the interviews. On the positive side, the improvement in the parents' psychological state was described by the adolescents. This is an interesting finding because we know that adolescents can feel guilty about making family members suffer because of their illness, which is very pervasive (Voriadaki et al., 2015). On the negative side, parents insisted on the difficulty of reconciling the families' agendas to get to the therapy sessions. They also mentioned their own difficulties to cope with content of certain sessions and their concerns about its effect on their children (both patients and siblings). Finally, adolescents and parents felt that the heterogeneity in the progress of the disease reinforced comparisons between patients rather than strengthened the group cohesion.

This pilot study completes the evaluation of THERAFAMBEST study (Carrot et al., 2019) by collecting the participants' subjective experiences of MFT. This qualitative evaluation allow identifying both the benefits and the factors of improvement related to MFT perceived by the families. The qualitative method is complementary to the quantitative analysis as it allows assessing participants' feelings and experiences (Aubin-Auger et al., 2008). Thus, qualitative methods promote a better understanding of lived experience or social phenomena. The different types of qualitative methodology (phenomenological, case study or grounded theory, etc.) involve data analysis and are intended to be just as rigorous as the quantitative method. A similar assessment will be carried out for single-family therapy to allow a comparison of the families' experiences of these two forms of therapy.

This pilot study has several limitations. First, as it is an ongoing study, the size of the sample is limited. Furthermore, the fact that two of the three adolescents showed significant improvements before the beginning of the MFT might not be representative of the families attending to MFT. The recruitment of FG will continue until the saturation point will be reached.

CONCLUSION

While this group was not representative of the AN population as a whole, these FG gave some indications about the experience of families in MFT. The group cohesion appears to be a key agent of change in MFT according to the families. The therapy seems to have consolidated adolescents' progress that occurred before its beginning. Analysis of a more diverse sample of families might highlight different kind of benefits allowed by MFT in accordance with the family's needs.

DATA AVAILABILITY STATEMENT

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by this study was approved by the French National Agency for Health and Medical Drugs (ANSM) and by the local Independent Ethics Committee ("Comité de Protection des Personnes" – Ile de France III; CPP: 2016-A00818-43). Written informed consent to participate in this study was provided by the participants' legal guardian/next of kin.

AUTHOR CONTRIBUTIONS

NR designed the ancillary focus group study in collaboration with VB, RZ, SJ-S, and LM. BC is the principal investigator of the THERAFAMBEST study. NG is the scientific director of the THERAFAMBEST study and co-investigator. LM is a co-investigator of the THERAFAMBEST study. All authors read and approved the final manuscript. VB and RZ contributed equally as first authors and LM and NR contributed equally at the latest authors. All authors contributed to the article and approved the submitted version.

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The Legal Vulnerability Model for Same-Sex Parent Families: A Mixed Methods Systematic Review and Theoretical Integration

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Globally, parents and children in same-sex parent families are impacted by many laws related to the parental sexual orientation. These laws vary considerably from one country to another, ranging from full legal recognition to criminalization. The psychological consequences of living in an ambiguous or hostile legal climate likely interfere with parental health, family functioning, and child development. However, a systematic evidence synthesis of the pertinent literature and its placement within a broader psychological model are currently lacking. The aims of this review were thus (1) to systematically review qualitative and quantitative evidence on the impact of sexual orientation laws on same-sex parent families in key domains and (2) to place these findings within a broader model informed by minority stress and family theories. Our review was preregistered and conducted in line with PRISMA guidelines. We searched for qualitative, quantitative, and mixed methods studies on the impact of sexual orientation laws on target outcomes (parental health, family functioning, child outcomes) via systematic database search (PubMed, Scopus, Web of Science) and forward-backward searches. Fifty-five studies published between 1999 and 2020 were eligible for inclusion and were synthesized using a data-based convergent synthesis design. Thirteen descriptive and three overarching analytical themes were identified through thematic synthesis. Linking our findings with minority stress and family theories, we propose a novel legal vulnerability model for same-sex parent families. The model posits that legal vulnerability constitutes an increased risk for parental and child health as well as family functioning through individual and shared pathways between family members. Additionally, the model introduces counteractions that families engage in on the personal, familial, and systemic level to mitigate the impact of legal vulnerability, as well as moderators on the contextual, familial, couple, and individual level that modulate this impact. Implications for research and clinical practice are discussed.

Keywords: legal vulnerability, sexual orientation law, structural stigma, same-sex families, minority stress, sexual minorities, systematic review, same-gender families

INTRODUCTION

Legal recognition and freedom from persecution have long been recognized as pivotal to the well-being and functioning of same-sex parent families by social scientists (Herek, 2006; Patterson and Farr, 2016), professional associations (e.g., American Psychological Association, 2011, 2020a,b; Manning et al., 2014; American Medical Association, 2015), and supranational organizations alike (e.g., UNICEF, 2014; European Commission, 2020). As these position statements show, *whether* same-sex parent families should be granted equal rights is not a question in need of scientific inquiry. However, much less is known about *how* access to equal rights (or the lack thereof) impacts both parents' and children's health in these families (Moore and Stambolis-Ruhstorfer, 2013; Umberson et al., 2015), representing an important lacuna in family theory and an overlooked component in clinical practice.

This lack of formalization in studying the impact of structural factors such as laws on same-sex parent families is not surprising: Research on same-sex parent families in general has been criticized as lacking explicit theoretical frameworks and integration within the broader family psychology literature (Farr et al., 2017; van Eeden-Moorefield et al., 2018), while scientific inquiry into structural determinants of sexual minority health is a recent phenomenon in itself (e.g., Hatzenbuehler, 2010, 2016).

The purpose of this review is to address both points by (i) systematically summarizing the pertinent evidence on the impact of laws and legal recognition on the health and family functioning of same-sex parent families, (ii) placing it within existing minority stress and family theories, and (iii) outlining implications for research and practice. We do so by introducing the concept of legal vulnerability, which – as we theorize in a novel integrative model – links the impact of laws and legal recognition of same-sex parent families with individual and family-related outcomes.

The Legal Landscape for Same-Sex Parent Families

Globally, the legal landscape for sexual minorities is varied and in constant flux (Waaldijk et al., 2017; ILGA World et al., 2020): In 2020, sexual minorities could face the death penalty (11 countries) or imprisonment (57 countries) in some parts of the world, while enjoying access to civil marriage (28 countries) in others (ILGA World et al., 2020). A multitude of laws (collectively referred to as sexual orientation laws) regulate the lives of sexual minorities in many other areas as well, including protection from hate crimes or discrimination, freedom of assembly, or even blood donation (ILGA World et al., 2020).

For same-sex parent families, laws related to the recognition or criminalization of the family or its members are particularly salient[1]. The legal recognition of same-sex parent families refers to (i) the recognition of the interparental relationship through civil union or marriage, as well as (ii) the recognition of the parent-child relationship through adoption (Shapiro, 2020). Adoption laws include the right to jointly adopt a biologically unrelated child (by both parents) and the right to adopt a partner's child (i.e., second-parent adoption). The combination of marriage and adoption laws can create varied and insufficient legal ties between family members, as some countries legally recognize the interparental but not the parent-child-relationship (or vice versa), require marriage in order to adopt, or lack automatic co-parent recognition at childbirth (see e.g., ILGA-Europe, 2020; ILGA World et al., 2020).

The tangible benefits of legal ties between family members are numerous (Shapiro, 2020). A legally recognized interparental relationship is associated with important financial and material benefits and safeguards, including fiscal relief, insurance, and inheritance. A legally recognized parent-child relationship ensures the child's access to these and other important resources (e.g., alimony). Additionally, non-legal parents lack power of attorney for their child in educational and healthcare contexts, which may prevent them from signing school documents or accompanying their child to medical visits (Pawelski et al., 2006; Shapiro, 2020).

Sexual orientation laws can also serve to criminalize sexual minorities (and thus, same-sex parents), for example through the criminalization of the parental sexual orientation (most commonly by penalizing same-sex sexual behavior; ILGA World et al., 2020), or through so-called "propaganda laws." These laws penalize the "promotion" of non-traditional sexual relations toward minors, thereby constituting a source of stress and anxiety for same-sex parent families in particular (Zhabenko, 2019) and legitimizing discrimination and stigma among the public (Hylton et al., 2017).

In recent years, many countries—particularly European and North American—have seen an unprecedented shift in the legal recognition of same-sex parent families (Waaldijk, 2020) and in concurrent attitudes of the general public (Baunach, 2012; Smith et al., 2014). Still, same-sex parent families do not enjoy equal rights in most of these countries. For example, in an overview of sexual orientation legislation in 49 European countries (www.rainbow-europe.org), only two (Belgium and Malta) are listed as providing full equality in the category "Family" in 2020.

Globally, the noticeable legal progress in some parts of the world stands in stark contrast to its halt or even regress in many others. It is estimated that the majority of sexual minorities worldwide conceal their sexual orientation (Pachankis and Bränström, 2019). The number of countries where a non-heterosexual orientation is illegal (35%) currently exceeds the number of countries that recognize the interparental (same-sex marriage legal in 14%, civil union in 18%) or the parent-child relationship (joint-adoption legal in 14%, second-parent adoption in 16%; ILGA World et al., 2020).

Sexual Orientation Laws and Individual Sexual Minority Health

The detrimental impact of restrictive sexual orientation laws (e.g., constitutional marriage bans), lacking legal relationship

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[1] Importantly, sexual orientation laws also regulate the access to reproductive technologies. However, the impact of legislation on family formation in same-sex parent families is beyond the scope of this review.

recognition or protection from discrimination, and a country's overall (socio-)legal climate have been repeatedly linked to adverse physical and mental health outcomes in sexual minority youth and adults. These include reduced life satisfaction (Pachankis and Bränström, 2018), impaired physical health (Kail et al., 2015), increased general mental distress (Rostosky et al., 2009; Tatum, 2017; Hatzenbuehler et al., 2018; Raifman et al., 2018), increased psychiatric morbidities (Hatzenbuehler et al., 2009, 2010; Everett et al., 2016), and suicide attempts (Raifman et al., 2017). Studies from countries with criminalizing legislation, such as Russia (Hylton et al., 2017), Nigeria (Schwartz et al., 2015), Senegal (Poteat et al., 2011), and India (Rao and Mason, 2018; Rao et al., 2020), document the pervasive fear, stigma, and negative mental and physical health sequelae among sexual minorities due to their illegal sexual orientation. Notably, it is not only the impact of adverse legislation that has been found to be detrimental to sexual minority health, but also campaigns and hateful rhetoric surrounding them (e.g., before a referendum; Russell and Richards, 2003; Maisel and Fingerhut, 2011; Frost and Fingerhut, 2016; Flores et al., 2018).

Sexual orientation laws have also been found to target stressors specific to sexual minority populations. These stressors are collectively termed minority stress (Meyer, 2003) and pose additional sources of stress on the distal (e.g., through discrimination and prejudicial events) and proximal level (e.g., through concealment of the sexual orientation, internalized homonegativity, and expectations of and sensitivity to rejection). Specifically, sexual orientation laws and concomitant societal attitudes have been linked to discrimination, victimization and bullying (Everett et al., 2016; Hatzenbuehler et al., 2018, 2019), sexual orientation concealment (Pachankis et al., 2015; Charlton et al., 2016; Riggle et al., 2017; Pachankis and Bränström, 2018), rejection sensitivity (Pachankis et al., 2014), and internalized homonegativity (Berg et al., 2013).

Sexual Orientation Laws and Family Functioning

On the family level, lacking legal recognition of family relationships places an economic burden by the need to secure a legally binding family structure by means of wills and power of attorney (e.g., Perrin et al., 2013). Psychologically, being in a legally unrecognized family has been found to be a chronic source of stress, anxiety, and safety concerns for both parents (e.g., Park et al., 2016; Zhabenko, 2019) and children (Goldberg and Kuvalanka, 2012; Goldberg et al., 2013). Conversely, the legalization of marriage or the granting of adoption rights have been found to foster family stability and security (e.g., Surtees, 2011; Rawsthorne, 2013). The legal recognition of family relationships (or the lack of it, respectively), decreases (or induces) doubts about being a legitimate parent (e.g., Padavic and Butterfield, 2011; Bacchus, 2018), and impacts interparental (Butterfield and Padavic, 2014), parent-child (Kazyak, 2015; Gash and Raiskin, 2018; Malmquist et al., 2020), and sibling relationships (Goldberg and Allen, 2013; Malmquist et al., 2020).

Objectives

Several key areas of parent and child health and family functioning seem to be affected by the legal climate and recognition of family relationships. However, the findings outlined above are characterized by considerable heterogeneity in terms of contexts, populations, study designs, and theoretical underpinnings and lack a unifying framework.

Accordingly, our review has two goals: First, we systematically review qualitative and quantitative evidence on the impact of sexual orientation laws on same-sex parent families on the following domains: (a) parental and child health, (b) family relationships and functioning (i.e., relationship quality, conflict, parenting), and (c) child educational and cognitive outcomes.

Second, we aim at deriving an integrative model that elucidates possible pathways through which sexual orientation laws affect same-sex parent families. For this purpose, we place our findings within well-established theories and key literature pertaining to minority stress (Meyer, 2003; Hatzenbuehler, 2009; LeBlanc et al., 2015; Feinstein, 2020), family resilience (Walsh, 2016), and parenting models (Feinberg, 2003).

METHODS

Protocol, Adherence to Review Guidelines, and Eligibility Criteria

The protocol for this review was prepared according to PRISMA-P guidelines (Shamseer et al., 2015) and preregistered on May 13, 2020 (https://osf.io/efgkr/). Eligibility criteria (see **Table 1** and the study protocol), information sources, search strings, and data collection and synthesis methods were specified in advance. The review was conducted in line with PRISMA guidelines (Moher et al., 2009; see OSF-Supplement S1 for the PRISMA-checklist) and guided by the ENTREQ statement for qualitative research synthesis (Tong et al., 2012).

Information Sources and Search Strategy

We searched three electronic databases (*PubMed, Scopus, Web of Science*) through May 10, 2020 using multiple combinations of search terms based on free and controlled vocabulary (100+ individual terms, 14 sets) related to (a) sexual minorities and (b) sexual orientation laws (search strings for all databases are provided under https://osf.io/hnp8g/). The systematic literature search was conducted by the first author as part of an on-going systematic review on the impact of sexual orientation laws on sexual minorities (Siegel et al., 2019). For the purpose of this review, records retrieved by this search were filtered by the following terms in titles, abstracts, or keywords: *parent**, *mother, father, couple, child**, *offspring, adolesc**, *teen**, *youth, family, families, familial* (asterisks indicate wildcards). Notably, the review by Siegel et al. (2019) addresses the impact of sexual orientation laws on individuals (not the family unit); thus, there is no overlap between reviews.

We did not systematically search gray literature databases due to the complexity of our search string and the limited possibilities of these databases to handle complex Boolean combinations and truncations (see e.g., Gusenbauer and Haddaway, 2020). Instead, we conducted forward (*Google*

TABLE 1 | Inclusion and exclusion criteria according to population, intervention/exposure, controls, outcome, study type (PICOS).

Criterion	Inclusion	Exclusion
Publication and study type	• Peer-reviewed articles, book chapters, dissertation theses, unpublished research reports • Empirical qualitative, quantitative, or mixed methods studies • Meta-analyses if legal variation was established at the between-study level	• Books, master theses • Non-empirical works (e.g., letters to the editor, position papers, conceptual contributions) • Narrative reviews
Population	• Members of a same-sex parent family[a] (either as a parent or as a child [b])	• Planned collaborative coparenting arrangements with more than two parents • Non-heterosexual single parents by choice • Mixed samples of relatives or friends of same-sex parents • Non-heterosexual parents in mixed-sex relationships • Sexual minority youth (unless growing up in a same-sex parent family) • Same-sex couples with unclear parental status or without children
Intervention/exposure	• Operationalization (quantitative study) or discussion (qualitative study) of one or more sexual orientation laws[c] (see Siegel et al., 2019) or the legal climate for same-sex parent families	• Laws related to asylum and sexual orientation, military laws and sexual orientation, local policies (e.g., at the workplace), laws concerned with gender identity (e.g., recognition of trans parenthood), laws related to sexuality in general (e.g., sex work) • Other influences at the structural level (e.g., societal attitudes toward sexual minorities)
Controls	–	–
Outcome	• Operationalization (quantitative study) or discussion (qualitative study) of one of the following outcomes: • Mental or physical health of parents or children (including general and minority-specific health-related protective and risk factors) • Family relations and family functioning (e.g., relationship quality, interparental or parent-child conflict, parenting) • Cognitive outcomes and educational attainment (child only)	• Material/financial outcomes, even if health-related (e.g., access to health insurance) • Parenthood aspirations • Family formation

Detailed information and examples regarding specific criteria are outlined in the study protocol (https://osf.io/efgkr/). [a] *A romantic relationship between the parents at time of data collection was not an inclusion criterion (i.e., parents could have been separated at time of data collection).* [b] *No age limit (e.g., < 18 years) was set for the child generation.* [c] *Although not specified in the study protocol, this also includes studies that investigate the impact of having to use different legal means than mixed-sex parent families, e.g., second-parent adoption by the non-birth mother after the birth of a child conceived via donor insemination.*

Scholar) and backward searches of (i) studies eligible for inclusion retrieved via our database search, as well as (ii) unsystematic reviews on same-sex parenting (Biblarz and Savci, 2010; Reczek, 2020) and associated legal vulnerabilities (Kazyak and Woodell, 2016; Kazyak et al., 2018). We deemed this approach reasonable given the extensive coverage of *Google Scholar* (including thesis and other gray literature databases) as well as the comprehensiveness of our database search.

Study Selection

The first and second author piloted the eligibility screening on a random sample of 50 records and then screened another 200 randomly selected records to calculate interrater reliability. Interrater agreement was deemed sufficiently high (94%; $\kappa_{\text{Brennan-Prediger}} = 0.88$) to ensure a reliable screening of the remaining records (2,514) by one rater (see **Figure 1**). The record's full text was assessed in case of ambiguous information.

The first two authors independently carried out the fulltext assessments of eligible studies identified via database search ($k = 131$) and subsequently via forward-backward-search ($k = 31$). All discrepancies in final inclusion decisions were resolved via discussion or arbitration by the third author (see OSF-Supplement S2 for references and reasons for exclusion).

Data Extraction

We developed standardized coding materials (OSF-Supplement S3) to ensure reliable extraction of the following variables: Publication source; methodology; study name and wave (if applicable); year, country, and mode of data collection; sample size and characteristics (e.g., generation [parent, child, both], age, gender, socioeconomic status); family type; type of law; timeframe (current, retrospective, mixed) for qualitative studies; measurement points (cross-sectional, longitudinal, repeated cross-sectional) for quantitative studies; outcome information on measurement and conceptual level.

The first and second author independently coded each study and resolved discrepancies by discussion and verification with original reports. Interrater agreement was excellent ($Md_{\%} =$

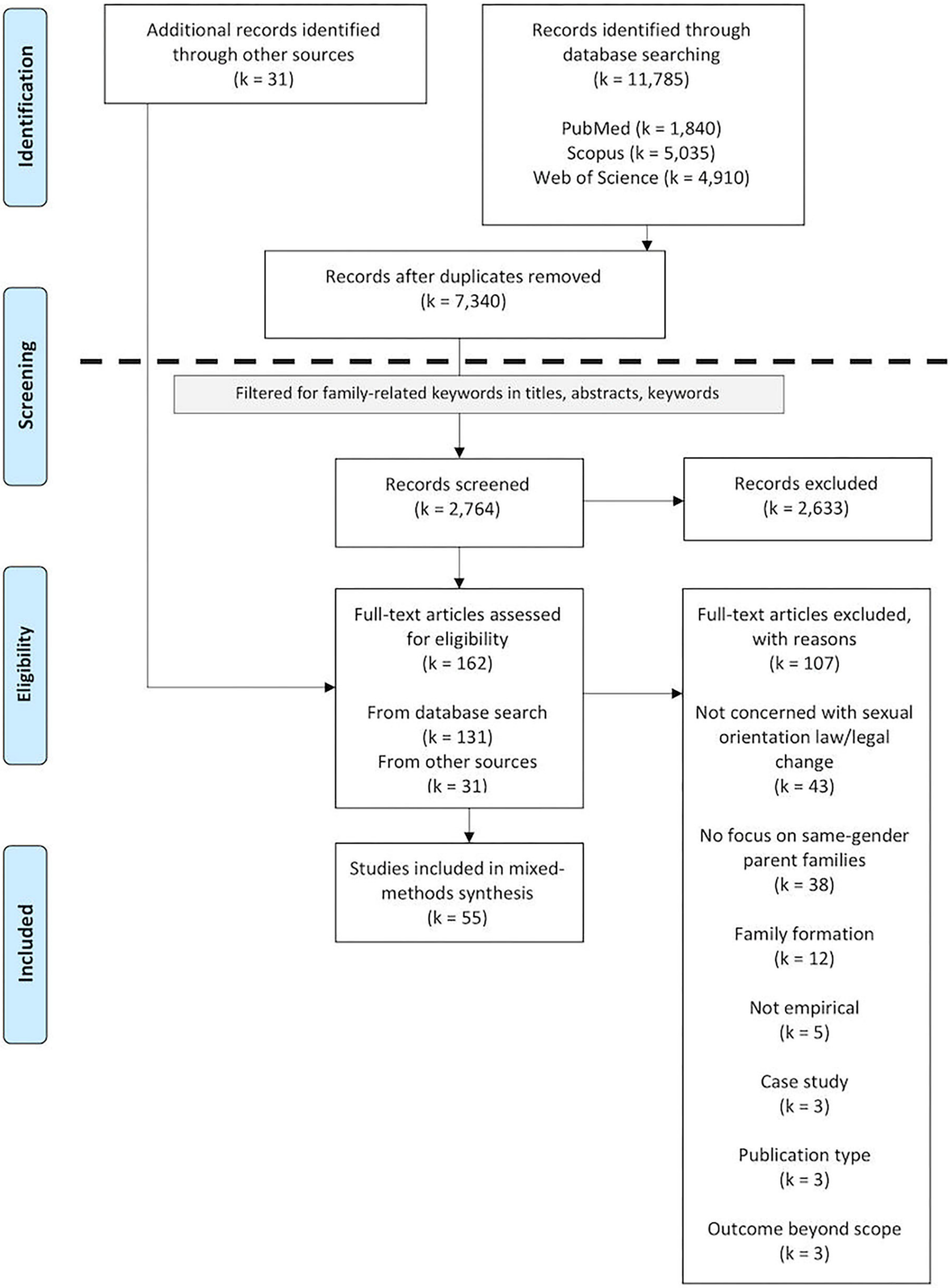

FIGURE 1 | PRISMA flow diagram of the study selection process.

97.67, $\text{range}_{\%} = 87.27\text{–}100$; Md_{κ} for categorical variables $= 0.97$, $\text{range}_{\kappa} = 0.79\text{–}1.00$).

Extraction of Effect Sizes

We extracted effect sizes on the strength of the association between either legal variation, parental legal status, or country of residence and any of our specified outcomes (i.e., parent and child health, family functioning, child educational attainment) from quantitative studies. Although not preregistered, we also extracted effect sizes on predictors of law-related health outcomes (e.g., predictors of worrying about legal status, Reeves, 2011). As expected, effect sizes were too conceptually dissimilar to be meta-analyzed but are reported for illustrative purposes. Coding information and forest plots are provided in the OSF-Supplements S4 and S5.

Synthesis of Results and Epistemological Position

Thematic Synthesis

We chose a data-based convergent design (Hong et al., 2017) to synthesize primary study results, which has been shown to be particularly suitable for generating frameworks or theories, the overall aim of our review. Here, a single synthesis method is used to synthesize results from both qualitative and quantitative studies by either "qualitizing" quantitative findings (by grouping them into themes) or "quantitizing" qualitative findings (by assigning them numerical values; Sandelowski et al., 2006; Hong et al., 2017).

Specifically, we chose to "qualitize" findings by using thematic synthesis (Thomas and Harden, 2008) based on our preliminary literature search that indicated a large share of studies using a qualitative approach. Our final sample composition (76% qualitative studies) corroborated this choice.

Thematic synthesis follows three steps, namely descriptive line-by-line coding, the generation of descriptive themes, and the generation of analytical themes that go beyond the data (Thomas and Harden, 2008). Based on the substantial number of possibly eligible studies, we employed a purposive sampling approach to derive a pilot sample of studies that served as the basis for developing an initial thematic codebook. To generate a rich set of codes, we aimed to maximize heterogeneity of included studies in this pilot sample with regard to populations, methodology, investigated laws, and outcomes. The pilot sample included the following seven studies: Boertien and Bernardi (2019), Butterfield and Padavic (2014), Goldberg et al. (2013), Hequembourg (2004), Malmquist et al. (2020), Ollen and Goldberg (2016), and Zhabenko (2019).

The first three authors independently performed inductive line-by-line coding of these studies' results sections and generated a first set of codes. During this early stage, we already placed codes within three groups (later defined as our analytical themes): (i) Codes that were concerned with the impact of laws, (ii) codes that were concerned with counteractions families engaged in to mitigate this impact, and (iii) codes that described possible moderators of this impact. For impact-related codes, we specified the valence (positive, negative, no effect). For codes relating to counteractions, we also extracted reasons not to engage in this counteraction or side-effects of this counteraction.

The resulting codebook was circulated among all researchers and iteratively refined. To facilitate integration with existing minority stress and family theories, codes were labeled in line with terminology used within these frameworks where possible.

Consequently, result sections of remaining studies were assigned codes using a deductive-inductive approach. That is, we chose to assign codes based on our initial codebook where possible but allowed for new codes to emerge. In quantitative studies, results from hypothesis tests of interest to our review were assigned codes. In qualitative studies, quotes from individual participants and study authors' interpretations or descriptions of themes were assigned codes. Including individual participants' quotes ensured the inclusion of studies not primarily concerned with the impact of laws or legal recognition or of studies that did not report higher-order themes relevant to the review.

The first author coded all studies and refined the codebook by collapsing or further differentiating codes. Due to the heterogenous sociolegal climate described in these studies, we chose to code every study at the lowest (i.e., the code) level. The refined codebook was again circulated among all researchers.

Separating the impact of sexual orientation laws from the impact of societal prejudice, general legal challenges for stepfamilies, or lacking biological ties to a child posed a challenge during coding. Arguably, the compound impact of these related (but distinct) phenomena makes a differentiation impossible for research participants themselves. We employed a conservative coding strategy and only included quotes and study authors' statements that explicitly referenced the impact of laws or (lacking) legal recognition. While this certainly resulted in a loss of codable data, it strengthens the validity of our results.

The first and second author independently coded 36% of studies according to the final codebook (OSF-Supplement S6). Remaining studies were coded by the first author and the assignment of codes was validated by the second author. Discrepancies were resolved by discussion within the research team.

After completion of coding, we developed and critically discussed broader descriptive themes. While being firmly grounded in primary study results, we assigned theme labels again in line with minority stress and family theories. Lastly, three overarching analytical themes were developed that reflected our initial grouping (i.e., impact-related themes, counteractions, moderators).

Negative Case Analysis

We conducted a negative case analysis after completion of coding (Yardley, 2015) to ensure methodological rigor. Here, researchers explicitly search for cases that contradict their theoretical prediction. Empirical evidence and theory (Meyer, 2003; Hatzenbuehler, 2016) predict a positive impact of favorable legal change and, conversely, a negative impact of lacking legal recognition or criminalizing legislation. Thus, we identified coded units concerned with a negative impact of favorable legal change or a positive impact of unfavorable legislation.

Epistemological Position

According to the classification of research synthesis by Suri (2013), we adopt a positivist approach, which is characterized by objectivity, rigorous systematization, and empiricism, to conceptualize our systematic review and to derive an overarching model. This is reflected in our preregistered protocol, our exhaustive sampling approach, and our standardized coding materials and procedures. Although our predominantly qualitative evidence base would allow for a more interpretative approach (e.g., Eaves, 2001), we see our model as guiding primarily quantitative, inherently positivist, study designs.

RESULTS

Study Characteristics

In all, the present review comprises 55 studies (49 unique samples). **Tables 2**, **3** report summary statistics of main study characteristics. Individual study characteristics are reported in OSF-Supplements S7 and S8. Included studies were published in peer-reviewed journal articles ($k = 49$), book chapters ($k = 3$), dissertations ($k = 2$), and in a research report ($k = 1$). Forty-two studies used a qualitative design, eight a quantitative, and five a mixed-methods design. Years of

TABLE 2 | Study characteristics related to sociodemographics; overall and stratified by investigated generation.

Variable	Overall ($k = 55$)	Parent ($k = 47$)	Child ($k = 6$)	Both generations ($k = 2$)
Family type				
Mixed (planned and stepfamilies)	28	22	5	1
Planned	17	16	1	–
Stepfamilies	1	1	–	–
Not reported/unclear	9	8	–	1
***N*^{a}**				
Overall (*M;* Range)	1,958,088 (39,961; 6–1,952,490)	4,470 (106; 6–732)	1,952,839 (390,568; 8–1,952,490)	779 (390; 37–742)
Excl. controls (*M;* range)	13,195 (269; 6–7,792)	4,275 (102, 6–732)	8,141 (1,628; 8–7,792)	779 (390; 37 – 742)
***N*^{a} (without Boertien and Bernardi, 2019)**				
Overall (*M*, range)	5,598 (117, 6–742)	4,470 (106, 6–732)	349 (87, 8–153)	779 (390, 37–742)
Excl. controls (*M;* range)	5,403 (113; 6–742)	4,275 (102, 6–732)	349 (87, 8–153)	779 (390, 37–742)
Gender				
Female	24	24	–	–
Male	1	1	–	–
Mixed	30	22	6	2
Parent education				
Predominantly^b well-educated	22	21	–	1
Not predominantly well-educated	3	3	–	
Unclear/not reported	24	23	–	1
Parent ethnicity				
Predominantly^b white/European American/Caucasian	29	27	–	2
Not predominantly White/European American/Caucasian	4	4	–	
Unclear/not reported	16	16	–	–
Child age group				
Children (0–18)	2	–	2	–
Adults (18+ years)	2	–	1	1
Mixed	4	–	3	1

Cell entries indicate number of studies (excepting rows reporting sample sizes). ^{a}Based on unique samples (k = 49). In case of studies reporting subsamples of other included studies (e.g., Goldberg and Allen, 2013, reports on a subsample of Goldberg and Kuvalanka, 2012) full sample size was used in sample size calculations. In case of studies reporting on participants with and without children (e.g., Rostosky et al., 2016), sample size for participants with children (i.e., parents) was used for sample size calculation. ^{b} > 75% or described as such by primary study authors (for education: 75% of sample at least some college education). Parent education and ethnicity not coded for studies investigating the child generation.

TABLE 3 | Study characteristics regarding investigated laws and timeframe.

Variable	Overall ($k = 55$)
Law type	
General legal situation for same-sex parent families	24
Adoption (general and second-parent)	12
Marriage and civil union	9
Country of data collection (proxy)	3
Marriage and civil union; anti-discrimination laws[a]	1
Adoption (general and second-parent); Anti-discrimination laws	1
Composite score of legal climate	1
Criminalization	1
Anti-discrimination laws	1
Other[b]	2
Timeframe (qualitative studies/qualitative part of mixed methods study)	
Current	21
Retrospective	11
Mixed	14
Study design (quantitative studies/quantitative part of mixed methods study)	
Cross-sectional	9
Longitudinal	1
Repeated cross-sectional	1

[a] Sensitivity analysis. [b] Same-sex marriage ban (Rostosky et al., 2010); legal status per parent (Reeves, 2011). k = 46 for qualitative timeframe because qualitative part of Kosciw and Diaz (2008) not coded. k = 11 for quantitative study design because quantitative part from Stambolis-Ruhstorfer and Descoutures (2020) and Chamberlain et al. (2015) not coded.

data collection (if reported) ranged from 1995 to 2018 ($Md = 2012$).

Almost two thirds of studies were conducted in the US ($k = 35$), 11 in one or more European countries (Belgium, Bulgaria, Croatia, Czech Republic, France, Hungary, Italy, Poland, Slovakia, Slovenia, Spain, Sweden, UK), four in Australia and New Zealand, and one in Canada and Russia each. Three studies reported cross-country comparisons between the US and the Netherlands (Bos et al., 2008), the US and Canada (Shapiro et al., 2009), and Canada and France (Vyncke and Julien, 2007). In line with our protocol, we included these studies because of their explicit reference to the (socio-)legal climate as a possible cause of the investigated group differences. However, we caution against interpreting findings from these studies as direct evidence of the impact of legislation, as they lack an explicit operationalization.

Thematic Synthesis

Descriptive Code Statistics

Our final database comprised 633 coded units of data ($M = 11.51$, $SD = 9.67$, range = 1–50 per study). Taking into account multiple assignments of codes in one study, this amounted to 458 individual codes ($M = 8.33$, $SD = 5.7$, range = 1–22 per study). Thirty-five coded units stemmed from quantitative studies, from which we extracted 68 effect sizes (see OSF-Supplements S4 and S5 for numerical results and forest plots).

We identified 50 codes that we grouped into 13 descriptive themes and three analytical themes (see **Table 4** for code frequencies and OSF-Supplement S9 for a correlation matrix). Detailed code descriptions and citation examples can be found in the OSF-Supplement S10. The most frequent codes (code and theme labels italicized) across studies were *Legal-Financial Security* (coded in 47% of studies), *(Frustration with) Discrimination and Unequal Treatment* (45%), and *Legal Documents and Paper Trails* and *Reaction of Others* (40% each). Six codes were only coded in one study each (2%): *Acquiescence*, *Creation of Emotional Dependency*, *Creation of Financial Dependency*, *Emotion Regulation (Self)* (all Butterfield and Padavic, 2014), *Relationship with Wider Social Network* (Vyncke and Julien, 2007), and *School Progress* (Boertien and Bernardi, 2019).

Descriptive and Analytical Themes

See OSF-Supplement S10 for detailed descriptions of codes and themes. The essence of our thematic synthesis is summarized below.

The analytical theme *Impact* (376 coded units) incorporates themes related to the impact of sexual orientation laws, most often those that regulate the legal recognition of family relationships. These themes relate to the impact on aspects of family life and relationships (e.g., division of parenting tasks, feelings of parental and family legitimacy, family relationships; descriptive theme *Family*), predictors and outcomes related to the health and well-being of family members (*Health, Well-Being, and Security; Minority Stress; Safety Concerns*), and child educational outcomes (*Education*). This analytical theme also incorporates the perception of no impact of legislation on any area of life or the insufficient or even detrimental consequences of (positive) legal change (*General*). It should be noted that only in two qualitative studies (Ollen and Goldberg, 2016; Malmquist et al., 2020), participants expressed that lacking legal recognition did not impact any area of their or their family members' life (see also **Table 4**). In both cases, the coded units from these studies referred to children.

The analytical theme *Moderator* (122 coded units) describes how some families or family members are impacted more than others due to contextual (*Contextual Factors*), familial (*Family Characteristics*), couple-level (*Couple Characteristics*), and individual factors (*Individual Differences*).

The analytical theme *Counteraction* (135 coded units) is concerned with the numerous counteractions on the personal (*Within Person*), familial (*Within Family*), and systemic (*Within System*) level that same-sex parent families engage in to alleviate the impact of sexual orientation laws on their relationships, their financial and legal security, and their health and well-being.

Negative Case Analysis

We identified eleven coded units from nine studies (3% of impact statements) in our negative case analysis (see OSF-Supplement S11). These include losing financial benefits due

TABLE 4 | Frequencies of assigned codes across studies as well as corresponding descriptive and analytical themes and model pathways.

Number	Code	Descriptive theme	Analytical theme	n (%)	$\%_{\text{no effect}}$	Model pathway
I-E-1	School progress	Education	Impact	1 (1.82)	100	F.9
I-F-1	Division of labor (parenting tasks)	Family	Impact	9 (16.36)	18.18	F.3
I-F-2	Family legitimacy and cohesion	Family	Impact	21 (38.18)	6.45	F.1
I-F-3	Interparental relationship	Family	Impact	9 (16.36)	33.33	P.6/F.2
I-F-4	Parent-child relationship	Family	Impact	14 (25.45)	26.09	F.7
I-F-5	Parental legitimacy	Family	Impact	17 (30.91)	12	F.6
I-F-6	Relationship with family of origin	Family	Impact	7 (12.73)	22.22	P.2
I-F-7	Relationship with wider social network	Family	Impact	1 (1.82)	100	P.2
I-F-8	Sibling relationship	Family	Impact	2 (3.64)	33.33	F.8
I-G-1	False panacea	General	Impact	13 (23.64)		P.1/P.5
I-G-2	No impact	General	Impact	2 (3.64)	100	–
I-H-1	Health and well-being	Health, well-being, and security	Impact	14 (25.45)	24	P.2/F.9
I-H-2	Hypervigilance	Health, well-being, and security	Impact	7 (12.73)	0	P.2
I-H-3	Legal-financial security	Health, well-being, and security	Impact	26 (47.27)	0	P.2
I-H-4	Perceived powerlessness	Health, well-being, and security	Impact	5 (9.09)	0	P.2
I-M-1	(Frustration with) discrimination and unequal treatment	Minority stress	Impact	25 (45.45)	10.64	P.1/P.5
I-M-2	(Legal) rejection sensitivity	Minority stress	Impact	15 (27.27)	0	P.1/P.5
I-M-3	Sexual orientation concealment	Minority stress	Impact	10 (18.18)	16.67	P.1/P.5
I-S-1	Backlash	Safety concerns	Impact	2 (3.64)	0	P.2
I-S-2	Constant concerns	Safety concerns	Impact	10 (18.18)	0	P.2
I-S-3	Family cohesion	Safety concerns	Impact	18 (32.73)	3.03	P.2
I-S-4	Health and well-being	Safety concerns	Impact	16 (29.09)	11.11	P.2
I-S-5	Legal-financial	Safety concerns	Impact	11 (20)	0	P.2
I-S-6	Physical symptoms	Safety concerns	Impact	2 (3.64)	0	P.2
C-F-1	Acquiescence	Within family	Counteraction	1 (1.82)		C.2
C-F-2	Creation of emotional dependency	Within family	Counteraction	1 (1.82)		C.2
C-F-3	Creation of financial dependency	Within family	Counteraction	1 (1.82)		C.2
C-F-4	Creation of legal dependency	Within family	Counteraction	17 (30.91)		C.2
C-F-5	Emotion regulation (others)	Within family	Counteraction	4 (7.27)		C.2
C-F-6	Parenting practices	Within family	Counteraction	2 (3.64)		C.2
C-P-1	Emotion regulation (self)	Within person	Counteraction	1 (1.82)		C.1
C-P-2	Information seeking	Within person	Counteraction	5 (9.09)		C.1
C-P-3	Overcoming heteronormativity	Within person	Counteraction	5 (9.09)		C.1
C-S-1	Activation of community accountability	Within system	Counteraction	7 (12.73)		C.3
C-S-2	Activism	Within system	Counteraction	8 (14.55)		C.3
C-S-3	Concealment	Within system	Counteraction	5 (9.09)		C.3
C-S-4	Legal documents and paper trails	Within system	Counteraction	22 (40)		C.3
C-S-5	Opposing/ignoring legal limitations	Within system	Counteraction	5 (9.09)		C.3
C-S-6	Relocation	Within system	Counteraction	8 (14.55)		C.3
C-S-7	Symbolism	Within system	Counteraction	17 (30.91)		C.3
M-CF-1	Anecdotal evidence and role models	Contextual factors	Moderator	7 (12.73)		M.1

(Continued)

TABLE 4 | Continued

Number	Code	Descriptive theme	Analytical theme	n (%)	$\%_{\text{no effect}}$	Model pathway
M-CF-2	Reaction of others	Contextual factors	Moderator	22 (40)		M.1
M-CF-3	Saliency of legal recognition	Contextual factors	Moderator	18 (32.73)		M.1
M-CC-1	Couple gender	Couple characteristics	Moderator	4 (7.27)		M.3
M-CC-2	Socioeconomic status	Couple characteristics	Moderator	11 (20)		M.3
M-F-1	Family member	Family characteristics	Moderator	9 (16.36)		M.2
M-F-2	Family type	Family characteristics	Moderator	6 (10.91)		M.2
M-I-1	Child characteristics	Individual differences	Moderator	5 (9.09)		M.4
M-I-2	Legal awareness	Individual differences	Moderator	2 (3.64)		M.4
M-I-3	Parental characteristics	Individual differences	Moderator	8 (14.55)		M.4

n = number of studies the code occurred in, % = proportion of studies (out of 55) a code occurred in. $\%_{noeffect}$ = proportion of coded statements that indicated no effect out of all statements pertaining to this code (impact codes only; no direction coded for False Panacea). Note that codes may have been assigned more than one time in the respective primary studies.

to legal change (e.g., single parent benefits, $n = 2$), growth of resilience, pride, and an improved parent-child relationship due to legal disadvantages ($n = 2$), negative effects of increased outness due to marriage or a positive effect of total concealment ($n = 3$), marginalization of same-sex couples not wanting to marry ($n = 2$), and exacerbated custody disputes due to a formal relationship recognition ($n = 2$).

The Legal Vulnerability Model for Same-Sex Parent Families

Our thematic synthesis identified (i) pathways through which sexual orientation laws might impact key predictors and outcomes of parental and child health and family functioning, (ii) factors that may moderate this association, and (iii) counteractions that family members engage in to mitigate these effects. We now integrate these findings with existing empirical work and theories from the field of minority stress and family research (see below) and propose a conceptual, empirically testable model of legal vulnerability for same-sex parent families. Given the mostly qualitative or mixed methods evidence (85%) and the heterogeneous or insufficient operationalizations of legal status or sexual orientation laws in quantitative studies (e.g., using country of data collection as a proxy), we emphasize the hypothesis-generating nature of our model.

Our model is illustrated in **Figures 2–5**: **Figure 2** depicts our overall model from a socio-ecological perspective (Bronfenbrenner, 1986). Here, we propose that sexual orientation laws[2] create actual and perceived *legal vulnerability* (a novel concept; see section "Legal Vulnerability") in all members of the family unit (innermost circle), which impacts parental and child health and family relationships in reciprocal ways (detailed in **Figures 3**, **4**). In **Figure 5**, we illustrate the counteractions that same-sex parent families engage in to mitigate the impact of legal vulnerability on themselves or family members.

Theoretical Foundations of the Legal Vulnerability Model

The legal vulnerability model is based on minority stress and family theories, which we briefly summarize below.

Minority Stress Theory

Minority Stress Theory (Meyer, 2003) posits that sexual minorities face unique, chronic, and socially based stressors due to their societally marginalized status. These stressors account for their heightened vulnerability to experiencing adverse (mental) health outcomes (e.g., Lick et al., 2013; Plöderl and Tremblay, 2015). Located on a distal-proximal continuum, minority stressors include stressful events such as experiencing discrimination, but also behaviors and cognitions such as internalized homonegativity, expectations of rejection, or sexual orientation concealment (Meyer, 2003). Importantly, minority stress theory and its application in therapeutic practice (Pachankis, 2015) assume minority stress to affect shared pathways across disorders which are susceptible to stress.

The Psychological Mediation Framework

The Psychological Mediation Framework (Hatzenbuehler, 2009) elucidates psychological pathways through which minority stressors impact (mental) health outcomes. It posits that general psychological processes, such as emotional dysregulation (e.g., rumination, hypervigilance), social problems (e.g., isolation), and maladaptive cognitive processes and schemas (e.g., hopelessness) mediate the association between minority stressors and (mental) health.

The Rejection Sensitivity Model

The Rejection Sensitivity Model (Feinstein, 2020) complements minority stress theory and the psychological mediation framework by formalizing rejection sensitivity as a (proximal)

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[2] Sexual minorities are impacted by the legislation in their country, but also by concomitant societal attitudes (Hatzenbuehler et al., 2017). The impact of societal attitudes and compound effects of laws and attitudes (collectively referred to as "structural stigma", Hatzenbuehler and Link, 2014) are depicted in our model for the sake of completeness, but not discussed in detail.

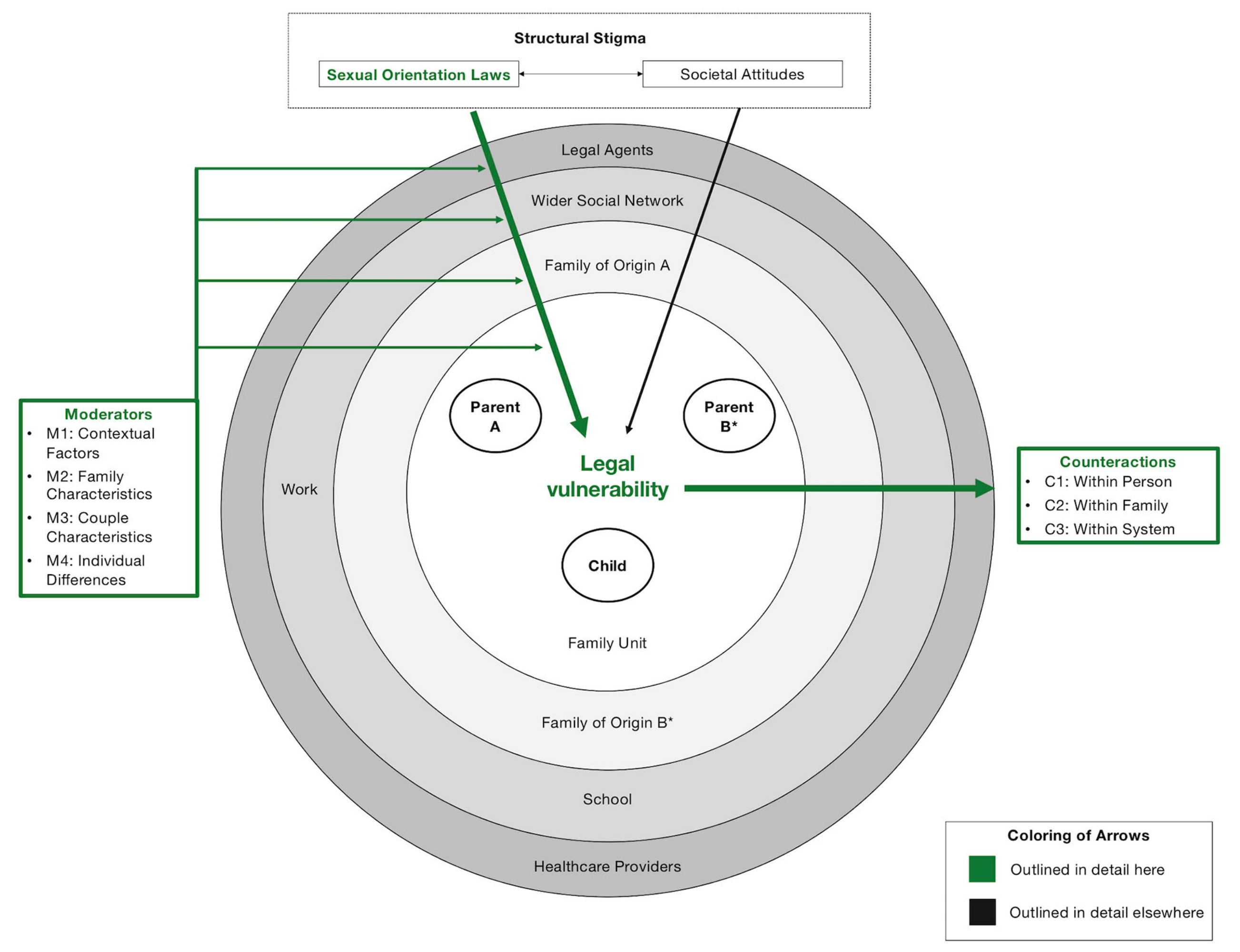

FIGURE 2 | The legal vulnerability model for same-sex parent families. Colored arrows (green) are outlined in detail here and depict empirically testable relations between constructs, not evidence strength. *Nonlegal status to (grand-)child and/or partner.

minority stressor. It is theorized to affect mental health via a combination of cognitive (i.e., expecting rejection, interpreting ambiguous situations as evidence of rejection) and affective processes (i.e., anxiety or anger about experiencing future rejection).

The Couple-Level Minority Stress Model

The Couple-Level Minority Stress Model (LeBlanc et al., 2015) extends minority stress theory by stipulating that individual minority stressors have an equivalent on the couple level. These include discrimination due to being visible as a couple (i.e., experiences of discrimination), beliefs about the relationship being less valuable (i.e., internalized homonegativity), or concealing the romantic nature of the relationship in public (i.e., sexual orientation concealment; LeBlanc et al., 2015). The model also considers dyadic minority stress processes between partners, including minority stress discrepancies, contagion, and proliferation (LeBlanc et al., 2015).

Family Systems Theory

Family Systems Theory conceptualizes the family as an organized whole, where family members (and consequently their behaviors, cognitions, and emotions) are mutually interdependent (Minuchin, 1974). Thus, from a systemic perspective, the behaviors and well-being of an individual family member can only be understood in relation to their location within the family system and its interrelations.

The Coparenting Model

The Coparenting Model (Feinberg, 2003) provides a formalization of coparenting (i.e., the cooperation, coordination, and mutual support in child rearing by parents) as a central executive subsystem of the family. It comprises four coparenting dimensions, namely joint family management, division of labor, childrearing agreement, and supporting/undermining the partner, as well as individual (e.g., parental self-efficacy), familial (e.g., the interparental relationship), and ecological predictors (e.g., financial resources) of coparenting.

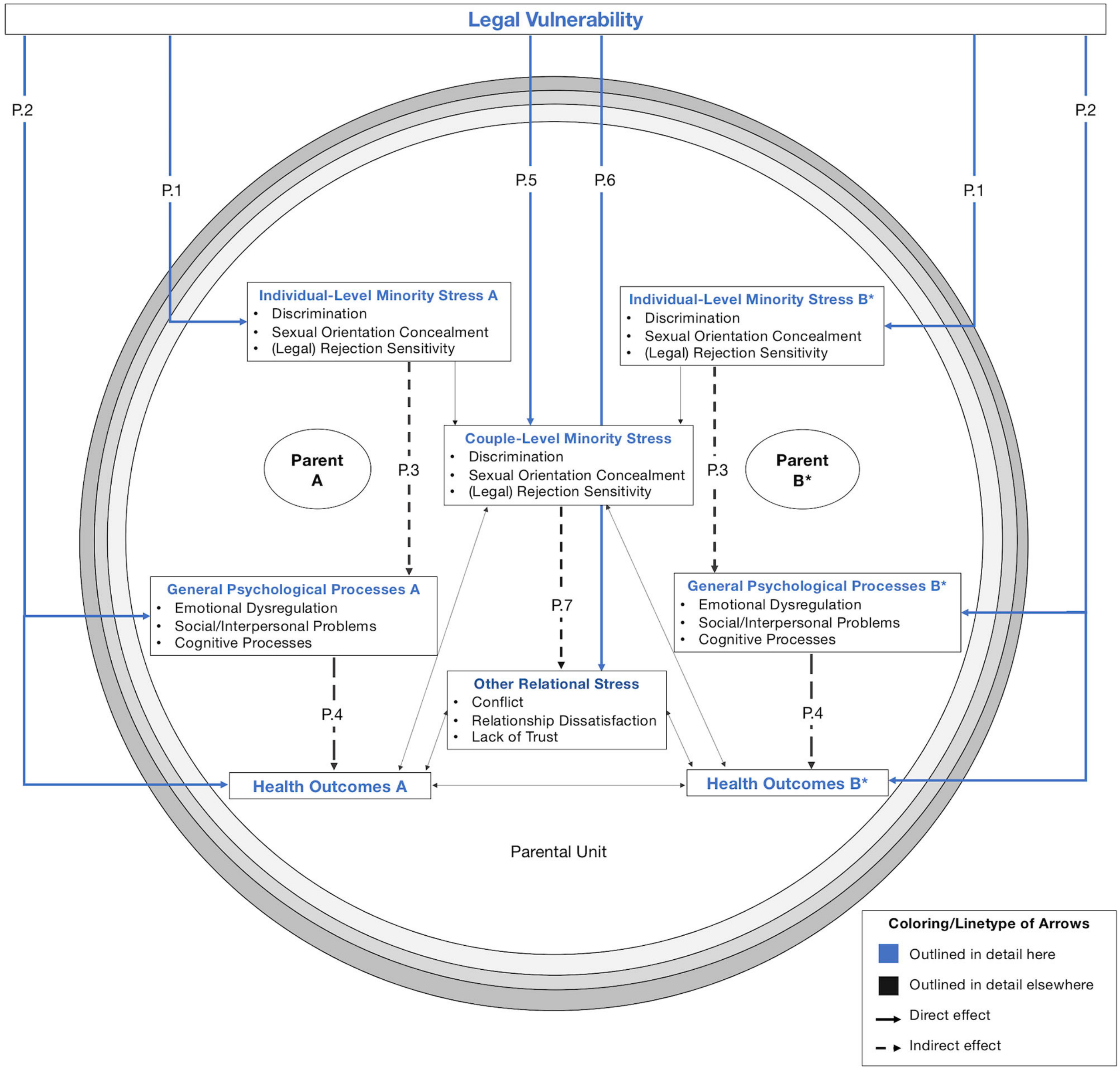

FIGURE 3 | Impact of legal vulnerability on parental health. Colored arrows (blue) are outlined in detail here and depict empirically testable relations between constructs (highlighted with colored headings), not evidence strength. Dashed lines depict indirect effects of legal vulnerability (i.e., through other constructs). Thin, unlabeled arrows (e.g., between other relational stress and health outcomes) depict interrelations between constructs outlined in detail elsewhere. Note that legal vulnerability is depicted outside the parental unit for clarity. Terminology was chosen in line with Feinstein (2020), Hatzenbuehler (2009), LeBlanc et al. (2015), and Meyer (2003). *Nonlegal status to child and/or partner.

Legal Vulnerability

Several studies in our review (e.g., Goldberg and Kuvalanka, 2012; Butterfield and Padavic, 2014; Acosta, 2017; Gash and Raiskin, 2018) used the term "legal vulnerability" to describe the precarious legal situation for same-sex parent families. However, to our knowledge, a formal definition of this concept is currently lacking.

Therefore, we offer a working definition of legal vulnerability for same-sex parent families[3]: Legal vulnerability is a heightened and stable risk for family members of expecting or experiencing adverse general and minority-specific outcomes related to

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[3] Notably, various other family forms may face legal vulnerability, including immigrant families (Brabeck et al., 2016) or stepfamilies (Cherlin, 1978), but these are outside the scope of this review.

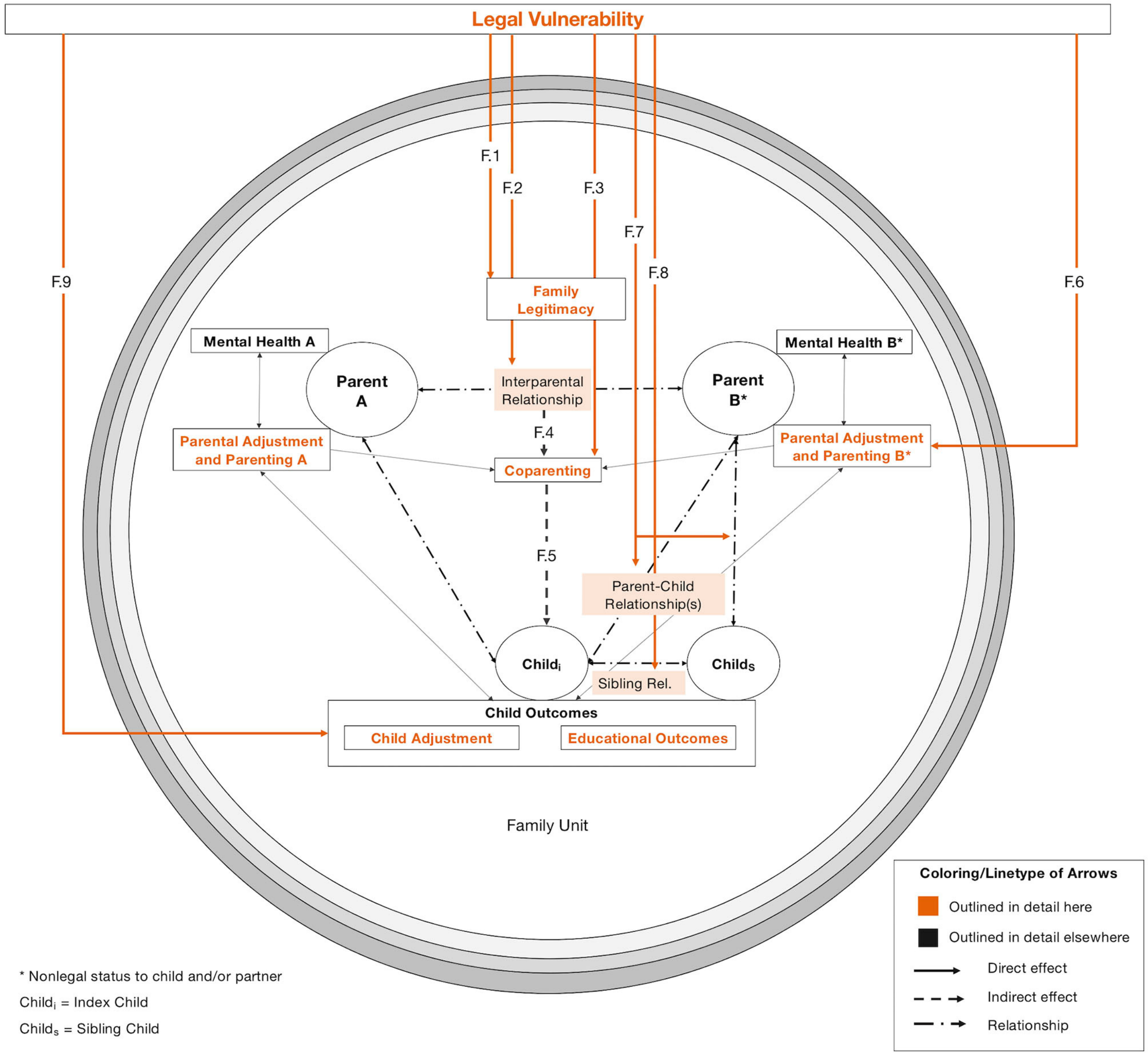

FIGURE 4 | Impact of legal vulnerability on family functioning and child outcomes. Colored arrows (orange) are outlined in detail here and depict empirically testable relations between constructs (highlighted with colored headings), not evidence strength. Dashed lines depict indirect effects of legal vulnerability (i.e., through other constructs). Thin, unlabeled arrows (e.g., between parental adjustment and coparenting) depict interrelations between constructs outlined elsewhere. Boxes colored in orange as well as dot-dashed-lines depict relationships between family members. Note that legal vulnerability is depicted outside the family unit for clarity. Terminology was chosen in line with Feinberg (2003).

health and family functioning due to the (i) lacking legal recognition of family relationships, (ii) lacking protection against discrimination, or (iii) criminalization of the parents' sexual orientation.

This working definition emphasizes four important characteristics of legal vulnerability: First, its influence on the family unit is defined as enduring and stable, rather than as instantaneous. Second, in line with family system theory (Minuchin, 1974), it emphasizes its interrelated (yet varying) effects on all members of the family, including children, and on the family system as an organized whole. Third, it is conceptualized as impacting both general and minority-specific outcomes, which results in a compound impact of legal vulnerability. Fourth, it explicitly includes the anticipation of risk or threat, thereby incorporating the role of (maladaptive) future-oriented cognitive patterns (Roepke and Seligman, 2016) and ruminative tendencies (Nolen-Hoeksema et al., 2008) for mental health. Importantly, we adopt an equifinal approach and do not systematically stratify by types of laws unless explicitly discussed.

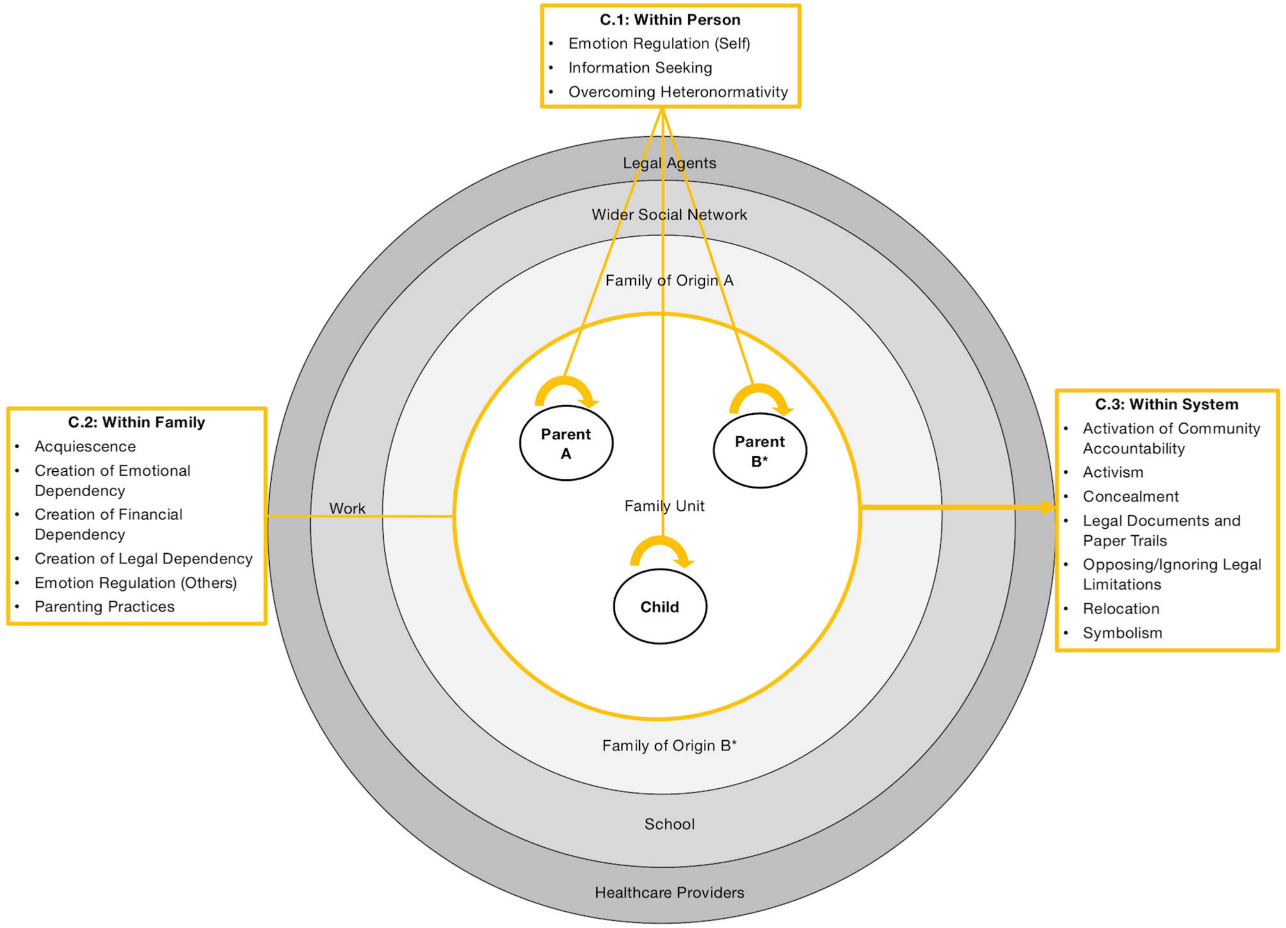

FIGURE 5 | Counteractions to alleviate the impact of legal vulnerability on the personal, familial, and systemic level. *Nonlegal status to child and/or partner.

Impact of Legal Vulnerability on Parental Health

Figure 3 depicts the impact of legal vulnerability on parental health by linking general and minority-specific processes in the creation of adverse parental health outcomes that operate through pathways on the individual (P.1, P.2, P.3, P.4) and the couple level (P.5, P.6, P.7). Individual minority stressors and general psychological processes for each parent are depicted on both sides of the model (i.e., mirroring each other). Shared processes between parents (i.e., couple-level minority stress and other relational stress) are depicted in the figure center. Health outcomes for both parents are depicted as primary outcomes in the bottom part.

Our empirical evidence base and the theoretical foundations of our model would allow for a focus on mental health. We chose to use the general term "health" for two reasons: First, physical health disparities and physical health correlates of minority stress are commonly conceptualized as sequelae of heightened (minority) stress exposure (Lick et al., 2013; Flentje et al., 2020). Second, lacking access to legally recognized parental relationships can lead to material and financial disadvantages for same-sex couples (e.g., lack of partner insurance or fiscal benefits), which are well-established health-related risk factors (Pampel et al., 2010; Phelan et al., 2010).

Pathways on the Individual Level

We propose that legal vulnerability exacerbates well-established minority stressors (e.g., discrimination, sexual orientation concealment, and rejection sensitivity; P.1) but also constitutes an independent minority stressor that impacts health-related outcomes and mediating psychological processes directly (P.2). Pathways P.3 and P.4 depict these mediational pathways (as theorized in the Psychological Mediation Framework; Hatzenbuehler, 2009) that link minority stress and (mental) health. These mechanisms are discussed in detail elsewhere (Hatzenbuehler, 2009) but included for the sake of completeness. Similarly, associations between sexual orientation laws and minority stress or mental health outcomes on the individual level (i.e., unrelated to parental status) are not the focus of this model but are hypothesized to impact parental health (as described elsewhere, e.g., Hatzenbuehler et al., 2010; Berg et al., 2013; Pachankis and Bränström, 2018).

P.1: Minority Stress. Legal vulnerability adds structural facets to well-established minority stressors such as discrimination, sexual orientation concealment, and rejection sensitivity. With regard to discrimination, evidence within our review suggests that members of same-sex parent families experience various discriminatory instances within the legal system or as a consequence of lacking legal recognition of family relationships (e.g., Kazyak, 2015; Park et al., 2016; Gash and Raiskin, 2018), as well as feelings of unequal treatment (e.g., Goldberg et al., 2013; Maxwell and Kelsey, 2014; Bacchus, 2018).

We found evidence that legal vulnerability can lead to concealment of the parents' sexual orientation or the parental role (e.g., Sobočan, 2013; Messina and D'Amore, 2018; Zhabenko, 2019), particularly so in hostile or criminalizing environments. In these instances (see our negative case analysis) concealment was sometimes preferred over the risks to personal safety associated with living authentically (Denman, 2016; Zhabenko, 2019). This adds to our understanding of the multifaceted nature of sexual orientation concealment, which can be beneficial to sexual minorities in highly stigmatizing environments (Pachankis et al., 2020). Some evidence in our review also suggests that legal vulnerability is associated with an increased selectivity in sexual orientation concealment, with same-sex parent families remaining open to their families of origin, but less so to people in the wider social network (Vyncke and Julien, 2007; Vučković Juroš, 2019b; Zhabenko, 2019). Conversely, decreased legal vulnerability (e.g., through a recognized parental relationship) may lead to increased outness and visibility as a member of a same-sex parent family (e.g., through being visible as a married couple).

Legal vulnerability also adds a structural facet to rejection sensitivity (Feinstein, 2020). Based on the evidence provided in our review, we propose that legal vulnerability is associated with rejection sensitivity toward the legal system (i.e., legal rejection sensitivity): Within our evidence base, this legal rejection sensitivity took the form of (anxiously) expecting that legal documents will not hold up in court (e.g., McClellan, 2001; Bergen et al., 2006; Goldberg et al., 2013), expectations of prejudicial treatment by actors within the legal system or the state (e.g., Goldberg et al., 2014; Gash and Raiskin, 2018; Wheeler et al., 2018; Zhabenko, 2019), distrust in the state or foreign jurisdictions recognizing the family structure (e.g., when traveling; Bergen et al., 2006; Gartrell et al., 2019), or questioning the motivation behind (e.g., Rawsthorne, 2013) or the permanency of progressive legal change (i.e., expecting a backlash; Goldberg et al., 2013; Denman, 2016).

Similar to individual rejection sensitivity (Feinstein, 2020), we propose that legal rejection sensitivity incorporates cognitive and affective components. The instances (i.e., the rejection within the legal system or its actors) outlined above are not only expected, but also anxiously anticipated. Pervasive safety concerns found within our review illustrate this anxious expectation of legal rejection that members in same-sex parent families experience due to their legal vulnerability (e.g., Shapiro et al., 2009; Rostosky et al., 2010; Goldberg et al., 2013; Kazyak, 2015; DiGregorio, 2016; Zhabenko, 2019). Conversely, strong institutional support through anti-discrimination laws and legal recognition of relationships might reduce legal rejection sensitivity, as evidence from our review suggests (Vučković Juroš, 2019b).

We did not find evidence for a link between legal vulnerability and internalized homonegativity (see Reeves, 2011, for the only and non-significant association). However, internalized homonegativity bears resemblance to feelings of decreased parental legitimacy due to lacking legal validation (e.g., Butterfield and Padavic, 2014; Malmquist, 2015; Gash and Raiskin, 2018). Specifically, negative societal messages about parenting capabilities (and rights) of same-sex parents could be internalized, which may lead to similar feelings of guilt and shame or other adverse mental health outcomes as internalized homonegativity on the individual level (Newcomb and Mustanski, 2010).

P.2: General Psychological Processes and Health Outcomes. We found evidence that legal vulnerability targets psychological processes (e.g., rumination or hypervigilance, social problems, maladaptive cognitive processes such as hopelessness) theorized to mediate the association between minority stress and (mental) health (Hatzenbuehler, 2009).

Ruminative tendencies are reflected in various and consuming safety concerns that parents experience as a consequence of their legal vulnerability. Within our review, these included concerns about the family's cohesion (e.g., Hequembourg and Farrell, 1999; McClellan, 2001; Bergen et al., 2006; Rawsthorne, 2013; Gash and Raiskin, 2018; Zhabenko, 2019), legal-financial security (e.g., Shapiro et al., 2009; Rostosky et al., 2010; Reeves, 2011), and their own or their family members' well-being (e.g., Padavic and Butterfield, 2011; Malmquist, 2015; Zhabenko, 2019).

Legal vulnerability is also associated with hypervigilance because of the non-recognized, ambiguous, or criminalized legal status of the family (members). This hypervigilance manifested itself in diverse ways within our review, for example by always having important legal documents at hand (e.g., Park et al., 2016; Gash and Raiskin, 2018; Gartrell et al., 2019; Zhabenko, 2019), being vigilant about when and where to publicly display the family structure (Vučković Juroš, 2019b; Zhabenko, 2019), or about a possible relationship dissolution that could entail loss of contact to a non-legal child (Butterfield and Padavic, 2014).

Legal vulnerability might also be associated with social support from people outside the family unit, particularly the family of origin, as evidence suggests (e.g., Hequembourg and Farrell, 1999; Hequembourg, 2004; Zamperini et al., 2016). This association was also found in other qualitative studies on the impact of marriage legislation, interestingly in all directions (i.e., increased support, continued support, continued non-acceptance; Rothblum et al., 2011; Kennedy et al., 2018; Riggle et al., 2018).

Lastly, legal vulnerability might amplify maladaptive cognitive processes such as feelings of invisibility, hope- and powerlessness. In studies within our review, these feelings were directed toward the state or legal system (e.g., Gash and Raiskin, 2018), but also toward the family unit, for example in non-legal parents with regard to parenting decisions (Butterfield and Padavic, 2014), or after a relationship dissolution (that results in a loss of contact with the legally unrecognized child, Kazyak, 2015).

The evidence found in our review also points to direct effects on parental health (but see Vyncke and Julien, 2007). Apart from the various safety concerns same-sex parent families experience, this includes feelings of stress, anger, frustration, and fear due to legally not recognized relationships or dealing with a discriminatory legal system (e.g., Ross et al., 2005; Butterfield and Padavic, 2014; Goldberg et al., 2014; Chamberlain et al., 2015; Kazyak, 2015). Conversely, we found that a positive legal shift is associated with positive emotions (e.g., relief, increased feelings of security; Short, 2007; Goldberg et al., 2013, 2014).

The economic consequences of sexual orientation legislation on the individual (Ash and Badgett, 2006) or the macro-level (Badgett et al., 2019) are beyond the scope of our review. However, we propose that legal vulnerability impacts parental health indirectly through material and financial burdens. The impact of legal vulnerability on the family's legal-financial security was indeed the most frequently assigned code in our review (found in 47% of studies). The health-related benefits of economic well-being are well-documented (Pampel et al., 2010; Phelan et al., 2010), and we propose that access to a partner's insurance, property, or inheritance via legally recognized relationships might be similarly beneficial for parental health.

Pathways on the Couple Level

We propose that legal vulnerability also impacts parental health through minority-specific (P.5) and general (P.6) psychological processes that parents experience jointly, as well as through mediating pathways linking minority stress to health outcomes (P.7). To conceptualize these effects, we draw on the couple minority stress model (LeBlanc et al., 2015).

P.5: Couple Level Minority Stress. We propose that individual minority stressors as a consequence of legal vulnerability also have an equivalent on the couple level. Specifically, these correspond to the minority stressors outlined in pathway P.1. We argue that they target parents both as individuals and as joint members of the parental unit, as the experience of them is contingent on their parental role.

P.6: General Relational Stress. In our review, we found preliminary evidence that legal vulnerability impacts general relational stress, for example due to conflicts that result out of (legal) power differentials between parents (Butterfield and Padavic, 2014). We discuss these mechanisms in section Impact of Legal Vulnerability on Family Functioning and Child Outcomes, where family relations are conceptualized as outcomes in their own right.

Of note, no study in our review directly addressed the impact of legal vulnerability on the mediating role of minority stress in impaired relationship functioning or general relational stress (P.7). We include this pathway for the sake of completeness (see LeBlanc et al., 2015; Cao et al., 2017) and to guide future research questions.

Impact of Legal Vulnerability on Family Functioning and Child Outcomes

Figure 4 illustrates how legal vulnerability impacts several interrelated areas of family functioning, including subjective and perceived family legitimacy (F.1), family relationships (F.2, F.7, F.8), coparenting (F.3), and parental (F.6) and child adjustment (F.9). Constructs pertaining to individual family members (i.e., parental mental health, parental adjustment and parenting, child adjustment and educational outcomes) are depicted in boxes next to respective family members. Constructs pertaining to all family members (i.e., family legitimacy, coparenting) are depicted in the figure center. Relationships are depicted as dot-dashed lines.

F.1: Family Legitimacy

Our review suggests that the legal recognition of the interparental or the parent-child relationship is associated with increased feelings of family legitimacy, stability, normalcy, and cohesion for all family members (Short, 2007; Porche and Purvin, 2008; Goldberg and Kuvalanka, 2012; DiGregorio, 2016; Gash and Raiskin, 2018; Malmquist et al., 2020), and also in the perception of others (e.g., Hequembourg and Farrell, 1999; Rawsthorne, 2013; Vučković Juroš, 2019b; Stambolis-Ruhstorfer and Descoutures, 2020). Conversely, lacking legal recognition has been described as being associated with feelings of diminished family legitimacy, notably only with regard to others, in studies within our review (Goldberg and Allen, 2013; Gash and Raiskin, 2018).

F.2: Interparental Relationship

We propose that legal vulnerability impacts the interparental relationship due to direct and indirect effects: First, lacking legal recognition of the interparental relationship (through marriage or civil unions) may translate into a lack of pre-defined relational roles for same-sex relationships (e.g., Zamperini et al., 2016). While we found only scant evidence for this hypothesis in our review, this notion has also been put forward with regard to relationship uncertainty and ambiguity in a shifting sociopolitical climate for sexual minorities (Monk and Ogolsky, 2019). Conversely, legal recognition was found to strengthen the interparental relationship by publicly signaling love and commitment (e.g., Taylor, 2011; Kimport, 2013). However, legal recognition of the interparental relationship was frequently not found to be necessary for a loving and committed relationship (e.g., Vyncke and Julien, 2007; Goldberg and Kuvalanka, 2012; Kimport, 2013; DiGregorio, 2016).

Second, we found evidence within our review that the consequences of an unrecognized parent-child relationship might spill over into the interparental relationship due to a legal power differential between parents (e.g., Padavic and Butterfield, 2011; Butterfield and Padavic, 2014). Coupled with an unequal division of parenting tasks due to this legal power differential (e.g., Kazyak, 2015; Malmquist, 2015; Bacchus, 2018; Zhabenko, 2019), this can result in dependency, interparental conflict, and maladaptive counteractions (Padavic and Butterfield, 2011; Butterfield and Padavic, 2014). Conversely, evidence within our review suggests that legal recognition of the parent-child relationship prevents these consequences (Malmquist, 2015). Third, individual psychological strain due to legal vulnerability in the parent-child relationship (e.g., a worrying non-legal parent) can translate into strain on the interparental relationship, as evidenced in one study within our review (Butterfield and Padavic, 2014).

F.3: Coparenting

Drawing on the coparenting model (Feinberg, 2003), we propose that legal vulnerability impacts the way parents relate to each other in their child-rearing. Most evidently in our review, legal vulnerability impacted division of (parenting) labor, when the non-legal parent was unable to take on responsibilities that required a legal guardian (e.g., signing documents, taking the child to medical appointments, e.g., Surtees, 2011; Maxwell and Kelsey, 2014; Kazyak, 2015; Malmquist, 2015; Bacchus, 2018; Zhabenko, 2019, but see Polaškova, 2007). However, we propose that legal vulnerability may also impact other coparenting dimensions either directly or through interparental conflict (F.4). Further direct effects include instances where the legal parent takes over important parenting decisions (i.e., child-rearing agreement, e.g., Padavic and Butterfield, 2011), or undermines the parental role of the non-legal parent (i.e., support/undermining).

No study in our review investigated the impact of impaired coparenting due to legal vulnerability on child outcomes directly (F.5). However, the general association between coparenting and child outcomes is a well-established finding in the family literature for both mixed-sex (Teubert and Pinquart, 2010; McHale and Lindahl, 2011) and same-sex parent families (Farr and Patterson, 2013; Farr et al., 2019).

F.6: Parental Adjustment and Parenting

Important determinants of coparenting are individual parenting behaviors and aspects of parental adjustment, such as parental self-efficacy and parental mental health (Feinberg, 2003). Based on the evidence within our review (e.g., Surtees, 2011; Rawsthorne, 2013; Malmquist, 2015; Bacchus, 2018; Gash and Raiskin, 2018), we propose that legal vulnerability might impact parental self-efficacy of the non-legal parent in particular through feelings of parental illegitimacy, and legally determined constraints to engage in parenting (e.g., being able to take parental leave; Ross et al., 2005).

F.7: Parent-Child Relationship

Within the studies included in our review, the impact of legal vulnerability on the parent-child relationship was most noticeable in the case of relationship dissolutions (Goldberg and Allen, 2013; Malmquist et al., 2020), when the non-legal parent's means to gain custody for the child are limited or inexistent. Without informal agreements between parents (Goldberg and Allen, 2013), this was reported to result in a loss of contact to the child (similarly in case of death or incapacity of the legal parent)—a pervasive fear for non-legal parents (e.g., Hequembourg and Farrell, 1999; McClellan, 2001; DiGregorio, 2016; Bacchus, 2018). As described above, this fear can permeate family relationships even before a relationship dissolution, and, in some instances, lead to increased caution on the side of the non-legal parent with regard to the relationship with the child (McClellan, 2001; Padavic and Butterfield, 2011).

Conversely, the legal validation of the parent-child relationship (e.g., through a second-parent adoption) can serve to validate the relationship between parents and children, as evidence suggests (Goldberg et al., 2013, 2014; Gash and Raiskin, 2018). The joint efforts to mitigate legal disadvantages was also reported as strengthening the parent-child relationship (Gash and Raiskin, 2018). Some evidence also suggests that the legal recognition of the interparental relationship might strengthen the parental role of the non-legal parent (particularly in stepfamilies; Goldberg and Kuvalanka, 2012).

F.8: Sibling Relationship

Similar to the impact on the parent-child-relationship, legal vulnerability can affect the sibling relationship after a parental relationship dissolution. Specifically, siblings with different legal parents might be reared apart (see Goldberg and Allen, 2013; Malmquist et al., 2020, for evidence within our review).

F.9: Child Outcomes

Children might experience stressors related to the lacking legal recognition of family relationships or the criminalization of their parents' sexual orientation. Within our review, this included feelings of reduced family legitimacy (F.1), but also experiences of discrimination (Bos et al., 2008; Goldberg and Kuvalanka, 2012; Goldberg and Allen, 2013; Goldberg et al., 2013) or concealment of their family structure (Bos et al., 2008; Goldberg and Kuvalanka, 2012; Messina and D'Amore, 2018; Zhabenko, 2019). No study in our review tested the impact of experiencing these legal vulnerability-related stressors on child health. However, evidence on the impact of general minority-related stressors in children with same-sex parents bolsters this assumption (Gartrell et al., 2005; Bos and van Balen, 2008; Koh et al., 2019). Some evidence within our review suggests that legal vulnerability (or associated structural factors) might indeed pose a risk to children's well-being and adjustment directly (Bos et al., 2008; Goldberg and Kuvalanka, 2012; Lick et al., 2012; Goldberg et al., 2013).

Only one study in our review investigated the impact of sexual orientation laws on children's educational attainment using eight waves of data from the large-scale American Community Survey (Boertien and Bernardi, 2019). This study found no evidence of an association between state-wide marriage laws (or anti-discrimination legislation) on children's school progress in same-sex parent families. This is in line with meta-analytic (Fedewa et al., 2015), representative (e.g., Rosenfeld, 2010; Potter, 2012), and non-representative (e.g., Gartrell and Bos, 2010) evidence suggesting that (when controlling for important confounders such as family transitions or socioeconomic status) parental sexual orientation is not associated with adverse academic or cognitive outcomes for children (see Boertien and Bernardi, 2019, for a detailed methodological review).

The impact of legal vulnerability on parental outcomes (see above) may have indirect ramifications for child adjustment. Specifically, a plethora of studies established that impaired parental mental health (Goodman et al., 2011; van Santvoort et al., 2015), interparental conflict (Rhoades, 2008; Van Eldik et al., 2020), negative parent-child relationships (Erel and Burman, 1995; Popov and Ilesanmi, 2015), dysfunctional parenting (McLeod et al., 2007; Yap and Jorm, 2015), low parental self-efficacy (Albanese et al., 2019), and coparenting problems (Margolin et al., 2001; Teubert and Pinquart, 2010) belong to the primary family risk factors for child development. These indirect effects of legal vulnerability on child outcomes have yet to be tested empirically as no study in our review addressed them.

While not focal to our review, we also propose that the economic and legal disadvantages of unrecognized family relationships (e.g., lack of health insurance, Gonzales and Blewett, 2013) and, conversely, increased legal and financial security of the family (e.g., Goldberg and Kuvalanka, 2012; Gartrell et al., 2019; Malmquist et al., 2020) impact children's health and well-being. This robust association between parental socioeconomic status and child health is outlined in detail elsewhere (Repetti et al., 2002; Conger et al., 2010).

Counteractions to Alleviate the Effects of Legal Vulnerability

Evidence for the delineated pathways in our model (particularly for family relationships) were not uniformly found within studies (see rightmost column of **Table 3**). This runs counter to minority stress and other stigma theories (Meyer, 2003; Hatzenbuehler, 2016). Adopting a systemic approach to family resilience (Walsh, 2016), we propose that same-sex parent families engage in counteractions (**Figure 5**) on the personal (C.1), family (C.2), and systemic level (C.3) to alleviate the impact of legal vulnerability. We do not make assumptions about the adaptivity of the counteractions presented therein. Similarly, some counteractions may serve several purposes and therefore may be placed within more than one level.

C.1: Within Person

Evidence within our review suggests that family members engage in person-centered counteractions such as emotion regulation (Butterfield and Padavic, 2014), seeking legal information (e.g., to protect their family or to regulate their emotions by looking for positive legal change in other countries; e.g., Dalton and Bielby, 2000; Short, 2007; Kazyak, 2015; Ollen and Goldberg, 2016), or questioning heteronormativity within legislation and family models (e.g., Hequembourg, 2004; Short, 2007; Rawsthorne, 2013; Zamperini et al., 2016; Vučković Juroš, 2019a).

C.2: Within Family

Family members engage in counteractions to mitigate legal vulnerability in other family members, as evidence within our review suggests. These relate to emotion regulation (e.g., parents instilling pride in their children about their family; e.g., Goldberg et al., 2013; Butterfield and Padavic, 2014; Maxwell and Kelsey, 2014; Ollen and Goldberg, 2016), emphasizing equal parenting (Goldberg and Allen, 2013; Malmquist et al., 2020), or creating legal dependency between family members (e.g., by obtaining second-parent adoption in the absence of legal partnership options; e.g., Hequembourg and Farrell, 1999; Dalton and Bielby, 2000; Acosta, 2017; Wheeler et al., 2018; Stambolis-Ruhstorfer and Descoutures, 2020).

Of note, three counteractions stem from only one study included in our pilot sample (Butterfield and Padavic, 2014). These counteractions are linked to the interparental relationship and focus on minimizing the probability of a relationship dissolution (which would entail loss of contact between the non-legal parent and the child). They entail the creation of emotional (e.g., by reducing other support systems or isolation of the partner) and financial dependency (e.g., by being the sole breadwinner), or acquiescing to the partner's wishes.

C.3: Within System

Family members engage in counteractions that are directed toward people or institutions outside the family unit. Within studies in our review, this entailed (legally) securing the family structure through obtaining wills or power of attorney (not surprisingly the most frequent counteraction; e.g., Dalton and Bielby, 2000; Bergen et al., 2006; Rostosky et al., 2016; Gash and Raiskin, 2018; Zhabenko, 2019), temporal or permanent relocation to gain legal security or recognition (e.g., Goldberg et al., 2013; Maxwell and Kelsey, 2014; Kazyak, 2015; Park et al., 2016) or safety (e.g., by seeking asylum; Zhabenko, 2019), or by concealing the family structure out of safety concerns (Zhabenko, 2019).

Evidence suggests that families also choose to ignore legal limitations (e.g., a non-legal parent acting as a legal guardian; e.g., Rawsthorne, 2013; Wheeler et al., 2018) or engage in symbolic actions such as commitment ceremonies or sharing the same last name (e.g., Bergen et al., 2006; DiGregorio, 2016; Zamperini et al., 2016; Bacchus, 2018; Wheeler et al., 2018). Families also advocate for legal change (Dalton and Bielby, 2000; Brown et al., 2009; Park et al., 2016; Gash and Raiskin, 2018; Wheeler et al., 2018), or actively engage other people in their family life (e.g., to create allyship or convey guardianship arrangements in the case of the legal parent's death; Dalton and Bielby, 2000; Butterfield and Padavic, 2014; Park et al., 2016; Gash and Raiskin, 2018).

Side-Effects and Reasons Not to Engage in Counteractions

None of the counteractions above provide the legal protection that would be automatically conferred by law and some may even have negative ramifications as our review suggests. Particularly strategies related to securing the family structure via other means were considered to be (too) costly, time-consuming, frustrating, or shameful (e.g., Rostosky et al., 2010; Denman, 2016; Bacchus, 2018; Gash and Raiskin, 2018). Other counteractions were described as inducing guilt, such as including a child in concealing the family structure (Messina and D'Amore, 2018), or creating financial or emotional dependency in a partner to prevent a relationship dissolution (Butterfield and Padavic, 2014).

Moderators

M.1: Contextual Factors

First, our review identified important actors outside the family (see **Figure 2**) who can ignore or emphasize lacking legal ties between family members. By doing so, they alleviated or exacerbated legal vulnerability, for example judges and notaries concerned with second-parent adoptions or notarizing important documents (e.g., DiGregorio, 2016; Gash and Raiskin, 2018; Zhabenko, 2019), border control agents questioning the family structure (Gash and Raiskin, 2018; Vučković Juroš, 2019b), healthcare staff or teachers in their regard of non-legal parents (e.g., Polaškova, 2007; Surtees, 2011; Goldberg and Allen, 2013; Malmquist et al., 2020), or (un-)supportive families of origin (e.g., Hequembourg and Farrell, 1999; Goldberg et al., 2013; Vučković Juroš, 2019b).

Second, anecdotal evidence from other families experiencing legal disadvantages (e.g., Surtees, 2011; Goldberg and Kuvalanka, 2012; Butterfield and Padavic, 2014; Gash and Raiskin, 2018) or, conversely, lacking role models for same-sex parents (Sobočan, 2013) were found to exacerbate or mitigate the impact of lacking legal recognition, particularly with regard to safety concerns and worries. Due to lacking norms, rituals, and language for same-sex parent families in general (see e.g., Hall and Kitson, 2000), as well as an ambiguous legal climate (DiGregorio, 2016), we propose that these families might be particularly reliant on anecdotal evidence in navigating the legal system.

Third, the impact of legal recognition fluctuates in everyday family life. Within our review, it was found to be more salient while traveling (e.g., Gash and Raiskin, 2018; Vučković Juroš, 2019b), in a medical emergency (Bergen et al., 2006; Gash and Raiskin, 2018), or after a relationship dissolution (Hequembourg and Farrell, 1999; Goldberg and Allen, 2013; Malmquist et al., 2020). Thus, while legal vulnerability is defined as enduring, its influence varies and is exacerbated in situations where legal ties are (expected to be) relevant.

M.2: Family Characteristics

Characteristics of the family may moderate the impact of legal vulnerability or the family's ability to engage in counteractions. We found that different family types, such as planned (Polaškova, 2007), foster (Goldberg et al., 2013), or stepfamilies (Gash and Raiskin, 2018), may experience different ramifications of lacking legal recognition (e.g., stepfamilies with a second legal parent outside the family unit). Additionally, evidence suggests that family members may experience lacking legal recognition differently, for example a non-legal parent being impacted more directly by legal vulnerability (e.g., Padavic and Butterfield, 2011; Kazyak, 2015; Wheeler et al., 2018), or a child who is unknowing of the family's legal status (e.g., Ollen and Goldberg, 2016).

M.3: Couple Characteristics

Moderating characteristics on the couple level found in our review are the gender of the couple (e.g., Taylor, 2011; Goldberg et al., 2013), and their socioeconomic status (which enables the engagement in many counteractions, particularly those related to legally securing the family structure; e.g., Taylor, 2011; Goldberg and Kuvalanka, 2012; Kazyak, 2015; DiGregorio, 2016).

M.4: Individual Differences

Characteristics of the parents, including age (Reeves, 2011), personality traits (e.g., optimism, Ollen and Goldberg, 2016), minority stress experiences (Goldberg and Smith, 2011; Ollen and Goldberg, 2016), history of migration (Vučković Juroš, 2019b), past experiences with the legal system (McClellan, 2001; Butterfield and Padavic, 2014; Goldberg et al., 2014), as well as characteristics of the child, such as age (McClellan, 2001; Ollen and Goldberg, 2016) or gender (Bos et al., 2008; Goldberg and Kuvalanka, 2012), may moderate the impact of legal vulnerability or their ability to engage in counteractions, as our review suggests. Furthermore, the awareness about the current legal situation or the family's legal status may moderate their impact on family members (e.g., children being unaware about their non-legal relationship to one of their parents; Ollen and Goldberg, 2016; Malmquist et al., 2020).

With regard to minority stress in particular, one study included in our review found that parental internalized homonegativity moderated the association between a state's legal climate and changes in depression and anxiety during the 1st year of parenthood (Goldberg and Smith, 2011). On the individual level, minority stress has also been found to moderate the impact of sexual orientation laws (e.g., Bauermeister, 2014; Pachankis et al., 2014; Hylton et al., 2017; Ogolsky et al., 2019).

DISCUSSION

Based on a thematic synthesis of 55 studies, we introduced the legal vulnerability model for same-sex parent families that aims to link the impact of legal recognition of family relationships with minority stress and family theories on the individual, couple, and family level. We propose that legal vulnerability increases the risk for all family members of experiencing or expecting adverse outcomes in health- and family-related domains. Family members also actively engage in counteractions to alleviate the impact of legal vulnerability. Characteristics on the contextual, familial, couple, and individual level may moderate the impact of legal vulnerability or their ability to engage in counteractions.

Based on the evidence within our review, we assume that a legally secure family structure is in the best interest of all family members. The relatively scarce findings that suggest no or a counterintuitive impact of sexual orientation laws on certain outcomes (e.g., family relationships) should not be used as a justification for denying sexual (or other) minority groups' access to equal rights. Rather, they can be seen as evidence of the resilience that same-sex parent families show when maintaining loving and committed family relationships amidst an unfavorable legal climate and concurrent societal stigmatization.

Strengths and Limitations of the Legal Vulnerability Model

A strength of our model is its empirical evidence base gathered via systematic literature search and synthesis. Its grounding in minority stress and family theories overcomes criticism in the field (Farr et al., 2017; van Eeden-Moorefield et al., 2018) and offers empirically testable pathways for future research and implications for clinical practice. By emphasizing the family unit (Minuchin, 1974), the model also moves away from the individuum-focused approach in minority stress research (LeBlanc et al., 2015). Our findings also suggest the need for a general family minority stress model that conceptualizes minority stress particular to parents and children.

Many of the proposed pathways in our model await empirical examination using rigorous, quantitative designs. Specifically, little is known about how legal vulnerability impacts family relationships and child outcomes and how it manifests itself in families deviating from the predominantly white, female-headed, and well-educated families within our sample (see below).

Moreover, a concomitant examination of impact-related factors, moderating characteristics, and counteractions seems warranted to advance our understanding of legal vulnerability.

Implications for Research and Practice

Operationalizing Legal Vulnerability: A Fruitful Challenge

Quantitative investigations of the pathways outlined in the legal vulnerability model are paramount considering the current primarily qualitative evidence base.

Across jurisdictions, we suggest including items related to family relationships, parenting, or child outcomes in multi-nation investigations into sexual minority health (e.g., European Union Agency for Fundamental Rights, 2020; Weatherburn et al., 2020). Research on sexual minority individuals has capitalized on the legal variation offered within these datasets by linking objective indices of the legal climate with health-related outcomes (Berg et al., 2013; Pachankis and Bränström, 2018; van der Star et al., 2021). This constitutes some of the most compelling evidence on the impact of sexual orientation laws (and concomitant societal attitudes) to date. Using legal variation across many jurisdictions (along with other country-level control variables) would overcome the limitations of the two country-comparisons found within our review (Vyncke and Julien, 2007; Bos et al., 2008; Shapiro et al., 2009).

Within jurisdictions, variation in legal vulnerability can be assessed in several ways. Many of the approaches outlined below have already been recommended in pertinent reviews on the advancement of research on same-sex couples and families in general (e.g., LeBlanc et al., 2015; Umberson et al., 2015) and can be extended to the structural level.

First, in jurisdictions without legally recognized relationships, dyadic designs (e.g., actor-partner interdependence models, Smith et al., 2020) can be used to contrast outcomes in legal and non-legal parents while taking further partner characteristics (e.g., minority stress) into account. Daily fluctuations in legal vulnerability and stress spillover effects could be assessed by dyadic diary studies (Totenhagen et al., 2018; Cooper et al., 2020).

Second, in jurisdictions with legally recognized relationships, investigations into “lingering” or continued effects of legal vulnerability (e.g., on parental legitimacy or legal rejection sensitivity) seem warranted. Legal advances for sexual minorities are recent phenomena globally and same-sex parent families today are likely to have faced legal vulnerability at some point in their shared family biography in the past. Indeed, referenda and campaigns on sexual minority rights can exert long-lasting influences on sexual minorities (Russell et al., 2011). Lifeline and relationship timeline approaches (LeBlanc et al., 2015) could elucidate lingering effects of legal vulnerability. Research with adult children would provide insights into lingering effects of legal vulnerability beyond childhood (see e.g., Lick et al., 2012).

Third, researchers could draw on legal variation within a jurisdiction by assessing outcomes before and after legal change (i.e., akin to a quasi-experimental design; see Hatzenbuehler et al., 2009, 2010). This entails re-analyzing existing datasets or capitalizing on periods of legal changes as they take place.

The proposed research designs necessitate psychometric innovations to measure the legal climate for same-sex parent families and aspects of legal vulnerability on the individual level. On the country level, several indices to measure the general (socio-)legal climate for sexual minorities have been recently developed (e.g., Lee and Ostergard, 2017; Lamontagne et al., 2018) that could be adapted to assessing the legal climate for same-sex parent families in particular.

On the individual level, we suggest developing and validating measures that capture different manifestations of legal vulnerability (e.g., legal worries, family legitimacy due to [lacking] legal recognition) and family members’ counteractions to tackle legal vulnerability. Researchers can utilize existing scales that measure aspects of legal vulnerability directly (e.g., legal worries; Shapiro et al., 2009). They can also adapt existing scales, such as couple-level minority stress (Neilands et al., 2020), parenting stigma (Gato et al., 2019; Shenkman, 2020), or challenges in achieving parenthood (Simon and Farr, 2020) to explicitly incorporate legal aspects.

Investigating Legal Vulnerability: Areas for Future Research

The development of models related to sexual minority health on the individual, couple, and family-level has proliferated in recent years. Future research could integrate legal vulnerability in the family resilience model (Prendergast and MacPhee, 2018), the relationship uncertainty model (Monk and Ogolsky, 2019), or adaptations of the vulnerability-stress-adaptation model (Karney and Bradbury, 1995; Totenhagen et al., 2018), among others. Conversely, researchers could link other concepts of legal meaning making for sexual minorities, such as legal consciousness (Hull, 2016), with legal vulnerability. Furthermore, assuming a rather contrasting theoretical perspective to minority stress (Meyer, 2003) and family systems theory (Minuchin, 1974)—for example through a psychoanalytical lens—could help elucidate and refine the epistemological boundaries of the legal vulnerability model and ultimately strengthen its value for theory and practice. Methodologically, a more interpretative approach to research synthesis—for example grounded theory synthesis (Eaves, 2001) or critical interpretative synthesis (Dixon-Woods et al., 2006)—could prove fruitful in analyzing the discursive strategies that study participants used.

Comparatively little is known about how legal vulnerability impacts family functioning, relationships, and child outcomes. Our evidence suggests that children are relatively unaffected by legal vulnerability (as compared to their parents), particularly in their family relationships and functioning (Malmquist et al., 2020), although reporting biases or normalizing strategies cannot be ruled out (Clarke and Demetriou, 2016). This adds to the robust body of evidence that documents how children with same-sex parents fare well-even in stigmatizing environments (see Pollitt et al., 2020, for a review).

The degree of spillover of legal vulnerability into family life can be considered the key determinant of how far it impairs the child’s well-being. Concurrent assessments of parents and children could shed light on the degree to which same-sex parents are able to “compartmentalize” legal vulnerability and avoid a spillover into the parent-child relationship or parenting practices (consequently influencing child outcomes).

With regard to populations, our sample is biased toward white, well-educated (presumably), cisgender, and female-headed families. Future research should strive for including diverse families in terms of parental gender and sexual orientation (e.g., bisexual parents in same-sex relationships, unique legal vulnerabilities of transgender parents), race/ethnicity, and socioeconomic background, while incorporating an intersectional approach (Bowleg, 2012) that is sensitive to the complex effects of multiple and intersecting discrimination.

Working With Legal Vulnerability: Implications for Clinical Practice

First, legal vulnerability for same-sex parent families is caused and perpetuated by the lacking legal recognition of family relationships, just as minority-specific drivers of sexual minority health disparities are caused and perpetuated by structural and societal stigmatization (Pachankis, 2015). In line with recommendations made by the American Psychological Association (2020a,b), clinical practitioners should promote the beneficial effects of protective legislation as being in the best interest of their clients.

Second, legal vulnerability needs to be acknowledged as a source of psychological strain for all family members in clinical practice. This entails adapting mixed-sex family therapy programs and minority stress related approaches for individuals or couples (Pachankis, 2018; Burton et al., 2019; Pepping et al., 2020) to the needs of legally vulnerable families.

Our model bears several implications for the derivation of such programs: Clinicians can use the counteractions proposed in our review to delineate counseling approaches for legally vulnerable same-sex parent families. Many counteractions found within our review map onto well-established family resilience processes (Walsh, 2003, 2016), such as meaning making of adversity (e.g., seeking legal information, overcoming heteronormativity), cooperative parenting, family connectedness, and mobilizing social and economic resources. Moreover, counteractions related to legal vulnerability have been identified as buffering against individual-level minority stress or promoting well-being in sexual minorities and their relationships (see e.g., Kwon, 2013; Hill and Gunderson, 2015): These include managing disclosure (Oswald, 2002; Kwon, 2013), activism (Oswald, 2002; DeBlaere et al., 2014), symbolic rituals and naming practices (Oswald, 2002), choosing kin, reframing minority stress experiences (Oswald, 2002; Frost, 2014), supportive dyadic coping (Randall et al., 2017), instilling resilience in children (Oakley et al., 2017), and legally securing the family structure (Oswald, 2002; Riggle et al., 2005).

Our list of moderators might be used to identify families (or individuals) that are particularly vulnerable or, conversely, equipped with many resources (e.g., families with a high socioeconomic status). Resilience-focused therapy and counseling approaches could aim at deriving useful coping strategies for dealing with legal vulnerability as parents and outlining effective and age-appropriate strategies to address legal vulnerability in children. However, the integration of legal vulnerability into clinical practice is by no means limited to structured therapy programs. For example, informal meeting groups have been found to be an important source of social support but also legal information for same-sex parents (Kazyak, 2015; Álvarez-Bernardo and García-Berbén, 2018; Appelgren Engström et al., 2019). Group facilitators (e.g., community members or clinicians) serve as important multiplicators in communicating the potential impact of legal vulnerability on these families and should be knowledgeable about adaptive counteractions in particular.

In jurisdictions with legal recognition for same-sex parent families, we argue that it is important to address possible lingering effects of legal vulnerability. For example, a study on same-sex couples (post marriage legislation) found that perceived unequal relationship recognition (e.g., feelings of the relationship being treated as "second-class" by the government) predicted adverse mental health outcomes irrespective of legal relationship status (LeBlanc et al., 2018). Clinicians should be prepared to address relics of past legal vulnerability on the individual (e.g., maladaptive beliefs about parental legitimacy) or family level (e.g., perceived unequal relationship recognition).

Clinicians should also be mindful about the legal shifts that have characterized the past decade in many countries, but they should not be oblivious to more insidious forms of minority stress that continue to shape sexual minorities' lives. Experiencing minority stress does not end when legal equality sets in, as evidence from our review (e.g., Rawsthorne, 2013; Goldberg et al., 2014; Gash and Raiskin, 2018) and elsewhere (Riggle et al., 2018; Wootton et al., 2019; European Union Agency for Fundamental Rights, 2020) suggests.

Limitations

First, we excluded studies that (i) focused on the impact of sexual orientation laws on family formation, (ii) were concerned with same-sex couples with unclear parental status, (iii) investigated discrimination unrelated to the legal system, or (iv) investigated family constellations with one or more than two parents. All of these studies are beyond the scope of our review and necessitate their own synthesis. Still, some of these studies may have yielded responses by participants that would have warranted inclusion in our review (e.g., studies concerned with family formation that reported data on the 1st years of parenthood).

Second, we did not systematically search for gray literature excepting our forward-backward search. Publication and other dissemination biases are typically framed as a threat to the synthesis of quantitative studies (Rothstein et al., 2005) but they can also impair qualitative evidence syntheses (Petticrew et al., 2008; Toews et al., 2017). However, the well-known schism between deficit- and resilience-oriented approaches in the study of sexual minority health (Frost, 2017; Prendergast and MacPhee, 2018) makes the direction of this bias hard to predict: Researchers could be inclined to draw attention to the detrimental impact of lacking legal recognition, but they could also be interested in emphasizing the resilience of same-sex parent families in a legally unfavorable climate. Because our review aimed to propose a framework (thus aiming for saturation of themes), we do not regard a possible impact of publication bias as a threat to the validity of our results. Still, future research would benefit from systematically searching various gray literature databases and sources from human rights organizations to look for convergence with the themes identified in our review.

In a similar vein, we only included studies published in English or German. This language bias might have resulted in the omission of studies investigating the impact of criminalizing laws in particular, as they might have been published in their native language or in a non-traditional outlet not to be found via our database search. Furthermore, our sample is heavily biased toward Western countries (with almost two thirds of studies originating from the US in particular) and only includes one study (Zhabenko, 2019) concerned with criminalizing legislation.

Third, we did not systematically stratify our results by different laws. We did not deem this distinction useful, as same-sex parent families often reported on the impact of lacking legal recognition of both the interparental and parent-child relationship. Future research might benefit from delineating the impact of specific laws (e.g., marriage) on key outcomes.

Fourth, synthesizing results across studies from countries with varying sociolegal climates gives rise to a possible decontextualization of findings (Thomas and Harden, 2008). The legal context must be regarded as part of a larger political context that shapes the experiences of same-sex parent families. For example, countries with the same level of legal recognition might differ with regard to how this legal recognition came about (e.g., via a court decision, a referendum, or a parliament vote) and how it is perceived by society. Our study's aim (i.e., the postulation of a valid model across different studies and contexts) required this decontextualization to some degree. Still, future research should take into account a country's surrounding sociopolitical climate (termed structural stigma, Hatzenbuehler and Link, 2014, in our model) when investigating legal vulnerability.

Fifth, the conflation of societal prejudice (arguably higher in countries with lacking legal recognition, Smith et al., 2014), lacking biological ties to a child, and lacking legal ties (to a child or a parent) in qualitative reports posed a challenge during the coding process. Our conservative coding strategy strengthens the validity of our findings with regard to legal vulnerability, but undoubtedly fails to capture the lived experiences of same-sex parent families in a society that is characterized by both legal and societal prejudice against them.

Conclusion

In this systematic review, we introduced the novel concept of legal vulnerability that serves to link sexual orientation laws impacting same-sex parent families with parental, child, and family outcomes. Many of the complex and reciprocal pathways outlined in our model have yet to be put to rigorous empirical tests. Yet, it is not premature to claim that a legally secure family structure is not only from a human rights perspective, but also from a psychological perspective in the best interest of both parents and children.

DATA AVAILABILITY STATEMENT

The datasets presented in this study can be found in online repositories. The names of the repository/repositories and accession number(s) can be found at: https://osf.io/qs6hp/.

AUTHOR CONTRIBUTIONS

MS, CA, NM, and MZ conception, design of study, analysis, interpretation of data, and approval of final version. MS, CA, and NM acquisition of data. MS drafting the manuscript. CA, NM, and MZ revised the manuscript critically for important intellectual content. All authors contributed to the article and approved the submitted version.

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Emotion Regulation Focused Family Therapy With Contemporary Families Affected by Information and Communication Technologies

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In the contemporary world, new information and communication technologies (ICTs) have revolutionized family relationships and organization. Mobile phones, tablets, and computers are entrenched in everyday family life. Therefore, families face new challenges with problematic internet use, blurring boundaries between the outside world and the domestic sphere. Sometimes these changes in living together lead to suffering. How do therapists respond to these new challenges faced by contemporary families? Considering the emotion regulation strategies underlying the problematic use of technology, we develop an Emotion Regulation Focused Family Therapy. Within the *Change Process Research* paradigm, which aims to explain how psychotherapy produces change, we examine this innovative therapeutic approach in an exploratory process in order to refine our own practice. We conducted a qualitative research for five families in family therapy under natural clinical conditions to identify the therapist's interventions and the family configurations. The core theme was *therapist interventions*. The results identified 12 subcategories under this category. We built an emotion regulation focused model with 12 steps from these subcategories. Each of the interventions is illustrated with some excerpts from the sessions. Clinical considerations, methodological issues limiting the current body of work, and recommendations for future research are discussed.

Keywords: family relationships, contemporary family, problematic internet use, ambiguous loss, emotion regulation focused family therapy

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INTRODUCTION

Psycho-social mutations have changed family configurations and concerns in family therapy. New ways of "being a family" are emerging: more prevalent stepfamilies, same-sex parenting, late adoption, medically assisted reproduction, etc. Families are also facing changes with the rise in the use of information and communication technologies (ICTs). Smartphone, tablet, computer, connected objects have become part of the family landscape and may be altering aspects of family life, increased even more by the covid-19 pandemic context, with telework and quarantine. Transhumanism asserts the notion that humans can be "augmented" by technology (Leary, 1994; Drexler, 2005; Roux and Coeurnelle, 2016). "The human being can 'become more human' thanks to technology: longer life, greater intelligence and creativity..." (Roux and Coeurnelle, 2020). Others denounce the dangers of these cognitive prostheses (Derian, 2013). Augmented

Man, "connected self": information and communication technologies have revolutionized human relations and the organization of families. Can we also talk about "augmented" families? The cell phone has become "an extension of oneself" and has come to interfere in people's daily life, creating a new relational dynamic. What are the challenges connected families are encountering? Although the internet use facilitates our lives, some individuals seem to show problematic Internet use (PIU). Among a variety of detrimental online behaviors, PIU is defined as "excessive or poorly controlled preoccupations, urges or behaviors regarding Internet use that lead to impairment and distress" (Weinstein and Lejoyeux, 2010, p. 277). What are the implications for changing family dynamics, family values, and family processes? In her multitheoretical model describing the process of how technologies are affecting couple and family life, Hertlein (2012) suggests two types of changes in relationships: changes to the family structure of relationships and changes to the family process. If families are changing and technology is part of that change, family clinicians may be challenged by the adoption of emerging technologies. How do family therapists respond to this emerging clinical reality?

From the structural-functional perspective, "family structure is the invisible set of functional demands that organizes the ways in which family members interact" (Minuchin, 1974, p. 52). Family structure is determined by boundaries which are invisible barriers regulating contact between members. When Minuchin (1974) defined boundaries, he was referring to the rules that underpin families' transactional patterns; i.e., how the larger system (the nuclear family) operates, as well as subsystems (parents and children) within it. Subsystems are organized hierarchically: power is distributed appropriately within individuals and between subsystems, making reliance on some members more expected than on others. The parents must assert their authority in a hierarchical structure. The respect of such rules in a family makes belonging possible. Technology use may modify these rules and blur work/family boundaries with negative consequences (Chesley, 2005). For example, when a parent works from home, the rules specific to their work system may take over family rules. The parent, who is usually attentive to their child, may become upset because they are disturbed by their 6-year-old son in their work. As for the child, the rules of online gambling may take precedence over the rules of the home. The adolescent, who is supposed to join their parents for lunch, refuses to leave their room because they are playing with friends online. These bubbles allowed by technology appear as subsystems with sometimes rigid boundaries within the family system, which are governed by different rules.

"Personal communication devices now transform the individual into a communicating cell that inhabits several spaces at the same time, that of the immediate environment and all possible spaces virtually accessible through its technological connections (Guillaume, 1994)" (Caron and Caronia, 2005, p. 255). Different affiliations enter into rivalry. The notion of belonging then appears to be obsolete, individuals being linked less by a common belonging than by connections (Gaillard, 2009). With this possibility of external connections, the modeling of the family as a system seems to be called into question, insofar as family members are no longer bound together by ties that would be hierarchically superior to any other ties (Gaillard et al., 2011). Submission to paternal authority is no longer relevant, young people are their own judge and have authority over themselves. Parents used to be able to control the games they were offering their children. Today children can "download their own games without parental knowledge. This may flip the structure in the family to unfavorably honor the youth or place them in a position of higher power, as youth are frequently more knowledgeable about technology than their parents" (Curtis et al., 2017, p. 114). "The family, the first cell of belonging, is subject to permanent reconfigurations and is going through a crisis of educational transmission. We are thus witnessing a generalized mutation of institutions and social and community rituals, which nourished the social bond by giving meaning and regulating individual behavior" (Lascaux and Couteron, 2015, pp. 165–166). Technologies amplify the phenomenon of individualization of children, who spend less time with their parents. Family cohesion[1] suffers as a result (Caron and Caronia, 2005). Escots (2011) speaks of an epistemological crisis linked to the change in the ontological status of families.

In new families, the children no longer build their identity based on belonging, with an injunction to heteronomy, but by responding to an injunction to be autonomous: "You alone can and must forge your identity!" Hence a high degree of self-esteem is needed. As beings are structured on an "individual" mode, the belonging bound is almost totally dissolved into a connective one. This connective mode of binding must leave each one with an intact space of personal development. His space having become vital insofar as they impose themselves as supports of the necessary personal visibility, of the sufficient deployment of the self of the individuals, of the presentation of oneself, would say Fourez (2004). Young people no longer construct their identity on the basis of belonging but on individuality, which can rely on digital supports that we can refer to the "technologies of the self," described by Foucault (1982). Young people tell their stories through social networks, recording their moods and the activities that have punctuated their day. Digital tools make it possible to produce a life story (Amri and Vacaflor, 2010), but the receptors of these messages, traces of the young person's narrative identity, are multiple and uncertain. Computer-mediated social ties, made possible by digital technology, are "floating" (Perriault, 2009) and the identity construction induced by this socio-technical logic will be unstable (Coutant, 2011). New fragilities emerge with these recent processes of individualization: narcissistic disorders, emotional dysregulation, new addictions, etc. (Coutant, 2011; Duriez, 2018a).

The process of deinstitutionalization of the couple and of the family induces "subjectivation" and "affectivation" of the bond. The relationship to the other is very concrete, subjectivated, and "affective," implying a relationship based on esteem -constantly measured- of the other and of oneself" (Gaillard et al., 2011). Regulations within the family are "no longer in an institutional mode, they are essentially in an emotional mode, so that there is a

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[1] Family cohesion is defined as the "emotional bonding that family members have toward one another" (Olson et al., 1983, p. 60).

negotiation process that is as continuous as it is tense" (Gaillard, 2009, p. 18). This change in regulation modes can be a source of suffering for some family members who do not adapt to this connective attitude (Duriez, 2019).

Technology carries changes to the family process, from belonging mode relationships to connective mode relationships. From the interaction-constructionist perspective, family process observes how family members develop relationships and interact with one another through communication, behavior, gestures, rituals (Berger and Kellner, 1970), and emotion regulation strategies (Duriez, 2017). Apart from symptomatic situations (addiction, cyberbullying, minor's access to inappropriate content, etc.), the main problem seems to be time spent using ICT with its consequences on family relationships (Hugues and Hans, 2001; Bacigalupe et al., 2014). With regard to parent-child relationships, for the adolescent, "too much isolation in the virtual world can mean a diminished attachment to parents and family. A too strong link to a machine to the detriment of other relationships with surrounding people, a too long period of time spent in its presence, substitutes, to a certain extent, for certain relationships that are indispensable in the context of social and emotional development" (Derian, 2013, p. 356). The widespread presence of new media technologies in homes may have relational impacts on the couples. Hertlein (2012) examines the consequences for couples and points out the effects of technology in daily family life on intimacy, relationship initiation and formation processes, and relationship maintenance. Chesley (2005) demonstrates that cell phone use over time is linked to increased psychological distress and lower family satisfaction.

For example, during a marital therapy speech, a woman explains that every evening, when the couple could meet once the children went to bed, her husband takes his cell phone to the toilet and disappears for 30 min: "he is there and he is not there." She then experiences a momentary loss. Although this experience can emerge in the context of divorce, it can also exist when all family members are together at home. The oscillations between presence and absence destabilize the entourage, which must learn to cope with the stress due to the fact that we never know if the other person is actually present and available or if they are locked in their technological bubble and inaccessible (Duriez, 2013). This experience of loss becomes an organizing core of the family dynamic as new hidden games regulate the relationships: one is psychically absent by locking themselves up with the computer, while the other feels the absence, the lack. This experience brings us back to the concept of ambiguous loss described by Boss (1999). In the context of an ambiguous loss, it is very difficult to integrate the other's absence because the other is present. The person is no longer present psychically but they are physically and can also return psychically. The process of "progressive detachment," the stage of grief for a real loss, is not possible. Connected families must learn to regulate the emotions related to the ambiguity of presence, to the uncertainty of the availability of the other.

How do therapists respond to these new challenges faced by contemporary families? Mesch (2006) proposes a compositional approach which includes work on internet use, self-esteem, family time, and family conflicts to strengthen family cohesiveness. Bacigalupe et al. (2014) propose a strength-based approach to support family relationships. "The confluence of an ambient intelligence, an environment of advanced technology capable of responding intelligently to human needs (Riva, 2005) a connected presence (Licoppe, 2004) and the continuous awareness of others through wireless tools, is fostering a new way for families to relate" (Bacigalupe et al., 2014). He recommends that therapists familiarize themselves with new ICTs. Jordan (2014) proposes to incorporate video games like board games in therapy. Curtis et al. (2017) proposes to accommodate and to highlight the benefits of video games in order to assist the youth in staying engaged and active in the process. They invite parents to do the same. "The caregiver, while being coached by the therapist, should facilitate a conversation with the child about what games they like to play or are interested in" Curtis et al.(2017, p. 115). Liu et al. (2015) explore both the effectiveness of a multi-family group therapy on Internet addiction and the underlying mechanisms of the effectiveness. They identify two mechanisms: (1) improving parent–adolescent communication and closeness, (2) fulfilling adolescents' psychological needs through strengthening their communication and relationship with their parents.

Working on communication difficulties is at the heart of therapeutic approaches, whether it be parent-child communication (Young Park et al., 2014) or communication within the couple (Hertlein, 2012). There may however be a paucity in considering the emotional regulation strategies underlying this miscommunication in family therapy with connected families. Researchers are increasingly studying the correlation of Problematic Internet Use (PIU) with emotional regulation (Zhou et al., 2011; Hormes et al., 2014; Casale et al., 2016; Spada and Marino, 2017; Evren et al., 2018; Wei et al., 2018; Amendola et al., 2019; Hernandez et al., 2019; Karaer and Devrim, 2019; Faghani et al., 2020). Sideli et al. (2017) demonstrate that low self-esteem, high aggression-hostility, and high sociability are significant risk factors for PIU. The Internet allows escape, distraction, extrication from a relationship (Lee, 2014) or procrastination (Hernandez et al., 2019), in short "a form of escapism to avoid certain aspects of their reality" (Hertlein and Hawkins, 2012). Schimmenti and Caretti (2017) show that PIU may be considered as a dissociative experience. They propose the clinical construct of Video-terminal Dissociative Trance (VDT) and discuss its potential usefulness for the assessment and treatment of people who display PIU. "As a defense mechanism, dissociation allows an individual to avoid emotional distress temporarily by screening out excessive or overwhelming stimuli (Bromberg, 1996)" (Schimmenti and Caretti, 2017, p. 65). In our practice with connected families these studies invite us to explore the function of problematic internet use in relation to emotional regulation. How does this use maintain the homeostasis of the family system?

MATERIALS AND METHODS

Our research questions are as-follow: What are the impacts of ICTs on family relationships? What are the difficulties encountered by families in relation to internet use? What are the relevant lines of work with living digitally families? How does the therapist act?

Within the new outcome research paradigm focused on identifying the processes of change in patients and on analyzing the actions of the therapist bringing about these changes (Goldfried and Wolfe, 1996), a qualitative and exploratory research approach was chosen. For some researchers, "it is no longer possible to be satisfied with studies that focus on comparing symptoms before and after treatment or not. It is necessary to open the 'black box' that worked in between" (Thurin, 2017, p. 57). This is what Greenberg (1986) proposes with the concept of "Change Process Research." Based on circumstantial study of therapies conducted in "natural" conditions, its perspectives are clinical, practical, and theoretical. At this stage of our research, the objective is not the evaluation of psychotherapy as it is not yet formalized. The objective is to identify the experience of families with ICTs through their discourse, what the family requests and how the therapist responds to it in order to build an emotion regulation-focused model for these wired families. Our research isn't an action research either because the data from completed therapies pre-existed the research.

Our research on change processes (Duriez, 2007) and our clinical practice gave us the opportunity to observe that in certain contexts, even if adapted to the individual, the emotional regulation strategies of some family members can be a source of suffering for other family members to the extent that they might question their own strategies. During the therapy we investigate emotion regulation strategies and how the others react to them. If there is an issue, then our therapeutic intent is to bring family members to a greater acceptance of each other's emotion regulating style, without feeling misunderstood or threatened by the differences in emotion regulation strategies (Duriez, 2017). The hypothesizing process stands out within the therapeutic frame in the context of the intersubjective encounter between the family and the therapist, with the therapist also experiencing her own emotional regulation strategies. We apply the principle of circularity between the therapist and the family, which can be defined as "the capacity of the therapist to conduct his investigation on the basis of feedback from the family in response to the information he solicits about relationships and, therefore, about difference and change" (Selvini et al., 1980, p. 6).

Setting

The setting for our practicum was a Center for Care, Support and Prevention in Addictology (CCSPA) in Paris which provides a no-fee service to people living in Ile-de-France. Professional referrals to the center are not required; individuals can refer themselves. The CCSPA is operated by the Groupe SOS and serves as a family therapy training facility.

Families

From the libraries of therapy sessions held by the author, five families have been selected because they mentioned a problematic use of ICTs. Forty-seven video-recorded family therapy sessions were sampled. To protect their identities and to ensure confidentiality, the families were assigned pseudonyms. These five families are presented in **Table 1**.

TABLE 1 | Population.

Family configuration	Number of sessions	Presenting issue
I Family, Stepfamily Mr Philippe I, 54 years old Ms Armelle I, 53 years old Carmen, 16 years old Axel, 14 years old Mr I's son from a previous marriage Diego, 25 years old	22	(1) Carmen's smartphone use (2) Axel's video games use (3) Ms. I's cyber infidelities.
R Family, Stepfamily Mr Jérémie R, 40 years old Ms Valérie R, 45 years old Lucas, 13 years old Ms R's sons from a previous marriage: Baptiste, 21 years old Simon, 18 years old	2	Video game use for the father and the boys.
S Family Mr Olivier S, 55 years old Ms Carla S, 48 years old Opale, 16 years old Logan, 12 years old	15	(1) Opale's smartphone use (2) Logan's video game use
T Family Mr Antoine T, 32 years old Ms Amandine T, 25 years old Soukaina, 3 years old	2	Online gambling for Mr. T
V Family, Divorced family Ms Catherine V, 56 years old Gauthier, 26 years old Florent, 21 years old	8	Video game use for Gauthier and Florent.

Researcher

The researcher was the therapist for the families, the author. The double role of being a researcher and a clinician presents advantages, facilitating both the development of clinically relevant research and the dissemination of evidence-based treatments into routine clinical services (Yanos and Ziedonis, 2006). It also presents challenges, with ethical conflicts between the clinical mandate and the methodological demands. To address this issue, therapy and research did not occur at the same moment. During the therapy, the analysis of the sessions was carried out by different groups of psychologists in family therapy training, guided by the clinical mandate. The presence of a recording device and of a video recording the interactions were integral to the family therapy setting. Once completed therapies, research was carried out, guided by the scientific mandate.

Data Analysis

Change process research (Greenberg, 1986; Watson and McMullen, 2016) includes qualitative methodologies that aim to find meaning in and conceptualize data from the complex interactions of psychotherapeutic work, and subsequently, contribute to theory development. We chose a conventional content analysis (Hsie and Shannon, 2015) generally used with a study design, whose aim is to describe a phenomenon, in this case the therapist's interventions that address the challenges faced by families, who are now using new technologies in an increased way.

Data have been obtained from completed family therapies. But a first data analysis started during the therapy. We work with families with a constant concern to question our practice, according to an Evidence-Based Practice (EBP) stance, which gives opportunities to bridge clinical research and practice, enhancing the knowledge base and improving patient care. We have viewed and reviewed the sessions with different groups of psychologists, who are in family therapy training and also with master students in order to allow the emergence of new insights and to gain a general sense of the therapy process. From this exposure and the case notes, which followed each session, we identify relevant moments related to a problematic use of technology. We visualized the significant sessions for the five families and transcribed the relevant passages. Two master students helped transcribing the sessions for families I and S. We started the initial open coding on paper copies of the transcripts, with categories being noted in the margins. Analytic procedures of content analysis are close to the "line by line" practice of supervision, which allows therapists to reflect on the meanings of clinical material. Then we began *axial coding* to relate categories to their subcategories.

We attempted to assume the credibility of our qualitative findings in a number of ways, including our use of triangulation with our colleagues in the group of family therapy training, with participants during workshops (Duriez, 2018a, 2019) and with master students, using more than one source to analyze the data (Merriam, 1998).

RESULTS

Two core themes were generated: *the experience of the family with technology* and *therapy techniques*. *Therapy techniques* refer to the exact means therapists used to achieve different therapy intentions. The family's experience is expressed through the therapist's exploratory interventions. Therefore, we have considered a single core theme, *therapist interventions,* that includes both the therapist's investigations to identify the family's experience and therapeutic techniques. Results identified 12 subcategories under the category of *therapist interventions*. **Table 2** shows these 12 therapist's interventions. We present these subcategories in the chronological order observed during therapy. For each category, we have distinguished these interventions based on the distinctions made by Tomm (1988) according to the therapist's assumptions (lineal or circular) and the therapist's intents (orienting or influencing).

- ✓ Lineal questions: The intent of this type of questions is to extend the therapist's understanding. The questions are based on lineal assumptions about the nature of the phenomena.
- ✓ Circular questions: The intent is also exploratory, but the questions are based on circular assumptions about the nature of the phenomena.

TABLE 2 | Results.

Therapist interventions	Subcategories
Exploration of the problem (Lineal questions)	Time-consuming activity Reduction in family time Impact on quality of family time Impact on studies and homework Impact on couple intimacy Impact on the family budget Permeability of the boundary between work and family
Exploration of the complaints (Circular questions)	Feeling of abandonment Lack of support Fear
Exploration of the perspective of the designated patient (Lineal questions)	Pleasure Relaxation Refocusing on oneself Connecting with friends Building a protective bubble Psychic unavailability of the parents Conflicting family environment
The negative interactional cycle (Strategic intervention)	Avoidance strategy amplified by the other person's confrontational strategy Low self-esteem amplified by the anger and disqualifications of the other person
The experience of ambiguous loss (Reflexive questions)	Loss of rituals Relationship shaped by loss Emotional unavailability Rigid boundary Bubble Threat of breakup Evocation of death
Making connections between past and present (Reflexive questions)	Non-elaboration of a previous loss Feeling of repetition Consistency with the past Paradox between the official program and the construction of the world
Reframing the use of technology as an emotional regulation strategy (Reflexive questions)	Time to relax Avoidant coping Behavioral disengagement Extrication from the couple's relationship Escape from the real world Distraction Procrastination Regulate neuroticism Emotion sharing Social support seeking
Building the emotion regulation strategies cycle (Strategic interventions)	Time to relax => Reduction in family time Distraction => Impact on homework Avoidant coping => Lack of support => Impact on problem solving Behavioral disengagement => Unsatisfactory intrafamilial communication Extrication from the couple's relationship => Impact on couple intimacy Escape from the real world => Non-elaboration of past suffering Procrastination => Fear for children future Regulate neuroticism => Reduction in family time Emotion sharing (with pairs) => Feeling of abandonment (for the mother) Social support seeking (outside) => Reduction in family time

(Continued)

TABLE 2 | Continued

Therapist interventions	Subcategories
Opening up earlier trauma wounds (Strategic interventions)	Childhood marked by loss (child abuse, parental separation, etc.) Migration Death
Building a sense of internal security/or autonomy (Strategic interventions)	Better knowledge of each other Exploration of "schema-of-being-with" Respect for intrapersonal differences Adjustment to intrapersonal differences Sharing emotions A new understanding at previous wounds
Implementation of new behaviors (Strategic interventions)	Learning to decompress in another way Building new family rituals Building new narratives New way of communicating Sharing emotions Using technology to serve the family cohesiveness
Changes (Reflexive questions)	Acceptation of emotions Refusal of the legacy of ancestor traumas Awareness Agency Discovery of new emotional regulation strategies Emergence of a stronger self

- ✓ Strategic interventions: The therapist reframes what was said from a circular perspective in order to influence the family in understanding the possible connection between observed behaviors. He expects the family members to take responsibility for the effects of one's actions on the others. The intent behind these questions is predominantly corrective.
- ✓ Reflexive questions: The therapist invites family members to reflect upon the implications of their current perceptions and actions and to consider new options. She triggers reflexive activity in the family's preexisting belief systems. The intent behind these questions is predominantly facilitative.

For each subcategory, we take a few verbatims or illustrative exchanges. We selected certain moments in the therapy according to several criteria: repetition of the evoked theme, the expressed emotion, the quality of reflexivity, and the family feedback about meaningful moments. These exchanges were translated from French for this report by the author, preserving the original phrasing where the sense was clear.

Exploring the Problem, the Interactional Dynamics of the Family, and the Family Structure

During the first session, the therapist asks everyone for a description of the problem and tracks the sequences of behaviors that they use to explain it. They identify the place of screens in family life and their impact on family time, studies, homework, and couple intimacy. They investigate how ICTs influence the way the family establishes rules, roles, and boundaries. With this information the therapist can map the family's underlying structure. The therapist also assesses the quality of the boundary with the outside world and the permeability of this boundary.

The S family is a wired family. Mr. S., the father, spends a lot of time on the computer. Opale, the 16 years old daughter, spends a lot of time on her smartphone. Logan, the 12 years old son, spends a lot of time playing video games. The father and the children are locked in a technological bubble and the mother suffers from this lack of exchange. She feels abandoned or neglected. The initial request for therapy concerns Opale's excessive use of her cell phone. Opale explains: "Actually when I'm with my friends, my phone doesn't exist. It's just that when I get home, I start using it to chat with my friends." Her mother complains about the lack of communication with her daughter. Opale describes the evening ritual when she comes home from school: "I say 'hello' to her, I come over to give her a kiss, I go to the kitchen, I eat and lock myself in my bedroom and she doesn't see me again until dinner and it actually annoys her because she says 'you pretend I'm not here!.'" Communication with parents becomes a source of stress. If the boundary separating the whole family from other systems is diffuse at home because Opale maintains a virtual contact with her friends, this boundary becomes rigid when Opale is out in her group of friends because she usually cuts off contact with her parents at these times.

Mr. S works a lot and when he is at home, he works too: "We don't have much time together, me and my wife, me first because I get eaten up by my work, everything administrative, accounting, etc." "Escape with work limits intimacy within the couple. From time to time on Saturday night, they plan to watch a movie together with the video projector. The children are in their room, playing video games or watching a series. Mr. and Ms. S are each in front of their computer, waiting for the other to finish what they are doing to start the DVD. But they don't tell each other and get caught up in answering e-mails, reading the news, checking social networks and then they realize it's too late to start watching a movie. That's the way it is for all the common activities. Mr. S is constantly connected. Ms. S is waiting for him and ends up going online as well and they don't do anything together anymore. The father is disengaged from his children. The mother is enmeshed with her children. She's over-functioning in area of parenting and household chores.

Exploring the Complaints

First, the therapist questions the person who initiated the demand for therapy, about their own feelings. Generally, it is the mother who demands therapy and expresses her suffering. She usually complains about the poor quality of communication, the perceived lack of support for educational or household tasks. She expresses a feeling of being disrespected and neglected, and a fear for the future.

> Ms. R: I have an expectation because I am experiencing a problem of communication with those around me.
>
> Ms. V: I was the one who initiated the demand. The motive at the beginning, I thought my sons were too addicted to video games and the internet and so on, and that's why we came... (...) Because I felt that the house was a bit like a hotel, that we didn't communicate, we didn't talk about real things, and

> everyone was a bit in their bubble, including me because I was very busy with my work. It made me unhappy to see that we didn't have deep exchanges with my sons.
>
> Ms. S expresses anger because she doesn't feel supported by her husband in the exercise of parenting. She has to over-adapt. This over-adaptation can go as far as a burnout. Ms. S is concerned about the time her son spends gambling to the detriment of his school obligations. She keeps an eye on him every day to limit the time he spends gambling and regrets not being supported by her husband: "It's only when there's a big problem, something that directly disturbs him, that's when he breaks down, that's when he explodes. But day after day, I'm the one who's behind the children. If I wasn't there, that's it! They would be left to their own devices!."
>
> Mr. T plays online poker when he's not feeling well. Ms. T is worried about the future:
>
> Ms. T: The fear comes because I have to raise a family with Antoine, I can't accept knowing that if one day he breaks down, he could squander the money on our children's education. The pain, the sadness, the disappointment will be intense. My children are everything to me. Telling me that I won't be able to pay for school because my husband screwed up... that's not even an option!

Sometimes the problem is no longer internet use but the parental response to the problem. Mr. I also had moments of anger toward his children, Carmen and Axel, who are playing game online or chatting with friends rather than doing their homework, which Ms. I blamed on him. He then said one day: "I don't want to have this kind of conflictual relationship with my children anymore, I don't want to take care of their education anymore!" Ms. I felt abandoned in this task: "I'm all alone in being the 'bad lady,' at least in setting limits." Mr. I's anger when there are problems with the children has not disappeared: "When Victor is angry about something, he tells me but not them. I tell him: 'Go and speak to the right person!.'"

Asking for the Perspective of the Designated Patient

According to the technique of circularization (Tomm, 1987), the therapist questions the persons designated as carriers of the problem about their feelings. The use of technology may relate to different psychopathological meanings according to the underlying psychological motives: pleasure, relaxation, refocusing on oneself, connecting with friends, building a protective bubble, coping with parents' lack of emotional availability, coping with conflicting family environment.

Besides family communication, several personality traits tend to affect technology use. When someone presents low self-esteem, neuroticism or sensation seeking, the problematic technology use can be increased by the family transactional patterns.

> Mr. T: It's a way out at a time t. It's as if I'm making my own parenthesis. I had a kind of weird childhood. I've always had a solitary aspect and I need "my moments." I was sad, I always put myself in this bubble. It's a habit that I picked up. It's almost intrinsic to my personality.

Gauthier explains that with his brother, they locked themselves in video games to escape conflicts with their mother. If they communicated with their mother, the atmosphere was systematically conflictual. He told to his mother:

> GAUTHIER: Being able to count on you was not possible because it was either "get by" or "yes" and that never happened. It doesn't help communication. We got into a system where everyone was in their own bubble and we didn't want to get out of it. For Florent and I, as we are solitary characters, it was comfortable, more comfortable than being exposed to the conflictual environment. We put up walls around us and there was no family life. Mom suffered more from that than we did because we are of a solitary nature, so we could survive. We endured it. (...) In terms of family life, this functioning is deleterious!
>
> Ms. V admits to having had a role in this family functioning: "I think it was good for the three of us because I also have a side like that, being in my bubble."

Identifying the Negative Interactional Cycle With the Family

The therapist proposes a circular view of the situation with the intent of getting everyone to assume their responsibility for what is happening. On the one hand the pathological ITCs use provides a refuge from the stress of everyday life for the addicted person but it also prevents the other family members from facing problems together. The therapist explains how the two behaviors, for example escaping work for the husband and aggressive communication for the wife, likely perpetuate one another, or are at least a small part of a larger cycle of behaviors. The therapist identifies the positive feedback loops responsible for maintaining the problem and emotional insecurity. A negative cycle is defined as a predictable interactional pattern that gets repeated and organizes the family around insecurity, rather than vulnerability. Negative cycles are fatiguing and destructive for family functioning. One operates with an avoidance strategy that clashes with the parent; the spouse who operates with a confrontational strategy and as a consequence one or the other is left alone to deal with daily life. Mr. S, trapped in his work addiction, is not receptive to the emotional needs of his wife and his children. Ms. S's anger prevents her from being receptive to the needs of her children. No one responds to the attachment needs of the other. Ms. I continues to fantasize a united family:

> Ms. I: When I'm at work, I fantasize about my family. I think when I get home: I'll make dinner, we'll have dinner together, it'll be fun. I come home and then I suddenly feel like everything is flammable. It's true, it's adolescence. In 5 min, it's apocalyptic, everybody's yelling at each other, I find myself with my fork in the air, I find it exhausting. We can no longer talk to each other!

Systemic reframing fosters empathy among family members, facilitates responsiveness, and helps the family deescalate. Defenses fall down, anger and disqualification give way to emotions that are harder to express: fear, hurt, and sadness. The feeling of loss induced by technological bubbles is expressed. Ms. R expresses the feeling of having lost her son to video games.

> Ms. R: When Baptiste started playing video games, I said to myself: “That's it! I've lost my son!.” The relationship we had died. Because we had a rather fusional relationship and so I lived our relationship... yes like a separation, a mourning, a small death, a loss in fact... a real loss!

Exploring the Experience of Ambiguous Loss

The therapist bounces off this experience of loss. Her intent is to help the patient identify their emotions and the consequences of these feelings on their behavior toward others. The therapist explores how the relationship to the screens of some people induces a feeling of ambiguous loss for the other members of the family who suffer from this emotional unavailability. Relationships are shaped by loss. Ms. T says about her husband: “It's as if he wasn't there! I am 8 months pregnant, I could give birth any moment but he doesn't help me shower our daughter.” Her husband, absorbed in online gambling, is no longer there for her even though she is going through a time when she needs support. She thinks it will be difficult to raise children with such an absent man.

> Ms. T: If it gets too much, I'll leave! I have to think about myself. I'm 25 years old, I'm not 40. If at some point I think it's too much and I can't live like this, I'll leave. It makes me sad to have someone by my side who has these defects. We all have flaws, but this one is the one that prevents me from taking a step forward with Antoine and that prevents me from projecting myself with Antoine ad vitam eternam.
> THERAPIST: And what would this cap be?
> Ms. T: It's trust and to tell myself that all that is behind us: these switches that you can have on the game... I don't think that this bubble is useful to you for the future. I think that whatever happens, this bubble won't serve you for life! And whether it's with me or someone else!

Making Connections Between the Feeling of Ambiguous Loss and Previous Losses

According to Stern, “you can't change without changing the functional past, that is, the past that is activated” in the interaction and that will impact the perception of what is happening in the present (Stern, 2003, p. 256). The lack of emotional availability of the dependent patient can reactivate a previous experience of loss. The death of a loved one or a painful separation is mentioned incidentally at some point in therapy. During the therapy, Ms. V never spoke about her sister's death. At the eighteenth session, she talks about the strained relationship with her parents and their opposition to her marriage with her first husband. She connotes the marriage in a negative way, referring quite unexpectedly to the death of her sister which occurred at that time. This drama could not be spoken. The therapist begins to build a hypothesis around the non-elaboration of this event.

> Ms. V: It was a failed marriage because it happened just before my sister died. We didn't change anything from the wedding, we kept the ceremony, we kept the wedding date when my sister had just been buried. It was horrible! It is a great sadness somewhere! She was 25 years old.

The evocation of this event may be stressful and emotionally challenging for the therapist. Sometimes it's better to wait to approach this material. The therapist waits until the family is ready for this work because at first glance the work on the past and the transgenerational seems unrelated to the problems of TCIs. The therapist assumes that the exacerbation of an ambiguous sense of loss, related to the use of ITCs, must be linked to a previous loss. The feeling of ambiguous loss brings some continuity with the past.

Reframing the Use of Technology as an Emotional Regulation Strategy

The therapist explores the relationship to the screens in terms of emotional regulation according to the Gross's process model (2014). Is it an escape from the real world? Procrastination? Extrication from the couple's relationship? Which emotions are regulated by the use of technology?

> Ms. I explains that her virtual relationship allowed her to survive because she was suffering in her couple. She was living with difficulty the lack of closeness with her husband.
> Ms. I: These stories with men are more virtual than real. It doesn't change anything to Philippe's suffering. I'm not trying to diminish the fact that I betrayed him, whether it was by texting, by fantasy... For me these stories were about survival from many different angles. I think that Philippe and I would no longer exist as a couple if I hadn't had that escapism and I think there was a real unconscious desire for Philippe to see them, I didn't erase them because I needed our couple, as it existed, to explode somehow, to disappear... and I wanted to annihilate that couple as it existed and build something else, preferably with Philippe. But I didn't want that old couple anymore! The only thing that hurts me is that Philippe is suffering! Because I know it hurts. And at the same time, I think I was ready to do anything to stop having that couple functioning. And we had long discussions with Philippe and I think it was the first time in our life together that I felt that Philippe and I were communicating, that he really heard me and that something was happening! I didn't want this couple anymore! I couldn't live in that couple anymore! So I think that was my way of shattering the whole thing! I couldn't leave him; I couldn't get our relationship to change to be harmonious. I was terribly unhappy and had been suffering for several years to the point of making myself sick with depressions, to the point of dissociating myself.

For Mr. T, online poker allows him to live with neuroticism.

> Mr. T: It's almost intrinsic to my personality.
> THERAPIST: What is your sensitivity?
> Mr. T: (...) I am sensitive. I'm not someone who's going to cry in front of a film, but I can be quickly hurt by people's behavior toward me. It's “sensitive”... “susceptible” in fact. What people may say to me brings back bad memories from my childhood.

> The fact of getting into a bubble means that you won't get affected by it.
> THERAPIST: The stock of bad memories, it stays in a corner?
> Mr. T: Yes! Exactly!
> THERAPIST: A form of anesthesia of a part you don't want to see?
> Mr. T: Yes! That's why at one time I was doing quite a bit of overdoing with medication. It's also a way to anesthetize myself because when I fell asleep, I would feel a lot, etc., and it kept me awake.

Building the Emotion Regulation Strategies Cycle With the Family

The therapist proposes a circular view of the situation with the intention of helping everyone to better understand their differences regarding emotion managing. Mr. T is seeking sensation with gambling to anesthetize negative emotions. Ms. T loses trust and is considering leaving him. Mr. T is affected in his vulnerability to loss. He gambles so that he no longer thinks she can leave. We can observe an escalation of the couple's distress. The therapist highlights the circularity of emotional regulation strategies and the impasse in which the couple or the family is stuck. At this stage, the family begins to understand the urgency of changing the emotional patterns related to the loss so that old patterns are not repeated. The therapist suggests alternative strategies. For example, in the case of the V Family, she helps Ms. V. accept that her sons do not share negative emotions.

> GAUTHIER: We have very different ways of coping. I don't handle excessive expression of emotions very well. My way of dealing with emotions is rationalism. I rationalize everything. I contain myself by rationalizing. And as a result, I am never on the side of amplification.
> Ms. V: As a young person, there was a major ban on expressing emotions in my family and I was very unhappy about that. I took French leave. It is as if with my boys, I was put back in the atmosphere of my childhood family. All the work I had done to free myself from this leaden screed, where it was forbidden to say anything and we had to pretend, seems useless today. I am trapped again. If I can't have intimate, intense conversations with my sons, I'm going to put myself at a distance so as not to get hurt.
> THERAPIST: Emotional intensity is experienced as a danger for your sons. The further you go in the expression of your emotions, the more they flee and a gap sets up between you. It is not a question of love, it is just that you are different, with a different way of regulating emotions and you have not yet managed to accommodate with this difference.

Opening Up Earlier Trauma Wounds

When the family is ready, the past can be put in perspective. The therapist explores transgenerational processes, with the genogram (McGoldrick et al., 2020) or the Goose Game (Colpin and Rey, 2019) or a systemic tale (Duriez, 2020). Our presupposition is that the emergence of symptoms related to pathological use of the Internet and family dynamics, sources of suffering, are the result of the weaving between transgenerational dynamics and social changes. The feeling of ambiguous loss has reactivated existing psychological wounds from the parents' lives, which intensified the emotional reactivity between the one with earlier trauma wound and the one who is locked in a technological bubble. These parents are vulnerable to loss. For the five families, we found unhealed wounds originated in childhood trauma: conflictual separation of parents and neglect (Mr. T), emotional abuse (Ms. R and Ms. V), violence within family of origin (Ms. I), abandonment (Mr. I and Ms. V), migration (Ms. S), death (Ms. V). For example, the therapist writes a systemic tale with the I family and evokes the adolescence of Mr. I when he was relegated to a maid's room. Ms. V also evokes a difficult adolescence:

> Ms V: I shared a room with my sister. She laid out all her things and there was no room for two in the bedroom. I stayed 1 year ½ sleeping on a cot in the living room. My father didn't want to do the work to create a new room. My parents rented a small maid's room for me, I stayed for a year there and then I left.

The family begins to make connections between past experiences of anger within the family of origin and current aggression. Reexperiencing trauma memories in a safe therapeutic environment is the key to changing maladaptive aspects of the memory. Such moments of high arousal appear to be imprinted in emotional memory with special potency. They result in emotional responses that can't be understood by children. The parents themselves don't understand. This leaves a person with potent emotional learned repertoires that are difficult to understand because they are stored in emotional memory in an unsymbolized manner. During therapy, anger or intense emotional reaction may need to be aroused to some degree to be reprocessed in the safety of the therapy situation.

Building a Sense of Internal Security/or Autonomy

The therapist's interventions aim to help family members accept their differences, whether in relation to the use of technology, to their values or to their emotional regulation strategies. The therapist questions and deconstructs the "schema-of-being-with[2]" (Stern, 1985) that is activated to interpret what the other person is saying. Together they feel more emotionally secure and can address each other's emotional needs more appropriately. Speech flows more freely, with respect for the other person. The parent's empathic adjustment to the child's needs, moods and fears helps the child internalize a sense of security from the parent and this helps establish a basis for internal security in the child.

> Ms. V is worried about her sons. She worries because Gauthier has no partner, she worries because Florent doesn't seem to have concrete plans for his professional future or even for the vacations. They both want to protect themselves from their mother's concern, which they perceive as a lack of understanding or trust. They react coldly to her concern. The therapist tries to deconstruct this "schema-of-being-with."

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[2] The schema of a-way-of-being-with is conceptualized by Stern from the assumed subjective perspective of the infant in interaction with the caregiver.

> THERAPIST: According to your mother's logic, for a vacation, it has to be planned, there has to be a program.
> Ms. V: A program or a desire! I don't hear him say "Mommy I want to." I don't hear any concrete project from you, I have a floating feeling as if you were weightless. I sent you back to that and you said, "But trust me!"
> FLORENT: I had the feeling that you didn't trust what I was going to do and I find that upsetting. I just didn't feel like talking about it at the time and it wasn't really organized yet.
> Ms. V questions her sons and they don't get her questions right. The interviews help Ms. V accept Gauthier's choice of life and respect Florent's path to set up his projects according to his own modalities.

Implementation of New Behaviors

In this more secure environment, family members can experiment with new ways of communicating. Together they build new narratives of their experiences. Ms. V. and her sons build a common narrative about the place of video games in the family. They agree that the withdrawal into video games is a consequence of the conflictual atmosphere that existed at the time.

> GAUTHIER: Video games were very far from what we could call an addiction, it was more of a passion, this was confirmed afterwards. Florent, like me, we continue to do quite a lot, it's a substantial part of our leisure time and my conception of addiction, it doesn't have the characteristics of it, neither before nor now. When Mom started things from that point of view, it seemed absurd to me!
> THERAPIST: Madam, do you make a link between playing video games and communication problems?
> Ms. V: Yes, I do.
> GAUTHIER: A link what? A causal link? A link of consequences? A correlation link?
> Ms. V: I don't have the same vision. Compared to some young people, you're not in a total addiction, spending nights and days playing, that's for sure, you manage to have your social life, to see friends, to work, etc. But for all that, at one time, it took up a lot of space on a time when we could have spent it together and we couldn't. I'm just saying that it was also a consequence of a mode of communication, of living together, a way of communicating, or also of conflicts, perhaps of things that we hadn't said to each other or that weren't resolved, that made you fall back on friends and video games essentially. There were no exchanges, no sharing time more than that.
> GAUTHIER: I agree that it was a consequence of an atmosphere, a way of life, rather than a cause.
> Previously repressed emotions are expressed. Gauthier can express his sadness at the old family functioning, which he describes as "deleterious."
> GAUTHIER: It was really a way of life that had settled down and an atmosphere that was perpetuated, it was a vicious circle that continued to turn and that was harmful for everyone. The best way to break it was to leave.

Together they build new family rituals. In the context of quarantine, they are in different geographical locations. Consultations are held by videoconference every month. At the same time, Gauthier initiates videoconference appointments with his mother and brother every week. Technology now fosters the family cohesiveness.

Toward the Acceptation of Emotions and the Affirmation of a Stronger Self

The intent of the therapist is to help each person use emotion regulation in a flexible manner and in a way that is consistent with their goals and is considerate of the needs of others. We expect that family members gain emotional intelligence, learn to review the context before deciding whether and how they should regulate their emotion and take into account and maximize intra-individual and inter-individual long-term welfare. For well advanced therapies, some may have reflected on what was passed down to them by their parents or by previous generations. They know that they can refuse this legacy. They have a better understanding of how "schemas-of-being-with-the-other" were created during their childhood and are ready to build new ones. This awareness increases the agency in one's own life and goes in the direction of the emergence of a stronger self. In the last session, Ms. V summarized her change as follows:

> Ms V: Now I can take a step back from the situation, to look at what is happening with fresh pair of eyes, a little bit detached from the scene. Then, I can get out of something epidermal, emotional, to really see what's going on for them. The feelings I had with regard to the wounds, allowed me to take a step back from them more: it's not very easy but it's less painful. From the moment, I can better understand what is happening to the other person, see them as part of a different world, in different relationships, and this makes it a lot it easier. Understanding the other is important.
> Ms. I asserts herself through writing. Ms. R practices hiking. Mr. T understands his gambling behavior as an emotion regulation strategy and uses alternative strategies, supported by his wife. Ms. S accepts that her husband will not change, does meditation to accept her sadness toward her couple and her worries about her children: "I do meditation, I take distance, I let go in the sense that I know that I cannot change him." She has the therapist listen to a podcast on accepting emotions.

DISCUSSION

The current study reports on a change process research focused on therapist interventions with five wired families. We can say that these families are healthy, there are no severe symptoms within these families. The internet use is problematic but life didn't stop. Teenagers go to high school. Young adults and parents go to work. These five families are contemporary families who are challenged by the effects of new technologies on their organization. More severe situations, for example with a teenager locked in his room night and day, would probably require a different approach, more focused on the subject and his psychic vulnerability. The therapist's interventions highlight family dynamics which are consistent with previous research which has shown that PIU and interpersonal relationship problems have a strong correlation. The family approach then seems indicated, which is in line with the recommendations of Young Park et al. (2014) for adolescents.

While 12 phases are presented for these interventions, there is fluidity in the therapeutic process that honors the family's priorities and dynamics as the point of entry. The interventions follow the family's focus, not necessarily in a prescribed linear progression but in a systemic fashion. The family therapist looks into family interactions that maintain problematic behaviors: transactional patterns (Minuchin, 1974 and First-Order Cybernetics), "official program" and map of the world (Elkaim, 1986 and Second-Order Cybernetics) and emotion regulation patterns (Duriez, 2017 and Third-Order Cybernectics). Behavior, cognition and affect work together to create specific interactions which contribute to intergenerational transmission. This consideration of emotion is not new (Bowen, 1978; Johnson, 2004; Greenberg, 2015) but with research in neuroscience and epigenetics, we now have a better knowledge of the complexity of emotional regulation strategies, which is essential for a good perceptivity of circularity in interpersonal relationships. Our work has therefore focused on emotional regulation strategies, whether intentional or automatic, to better identify mechanisms of homeostasis. Bowen (1978) taught us that the lower the level of differentiation is, the more difficult it will be to regulate negative emotions. In the families studied, we observe a low level of differentiation. In fact, we can consider escapism into a technological bubble as a triangulation process that regulates stress, anxiety or tension. Bowen found that tension in a two-person relationship is relieved by focusing on a third person. Today the third party can be a computer, a tablet or a smartphone. Our clinical practice is influenced by the Bowen Model to help the patient identify their relationship to the technological object as a triangulation process, avoiding communication about a problem.

Corroborating previous findings (Lee, 2014), underfunctioning, uninvolvement, and the irresponsibility of the father in areas of parenting and household chores appeared in four of the five families. For the fifth one, the parents are separated. The over-functioning partner was commonly female. We cannot link this underfunctioning to PIU. In the case of the I family, it is the woman who has a PIU but this use does not prevent her from carrying out her parenting responsibilities, at times she could even appear as too invasive according to her children. She builds an intimate emotional cyber relationship with another man to escape from a feeling of abandonment, to forget the lack of connection with her husband and their problem relating to intimacy. Men escape from family responsibilities and rely on women. Women have to cope with a higher mental load and feelings of loneliness. We find the pattern: "The over-functioning spouse was often other-focused in contrast to the excessive self-focus of the underfunctioning partner" (Lee, 2014, p. 381). Within this framework where the woman gives and the man takes, Contextual Family Therapy can help to consider the balance of fairness in family relations. But it's really difficult with the excessive self-focus men. As Lee we were seeing rebuffs and the absence of acknowledgment by the men (M. I. and M. S.). "Shame and a feeling of unworthiness also curtailed self-disclosures" (Lee, 2014, p. 379). This was not the case for the T couple, perhaps because of their youth. When Ms. S tries to express herself, her husband, unable to connect with her emotion, empathy, ends up leaving the session. It seems biologically impossible for him to take his wife's needs into account. An exploration of the literature on dynamic self- and other-focused emotional intelligence (Pekaar et al., 2020) may allow us to refine interventions.

According to the literature Mesch (2006), our findings show that the main problem challenged by the families is the time spent on the Internet to the detriment of family time. "Family time is a major component contributing to family cohesion. It facilitates the development of a collective identity and shared experiences" (Mesch, 2006, p. 125). Weak family cohesion, lack of communication and loss of rituals reduce the perception of family belonging and increases individuality. This creates suffering (Crosnoe and Elder, 2004; Cavanagh, 2008; King et al., 2016). This suffering may be amplified by the presence of old wounds. Can we then consider these relational patterns, with a reorganization of family time, as a new challenge for contemporary families? Is this a specific challenge for wired families? We can assume that if there was no such possibility to escape from negative emotions with technology, there would be an escape by other means (working, playing music, reading, practicing sports, gardening, tinkering, housework, etc.). Already 50 years ago teenagers locked themselves in their room to listen to music or read to extricate from the relationship with their parents. Men went out to see friends when they didn't want to spend the evening with their wife. What is new is that technology is within reach, in the household, and offers very attractive and addictive activities.

Therapeutic accompaniment must therefore make it possible to find the meaning of this problematic use, rather than eradicating it without taking into account the function of this use in terms of emotional regulation. This emotional regulation strategy which can be procrastination for Mr. S who watches series instead of working, an escape for Baptiste, Simon and Lucas R, for Logan S, for Gauthier and Florent V, for Ms. I and her son, Axel, and an anesthesia for Mr. T. As Bowen (1978), we assume that the past influences the present, as past relational patterns continue to influence the present family system. If the family has become rigid in its organization where avoidance strategies dominate, can it be a way of dealing with grief or separation from previous generations? This refocusing on transgenerational processes helps the system to become more flexible, to stop blaming and to assume its own role in this rigid functioning. As therapist and family members see how patterns repeat over generations, it is possible to identify the automatic reactions of family members toward each other. The ability to act on the basis of more awareness of relationship process can lead to some reduction in problematic internet use.

Our approach is similar to that of D'Amore who also worked on the impact of losses on contemporary families: "The family suffering from breakups could freeze in on itself and organize itself as a grieving relational system where the loss would constitute the organizing core of its identity and experiences"

(D'Amore, 2010, p. 17). We suppose that these families where dependence on technological objects is such that it makes some people experience a sense of ambiguous loss are families that are self-organized around the loss: some behaving in such a way as to make others experience this feeling, while others experience this sense of ambiguous loss. In this way, family identity is maintained generation after generation.

The study has several limitations. Great caution should be taken when generalizing the results. Further research with larger and more homogeneous samples (e.g., recruitment of families with the same problem) and studies that test the ecological validity of interventions listed in this study are suggested. This research does not investigate the effectiveness of the model presented. It is only an exploratory research, conducted in natural clinical conditions. This is why the population is heterogeneous as it exists in the active file of the center. The duration of care is not the same. The T family stopped after two sessions because they found a positive dynamic. Ms. T expressed herself and felt heard. The birth of the baby brought them into a new dynamic. Confidence has returned. The R family did not come back after Simon left for another region for his studies. The individual follow-up of Baptiste in a partner center continued. The three other therapies are longer.

It may be interesting to conduct separate research with larger populations and separate therapists on each of the problems presented: video game addiction for adolescents, work addiction for adults, cyber infidelity and poker addiction. This would allow us to assess whether it is relevant to specify family therapy process for each problematic internet use and to build an innovative therapeutic support for each of these clinical situations.

Third, this study only focused on the therapists' interventions without taking the family's behaviors into consideration. Data on family dynamics were collected in a therapeutic context. However, the therapist's objective is not the same as the researcher's objective. An evaluation of family dynamics with standardized tools, such as the evaluation of cohesion with the FACES IV, would have been more rigorous.

The therapist-researcher works with her own subjectivity. The therapist's self is an important factor in the therapeutic process. We have not explored this subjectivity here. The choice to work on emotional regulation strategies and the relationship that the therapist herself has with connected objects deserves to be explored. We suggest further research concentrating on the interaction between therapists and clients in this context. We examined before how the therapist regulates their own emotions regarding the problem brought by the family within the therapeutic encounter. In this way they offer the family an alternative model of emotional regulation that introduces a difference within the system. The therapist's emotional regulation strategies are a core component of the therapeutic process (Duriez, 2018b).

Rather than categorizing the therapist's interventions with grounded theory, it might have been interesting to build five distinct intensive case studies (Duriez, 2009) in order to tackle clinical case's complexity and to identify therapeutic process in all its singularity for each family. We should track changes in family members' constructions over the course of the entire treatment for each family, with measurement of the client's problems, for example with the Generalized Problematic Internet Use Scale 2 (GPIUS2; Caplan, 2010), and with The Difficulties in Emotion Regulation Scale (DERS; Gratz and Roemer, 2004) at different times. Post-treatment interviews with members of the families could provide another perspective.

CONCLUSION

These findings led to propositions for an innovative therapeutic support in family therapy, the *Emotion Regulation Focused Family Therapy* with wired families. Therapeutic work has two directions: (1) the problematic internet use as a maladaptive self-regulatory strategy and its consequences for the addicted person as well as for their entourage according to the contextual approach and (2) the elaboration of a previous loss for the suffering person in order to have a stronger self, regain autonomy and get out of co-dependency. We hope that this study will enrich the practice of family therapists with wired families.

DATA AVAILABILITY STATEMENT

The data analyzed in this study is subject to the following licenses/restrictions: The datasets analyzed during the current study are not publicly available due to confidentiality but are available from the corresponding author on reasonable request. Requests to access these datasets should be directed to nathalie.duriez@iedparis8.net.

ETHICS STATEMENT

The research presented in this manuscript was conducted using the records of five families whose therapy has been completed. It's a retrospective non-interventional research. Written informed consent for the use of these data for research, in particular video recordings, was collected from all the members of family. They were informed that the data may be used for practice analysis and change process research. They were informed they were free to request that the recordings be erased should they change their mind. They were assured they would remain anonymous and fictitious names are used in this text as a safeguard. Ethical review and approval was not required for the study on human participants in accordance with the local legislation and institutional requirements.

AUTHOR CONTRIBUTIONS

ND was the principal investigator who formulated the research question, developed the study protocol, conducted data analyses, and wrote the manuscript.

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Relational Spirituality and Transgenerational Obligations: The Role of Family in Lay Explanatory Models of Post-traumatic Stress Disorder in Male Cameroonian Asylum Seekers and Undocumented Migrants in Europe

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Context: Diasporic Cameroonians are increasingly leading a transnational life in which family members are sustained through networks of relations and obligations. However, before arriving in Europe, the vast majority of African migrants who take the Mediterranean route are exposed to trauma and hardship. Moreover, the joint occurrence of forced displacement, trauma, and extended separation from families has a significant impact on mental health.

Objectives: This study explores the role of culture-specific conceptualizations of family structures and transnationalism in explanatory models of post-traumatic stress disorder (PTSD) among male Cameroonian asylum-seekers and undocumented migrants in Europe.

Methods: An in-depth study of two samples of Cameroonian migrants with a precarious residency status in Europe was conducted. Focus group discussions and interviews were carried out with asylum seekers in Germany ($n = 8$) and undocumented migrants and failed asylum seekers in France ($n = 9$). The verbatim transcripts of these interviews served as the data for interpretative phenomenological analyses.

Results, Analysis, and Discussion: Family was conceptualized in religious and spiritual terms, and relational spirituality appeared to be a crucial element of family cohesion. Explanatory models of PTSD were mainly based on an intersection of family and spirituality. The disrespect of transgenerational, traditional, and spiritual obligations toward parents and ancestral spirits represented a crucial causal attribution for post-traumatic symptoms.

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Conclusions: Conceptualizations of post-traumatic stress were based on a collective family and spiritual level instead of an individualized illness-centered perception. The Western psychological and psychiatric perspective on post-traumatic stress might conflict with traditional, religious, and spiritual practices in the context of family conceptualizations of Cameroonian forced migrants with a precarious residency status.

Keywords: asylum seekers, explanatory models, family, post-traumatic stress, transnationalism, trauma, undocumented migrants

INTRODUCTION

According to the United Nations, the security and human rights situation in Cameroon has significantly deteriorated (1), leading to substantial displacement and irregular migration flows toward the European continent via the Mediterranean route (1–3). Further perpetuating the high rates of irregular migration is the difficult economic situation of Cameroon, with families' incomes declining, the costs of education rising, and the unemployment rate growing (4). France and Germany are the top two destinations of resettlement for Cameroonian migrants in Europe, as the countries are bound by cultural, historical, and post-colonial ties (2, 4, 5). Many forced migrants need to reorganize relationships within the fragmented family, redefine the roles and relationships within the changed family structure, adjust to a new environment, and reevaluate future perspectives (6). Accordingly, the term "transnationalism" describes the unique diasporic experiences of migrant families in terms of maintaining family relationships within and across nations simultaneously (7). Diasporic Cameroonians are increasingly leading a transnational life, in which family ties are sustained through networks of relations, obligations and resources that are located in different nation states (4, 8). The complexity of relationships that arise from transnational connections calls dominant discourses about family bonds into question and requires the adoption of new theory and treatment considerations within a transcultural context (9, 10). Transnational families are one form of contemporary families that demand new analytical frameworks for understanding family relationships (10).

Prior to their arrival in Europe, the vast majority of African migrants taking the Mediterranean route have experienced traumatizing events that have altered their lives drastically (11, 12). During their journey, migrants often depend on human traffickers and are liable to experience physical and sexual violence, torture, and abduction (11, 13–15). When a person experiences a trauma, the range of psychiatric consequences can, inter alia, include anxiety and depressive disorders (16). Moreover, lasting impressions can lead to health problems that are labeled as post-traumatic stress disorder (PTSD) (17). The concepts of trauma and PTSD have been addressed through the lens of an individualistic Western medical nosology (17). According to the World Health Organization (18), PTSD is defined by the core symptoms of intrusiveness or re-experiencing the trauma (nightmares, flashbacks, and recurring memories), hyperarousal (difficulty sleeping, irritability, and hypervigilance), and avoidance (reminders of events and dissociation) (17). Past research in asylum-seeking and refugee populations from Africa found PTSD rates of up to 79% (19–21). Individuals without secure residency status—be it pending cases (22, 23), rejected asylum seekers (24, 25), or undocumented migrants (26)—appear to be at a particularly high risk for ongoing mental health problems and post-migration stress (25, 27).

In Cameroonian cultures, extended family systems and strong kin relations are important, since they provide a sense of belonging and solidarity (4). However, many individuals, traumatized by the hardship endured during their migration path, face a situation of radical rupture and separation from their families remaining at home (28, 29). Accordingly, past research suggests that asylum seekers and forced migrants have the impression of being ripped out of their familial environment, which might provoke feelings of distance, exclusion, loss, and grief (15, 28, 30). Moreover, leaving behind families living in poverty, privation, and danger may precipitate and perpetuate the development of symptoms of PTSD (7, 29, 31).

Critics have blamed the one-sidedness and reductive character of a purely symptom-oriented conception of trauma and post-traumatic stress (32), and have noted that PTSD may be an overly narrow characterization of traumatic stress across different cultures (17, 32–34). Taking individuals' sociocultural backgrounds into account, explanatory models describe the way in which individuals perceive, interpret, and respond to illness, and demonstrate how causality and help seeking behavior vary across cultures (35–39). The concept of explanatory models was first introduced by the medical anthropologist and psychiatrist (40). Explanatory models are shaped by the underlying socio-cultural contexts and can be understood as fluid and multilayered constructs that reflect the cultural knowledge of each individual (37, 41). Conceptualizations about health are, therefore, cultural. They vary widely across societies and sociodemographic groups and should not merely be defined by measures of clinical care and disease (42). In this regard, symptoms of mental disorders and explanatory models are two different constructs and it is possible that there may be different explanatory models for the same symptoms. Whereas, members of white middle-class communities in Western cultures may be apt to view PTSD as a medico-psychological problem requiring individual examination and professional treatment, members of African immigrant populations may conceptualize the symptoms as social problems, requiring collective and relational forms of treatment (15, 38, 43). Considering the important role of the extended family system in Cameroonian society, explanatory models of PTSD in this group cannot be assessed without reference to the family and its involvement (4). Furthermore, to fully understand individual psychopathology, culture specific and transnational conceptualizations of family structures and cohesion need to be taken into account (44). Therefore, researchers and clinicians need to consider not only patients' culturally shaped explanatory models, but also their culture-specific and transnational family conceptualization, as these most commonly differ from Western nuclear family norms (45).

In the literature on African causal theories for mental disorders, the role of family and spiritual etiology is often emphasized (46–48), a finding that also emerged in asylum-seeking populations from Sub-Saharan Africa in Western resettlement countries (49). Past research has documented attributions to causes such as dead, missing, or separated family members; and spirit possession or curses (50). Rather than seek help from a clinician, migrants preferred to first use family support, prayer, or traditional therapies (50, 51). In this regard, scholars have stated that spiritual beliefs and practices are tightly interwoven with sociocultural influences, and vary greatly across and within cultural groups (52). Moreover, spirituality is deeply entrenched in most aspects of family life, influencing the ways in which families deal with adversity, their experience of suffering, and the meaning of symptoms (53). In previous work, we described the interrelatedness of family and spirituality and the way in which symptoms of PTSD were conceptualized among asylum seekers from Sub-Saharan Africa in Germany (15, 43). We found that perceptions of PTSD were conceptualized, inter alia, by familial discords intersecting with supernatural and spiritual levels. Moreover, the role of the family was emphasized with regard to the management and treatment of symptoms of PTSD (43). Thus, we assume that culture-specific conceptualizations of family structures and a relational form of spirituality might influence explanatory models of PTSD of Cameroonian migrants. To date, however, there is no research examining the role of family in explanatory models of PTSD in this group. Moreover, most evidence on asylum-seeking and migrant populations still conceptualizes PTSD primarily on an individual illness-centered level, with the cultural and social embeddedness remaining relatively unexplored.

Theoretical Framework and Study Objectives

The objective of the present study was to explore lay representations and explanatory models of PTSD in Cameroonian migrants with a precarious residency status in Europe, who had migrated via the Mediterranean route. Moreover, in the present paper we focus on the role of culture-specific conceptualizations of family and transnationalism in explanatory models of PTSD. As analyses have shown that African migrants coming to Europe typically show the characteristics of being young, male, and optimistic about attaining a higher standard of living (54), we focused on a male sample in the present study. As study locations, we chose France and Germany, as these are the top two destinations of resettlement for Cameroonian migrants in Europe.

We followed a combined emic–etic research approach by focusing on the etically defined construct of PTSD and employing emic methodologies to measure it. Through such an approach, an emically defined etic construct can be obtained, which facilitates comparisons across different cultural and demographic groups (53). Accordingly, the present research used qualitative methodology that allowed us to focus on the intrinsic cultural and demographic distinctions that are meaningful to the young Cameroonian migrants regarding the intersection of culture-specific family conceptualizations on the one hand and symptoms of PTSD on the other hand. Moreover, the present study is placed within an illness explanatory model framework using a vignette methodology (35, 54, 55). In this regard, we aimed to explore culturally shared and constructed perspectives regarding explanatory models and illness representations of forced Cameroonian migrants, by extending the explanatory model approach beyond just the patient's perspective [see also (38, 55, 56)]. Rather than focusing on a clinical population, we included lay people of Cameroonian origin in the present study. The high prevalence of PTSD among asylum seekers of Sub-Saharan African origin suggests that a large proportion either experiences this disorder themselves or has to cope with other members of their families or communities who experienced trauma and suffer from traumatic stress (55). Research suggests that, particularly in communal cultures, family members have a strong influence on representations of mental health and illness (57). Thus, the views of lay people may be highly informative about how forced migrants with a precarious residency status conceptualize symptoms of PTSD.

In the present study, we conceptualize culture not solely as a set of habits and beliefs about perceived health and illness, but also as political, economic, legal, ethical, and moral practices and values (42). In order to gain a more comprehensive understanding about the explanatory models of PTSD in Cameroonian forced migrants, we aimed to consider the intersectionality of cultural explanatory models and illness representations on the one hand and the current legal and economic situation on the other hand. As common practice in cross-cultural research, we focus on culture at the level of nationality, while recognizing that nation states are rarely homogeneous (55). However, scholars have characterized Sub-Saharan cultures by an emphasis on embeddedness and hierarchy that implies expectancies of obedience, conformity, and group identification (58). We therefore assume that Cameroonian forced migrants might adhere strongly to culturally shaped representations and beliefs as regards how they understand symptoms of PTSD (55). On the other hand, we focus on culture at the level of a particular sociodemographic, legal, and economic level, as the precarious living situation of forced migrants on a foreign continent might have a strong influence on explanatory models as well. The present study therefore contributes to a dialogue between medical anthropology, sociology, social psychology, and transcultural psychiatry.

TABLE 1 | The vignette.

"Since the flight, I have become a totally different person. In the evenings, I lie in bed and then these thoughts and images come and I lie awake forever. Now I have reached a point where I realize I can't go on like this anymore … Sometimes I scream at night and I wake up drenched in sweat because of the nightmares. If I have arrived somewhere and there is a noise, I wince. There it is again. I can't turn it off, it's like an electric shock that immediately goes straight up and triggers intense sweating. My wife/My husband accuses me of often being aggressive, easily irritable and she/he is afraid of my outbursts of rage. That's why I prefer to withdraw myself because I always have a feeling that no one can be trusted anymore. Many things just don't interest me anymore. Sometimes my environment appears distant and unreal and I have a feeling of "standing next to myself," then I become totally numb. Afterwards I sometimes can't remember what has happened. I have no hope left anymore…"

TABLE 2 | Interview guide with regard to a case vignette in which a hypothetical friend described symptoms of post-traumatic stress disorder.

- What, if anything, is the problem?
- What do you call these problems?
- Does he or she have an illness? If yes, what is it?
- Do you have an understanding of this discomfort?
- What are the causes of his/her problems?
- How can you explain what this person is going through?
- What should he/she do about it?
- Has he/she the power to influence the discomfort?
- Where would he/she seek help from?
- What should a practitioner do about it?
- What could a treatment look like?

We formulated the questions based on the Short Explanatory Model Interview [SEMI, (65)]. All questions were open to further exploration.

PROCEDURE

The study involved discussions with 17 young men from the French-speaking part of Cameroon who had taken the Mediterranean route in order to seek refuge in Europe. The first author FG undertook individual research interviews and focus group discussions with eight Cameroonian migrants applying for asylum in Germany, and nine undocumented migrants and failed asylum seekers (who had no authorized or legally recognized presence) in France.

Ethical approval was obtained from the local review board of the Department of Psychology, University of Marburg, Germany, and all participants provided informed consent prior to participation. Contacting the participants required anthropological work by the first author FG. Purposive sampling was utilized in order to approach participants during ethnographic fieldwork in suburban areas of Paris and urban areas of Southern Germany, where asylum seekers are commonly located in accommodation facilities (59–61). This gave the researcher the opportunity to immerse herself into her study field (60). Moreover, it also enabled us to study the research topic in the actual living environment of the participants, in order to get a feel of the life world of migrants with a precarious residency status in France and Germany (60). Concurrently, snowball sampling was employed to recruit additional participants. In this case, we asked men to nominate friends or acquaintances similar to themselves. Specifically, we asked to suggest other Cameroonians with a precarious residency status, who had taken the Mediterranean route in order to come to Europe. Though the snowball method obviously calls into question the representativeness of the sample, the authors' own previous research experiences within African asylum seeking migrant communities, as well as that of other researchers (38), showed that it is necessary for this particular population. Especially with regard to the privacy concerns among undocumented migrants, alternative sampling strategies are unlikely to be equally successful [see also (38)].

For the study, men had to self-identify as having migrated from Cameroon via the Mediterranean route, having a precarious residency status (being undocumented/seeking asylum/failed asylum), and aged 18 years or older. The research interviews and focus group discussions took place in the spring of 2017 in Germany and the summer of 2017 in France. In the present study, no specific assignment of participants to individual interviews or focus groups was made. Participants rather naturally allocated themselves to the different survey methods. We applied this strategy of data triangulation to combine qualitative data drawn from different sources that complement each other in order to gain a richer understanding of the phenomenon under research [see also (62)]. Through such an approach, we ensured a contextual basis for making culturally and demographically sensitive interpretations [see also (63)].

Most of the interviewees expressed concerns about being interviewed in an official facility such as a university. In France, we therefore decided to conduct the discussions in a quiet park that seemed appropriate. The focus group discussion undertaken in Germany took part in prepared rooms in participants' accommodation facilities. The interviews and focus group discussions lasted between 30 and 90 min and were undertaken in French. The mean duration was 1 h. Each interview was audio-recorded and transcribed for later analysis.

We asked participants to provide demographic information and gave them a standardized vignette, illustrating a hypothetical close friend describing symptoms of PTSD according to criteria outlined in the International Classification of Disease, 10th revision (18, 64). Neither the terms trauma nor PTSD were used (see **Table 1**). Participants were asked to imagine the scenario and to indicate their ideas, concepts and impressions concerning the described condition, using the Short Explanatory Model Interview [SEMI; see **Table 2** (65)]. The SEMI is a semi-structured interview using open-ended questions to elicit explanatory models, exploring the respondent's cultural background, the nature of the presenting problem, and help-seeking behavior. The first author FG encouraged participants to talk openly about their attitudes and experiences with the aim of eliciting the concepts held, and to explore their relationship to the current situation and culture. Probes were employed to confirm the concepts mentioned and to explore areas of interest that were

TABLE 3 | Structured presentation of the themes and subthemes of the interpretative phenomenological analysis.

Superordinate themes	Subthemes
Conceptualizations of family	Extended self
	Transcendental family cohesion
	Religion
	Intergenerational obligations
	Tradition and customs
Family in the context of forced migration	Assignment of a family mandate
	Challenges for families
Perceived causes for symptoms of PTSD	Incapacity to adhere to intergenerational obligations
	Malediction
	Disrespect of parents/elders
	Disrespect of ancestors
	Failure to carry out cultural customs
	Incapacity to support one's family remaining at home
Sources of resilience	Reliance on family network
	Receiving blessings from parents
	Performance of cultural customs
	Reliance on ancestors

not raised spontaneously (65). Participants could discontinue the focus group discussion and interviews at any time.

Data Analysis

The analyses presented here are part of a larger study investigating illness representations for PTSD in asylum seekers from Sub-Saharan Africa (15, 43). Interviews and focus group discussions were audio-recorded and transcribed verbatim before being subjected to Interpretative Phenomenological Analysis [IPA; (66)]. We used the analysis software MAXQDA© version 12 to organize and manage the data. IPA is one of the best known and most commonly used qualitative methodological approaches in psychological research (67). It is concerned with the detailed examination of personal lived experience, the meaning of experience to individuals, and how individuals make sense of that experience (67). The present study applied an inductive research methodology aiming to build a theory based on the collection of empirical data rather than to validate or invalidate an initial hypothesis (68). A detailed analytic treatment of each case was followed by the search for patterns across cases, resulting in the presentation of shared themes and particular ways in which these themes played out for individuals (67).

Following different stages described by Smith and Shinebourne (66), the first author began by summarizing and connecting statements recorded for each piece of respective discourse after closely reading the first transcript several times. Initial notes and responses to the material were captured and translated into preliminary themes at one higher level of abstraction. Several themes were interlinked and subthemes were developed, which were visualized in the form of a heuristic chart. This procedure was repeated for each transcript and patterns were established cross-case. This resulted in a master table of themes for all of the transcripts. In a first step, this process was undertaken separately for the two groups of participants (divided by country of residence and residence status), resulting in the presentation of shared themes in a first place separately. In a second step, the themes and subthemes found separately for the two groups were compared with each other. Within this process, we found no differences with regard to explanatory models and family conceptualizations between migrants with different residency statuses (asylum-seeking or undocumented) or regarding the country of residence (France or Germany). For this reason, we treated them as one group within the present study.

Furthermore, the lead author FG received feedback from Cameroonian psychologists and psychiatrists, and the audited themes were reviewed and discussed with other Cameroonian migrants to ensure that conclusions were culturally accurate and well-derived from the transcripts (66, 69).

Sample

Five qualitative interviews and four focus group discussions were completed, with a total of 17 participants. In France, nine young men participated in the study within two focus group discussions and five interviews. In Germany, eight young men participated in two focus group discussions. Overall, the 17 participants had an age range from 20 to 30 years, with a mean age of 26 years. Participants in France had a mean age of 26 years and participants in Germany 25 years. Most of the participants were single, and seven participants had children. One participant was married. Five participants were without formal education, one participant had obtained a school leaving certificate, two a secondary school certificate, and seven had a higher-education entrance-level qualification. Participants' mean duration of stay in France was 1 year and 9 months (range 3 weeks—5 years), whereas the mean duration for participants in Germany was 1 year and 6 months (range 1–2 years). Most of the participants were Christians (12 participants), three participants stated not being religious, one participant was Muslim, and one participant was Animist. Participants were from various ethnic backgrounds, with most identifying themselves as belonging to the group of the Bamiléké (seven participants), the largest ethnic group in Cameroon. Other participants identified themselves as belonging to the group of the Bassa (four participants), the Sawa (three participants), the Foulbé (two participants), and the Beti (one participant).

RESULTS AND ANALYSES

Participants responded promptly to the vignette, and all participants seemed to find it interpretable. Moreover, they stated that the described PTSD symptoms appeared familiar, as they identified them in either themselves or in somebody they knew. The initial objective of the research project was to explore explanatory models of symptoms of PTSD in lay Cameroonian forced migrants who had taken the Mediterranean route to Europe. The importance of family, spirituality and transnationalism in explanatory models appeared as in response to our initial research question and emerged in the themes generated from the transcripts (**Table 3**). The relevance of family in explanatory models of symptoms of PTSD was strongly emphasized in all of the discussions, with the majority of participants bringing up the topic of their own volition.

Relational Spirituality and Conceptualization of Family Cohesion

In general, participants described family in the Cameroonian context as conceptualized not only biologically, i.e., including parents, siblings, grandparents, uncles, and aunts, but also socially and geographically, i.e., including the parents' village communities. The village of origin appeared to be of special importance in creating a sense of belonging and rootedness in a traditional family context. The young men strongly perceived themselves to be members of these collectives and referred to their social positions within their families and their village communities. They often made use of their collective self and their membership within a social collective by referring to "we" instead of "I" when expressing their opinion. In particular, the young men emphasized the special importance of their parents within the familial framework. This was described as being embedded within a spiritual and religious context.

> "In the Bible it is stated: After God there is the parents. (...) So to speak your mother (...) and your father are like God too. That's why we are trying to make an effort to be obedient".

Participants conceptualized religion and spirituality in relational and familial terms, and relational spirituality appeared to be a crucial element of family cohesion within the Cameroonian family, especially characterizing the relationship with the parents and elders. Scholars have defined relational spirituality as the way in which particular aspects of spirituality affect the formation, maintenance, and transformation of family relationships (70–72). This spiritual conceptualization of family cohesion even included transcendental connections with deceased parents, grandparents, ancestors, and ancestral spirits. The communication was described as occuring during sleep *via* dreams and apparitions, often mediated by the parents.

> "Where we come from this will mean that the elderly are not dead. The ancestors/"

Challenges for Families in the Context of Forced Migration and Transnationalism

In the context of migration, the conceptualizations of family were described as entailing obligations and responsibilities, especially toward the parents. The main reason behind migration was reported to be implicit or explicit assignments of a family mandate in order to improve the family's socio-economic situation in Cameroon. In this regard, participants described holding the main responsibility to financially provide for the family in Cameroon.

> "If you are leaving your country for Europe, it's for one purpose: Seeking help for your family. (...) It's the full faith of a family. There is a family waiting for you. You have to help them. (...) So if you are combating, it's for your family".

In this regard, participants perceived their migration as a complex and multifaceted challenge and a combat on behalf of their families. The migration path via the Mediterranean route was described as especially burdensome for the migrants' families. When reporting about the hardships encountered during their traumatizing journey, participants frequently chose their family's rather than their own perspective. They outlined that for their families, their migration meant not only separation and loss of contact, but also uncertainty about their physical integrity and survival. The participants reported abductions by human traffickers ("*coupeurs de route*") and the extortion of their families in Cameroon as common occurrences during their journey. Some participants disclosed that their families were obliged to sell their assets in order to free their kidnapped sons.

> "When you are walking in the desert (...) There are these *coupeurs de route* (human traffickers). (...) They catch us and make us all kneel. They search us. (...) They see that you don't have any money: if they are kind they will let you off. If they are not kind, they will just kill you. They break your legs. (...) They kidnap you. When they kidnap you, they say: those who have money pass. Those who don't have money stay here. (...) And when he finishes like that he will kill you. They will ditch your corpses everywhere".

> "They take Africans to make business, human trafficking. Tomorrow they call your poor family, your family that has nothing to eat, to send money. Your family sells the house that they are living in. (...) There are families that no longer have a house, they have been left homeless. They have sold everything to help their son on his journey".

> "There was no money left. We lost all of the assets we had. What little we had, we took it to pay my journey. I was abducted three times. I lost 3000 Euro during my journey. As I left for my adventure, I did not foresee this. We had to sell our land".

The Role of Family in Explanatory Models of Symptoms of PTSD

The conceptualization of symptoms of PTSD on a relational, familial, and spiritual level appeared to be an important part of explanatory models of the Cameroonian men. Transgenerational and spiritual obligations toward parents and ancestors, and the deliberate disrespect or the perceived incapacity to adhere to these obligations were construed as a crucial causal factor for symptoms of PTSD. Independently, all of the participants brought up the concept of malediction (*malédiction*) for explaining the symptoms of PTSD. Embedded within a spiritual and religious context, a malediction was described as being associated with disobedience to the parents and the disregard of the parents' requests. A malediction was explained as originating from disrespectfully treated or ignored parents and as having the potential to cause serious misfortune in the future life. The transmission was believed to happen from the parent to the child through words:

> "Actually, it's like somebody cursed her. Because she does not recognize herself anymore. It's like somebody cursed her with a malediction".

> "Your mother may be very angry, very. She curses you. (…) Everything you are going to do won't work. You are blocked. (…) Imagine now that with her anger (…) she dies. Your mother dies being angry with you. (…) This is a malediction".

> "For me, the only thing I believe in is the word. For me, words have a significant effect. It means for example, one parent who is dissatisfied with you, employs certain words. This can influence your life. Like the Bible says before: there was the word. This means that God gave a power to the word. (…) So if there is a conflict in your family. Maybe you were disrespectful to an elder or a father or your grandfather, he can curse you. (…) A malediction comes from the word. (…) He can speak some serious words that have aftereffects in your life".

Participants reported the disrespect of ancestors and a failure to honor ancestral spirits as another important cause for symptoms of PTSD. This could be provoked by not honoring the family's or the parents' estate in disregarding their directives. Moreover, another causal attribution for upsetting ancestral spirits was the failure to carry out distinct cultural customs and traditions, such as sacrificing food to the ancestors' tombstones.

> "I am giving you a short example: You are very rich. You have a lot of money. (…) But you have forgotten your great grandfathers. (…) They see that you have forgotten about them. They will make you poor until you have nothing left anymore. (…) This is a malediction. And this can also show in symptoms like that".

> "It's always the customs. You have to renew the tombstones and often buy oil to blend it with salt and everything. You blend it and put it onto the tombstones. (…)You will be asked what you have; you eat with your ancestors. Yes, don't be stingy. It's not good. Because if you don't do it, you can be cursed by the ancestors".

In the context of migration, the young men felt separated from their native land and described that in some cases they were incapable of carrying out certain cultural customs and traditions regarding their ancestors. Moreover, some felt that their spiritual connection was interrupted by the Mediterranean Sea and the hardships encountered on their journey.

> "Before, when I was in Africa, things came to my mind. But since I am in Europe these things don't come to my mind anymore. But in Africa I saw while I was asleep. (…) My ancestors talked to me the day before, while I was sleeping to tell me what would happen the next day. (…) I crossed the Mediterranean Sea, because the Mediterranean Sea is a sacred water. (…) It remained in Africa".

As another important cause of the described symptoms, participants stated the perceived pressure regarding their financial familial obligations and their own incapacity to support their families remaining at home. Beforehand, these implicit or explicit family-instructed assignments were often reinforced by unrealistic and paradise-like ideas about the life circumstances in Europe. Upon finally arriving in Europe, the participants described their shattered assumptions about the realities of life and the dilemma between carrying high expectations and being bound to their transgenerational obligations on the one hand and their own precarious situations on the other hand. At worst, participants described that this could lead to a complete separation from one's family, causing trauma and symptoms of PTSD.

> "If you leave your country in order to get to Europe, it's for one objective: Helping your family. (…) You see somebody who is so eager to go to Europe. He knows in Europe he will find the diamond, gold. But afterwards, he does not find the diamond. (…) He arrives in Europe and he understands that it's not how he has imagined".

> "You know that you have nothing. (…) It's better to part. You see the way you settle down. You know that you have nothing to give".

> "It's a lot. He does not even know his family any more. Since I lived with him, I have never heard him calling his family. So, he lost everything. (…) Actually, I say this may cause a disorder like this".

The Role of Family in Conceptualizations of Cure and Resilience

In general, the cure was strongly dependent on the perceived cause of the symptoms. Most commonly, the treatment decisions were placed in a familial context and help-seeking was reported to rely strongly on the parents or elders. These were stated as the first point of orientation, especially within a spiritual and religious context. Psychological problems were described as being resolved within a family network, and parents and elders were reported to give advice and guidance in the case of mental distress.

> "You don't have the power yourself. It's the mother who will take you somewhere. (…) Maybe she goes to see a seer for this. (…) Either she will say: My son you need to pray. You always have to pray. Or go and see our ancestors and ask them what is wrong. Why does my son have these problems?"

Most commonly, resilience and cure for mental distress was understood to be embedded within a familial context highly intertwined with spiritual, religious and traditional practices. If the cause was perceived to be upset ancestral spirits, the performance of sacrifices was reported as an effective cure to pacify the ancestors and reduce symptoms of mental distress, most commonly mediated by the parents. In this case distinct cultural customs need to be carried out, such as sacrificing food to the family or the ancestors' tombstones, in particular goat meat, red palm oil, salt, and rice. If these practices cannot be carried out by the affected person directly, the sacrificial offering could be performed by the affected person's family in the country of origin (*appeler au pays*).

> "Maybe you are trying to do something but it is not moving forward (...). You approach your mother: Mother, I am trying something here but something is always blocking. (...) Your mother tells you the next day that the ancestors could be upset with you. And if your ancestors are upset, (...) go and see your ancestors. You speak to them. You nourish them. They need to eat as well".

At the same time, the ancestors were described as being a great source of resilience and protection against every form of harm and mental distress.

> "Because after God it's the ancestors who are protecting you. You have to honor your ancestors. (...) They can protect you against witchcraft or against those who want to hurt you, who want to kill you, who want to harm you. (...) One of your ancestors came and gave my mother a sign: your mother has nightmares about you. (...) Somebody wants to harm you. As soon as she has these nightmares, your ancestors will tell [her] what to do because your child is in danger. It's happening like that, where we come from".

In the context of migration, the migrants' family appeared to be the main root of resilience while coping with the hardships encountered during their traumatizing journey. Participants independently brought up the concept of receiving blessings (*la bénédiction*) from parents and the family elders as a crucial source of resilience during their journey and in life in general, and as a cure for the symptoms of PTSD and mental distress. In order to receive a parent's blessing the child needs to respect the transgenerational obligations and duties, and carry out the traditional spiritual customs.

> "Before you are leaving, we make a family reunion. It's a reunion managed by the family of the person that will leave and his whole family needs to come. That ensures that everybody blesses him in order to protect him. (...) They will do a little ceremony"
>
> "The motivation of my family. They were motivating me a lot. You can! I arrived!"

DISCUSSION

The use of an explanatory model approach allowed a detailed exploration of the role of culture-specific conceptualizations of family in concepts of PTSD in lay male Cameroonian migrants with a precarious residency status in Europe, who took the Mediterranean route. Moreover, it enabled us to gain an understanding of the impact of forced migration and transnationalism on relational patterns and family cohesion.

The present results show that Cameroonian forced migrants with a precarious residency status in Europe understood family not only in biological, but also in spiritual and religious terms. Thus, religion and spirituality was conceptualized in relational and familial terms, and relational spirituality appeared to be a crucial element of family cohesion, especially characterizing the relationship with the parents. Overall, studies in different populations suggest benefits of religion and relational spirituality for family functioning and the quality and stability of relationships (52, 73). However, research to date is still limited, and previous studies have predominantly been conducted within Western, highly religious, white Christian families (52). This spiritual conceptualization of family cohesion of Cameroonian migrants with a precarious residency status even included transcendental connections with ancestral spirits. In general, past research has found that transcendent values foster healthy family functioning (52). Moreover, a shared belief system that transcends the limits of family members' experience enables better acceptance of inevitable risks and losses (52). Within a transcultural perspective, the present findings emphasize the intersection of family and spirituality in Cameroonian migrants with a precarious residency status and propose a corrective to a mainly Westernized, overly individualistic and distinct understanding of spirituality and family (70).

Regarding the impact of forced migration and transnationalism on relational patterns and family cohesion, the present study revealed that migration appears to be a multifaceted challenge for families. The migration path via the Mediterranean route was described as especially burdensome, and migration meant not only separation and loss, but also uncertainty about the physical integrity and survival of the departing family member. Therefore, family separation in asylum seekers and forced migrants can be understood as a transnational relational stress and ambiguous loss, insofar as the temporary absence of other family members cannot be fully acknowledged due to the perpetual uncertainty and permanent risk to them (29). Against this background, current European policies that intend to restrict irregular immigration and hamper asylum procedures perpetuate the negative consequences of separating families even more, by impeding reunification (9, 10).

With regard to explanatory models, Cameroonian migrants with a precarious residency status conceptualized symptoms of PTSD on a relational, familial, and spiritual level. The transgenerational and spiritual obligations toward parents and ancestors and the deliberate disrespect in failing to adhere to these obligations were construed as crucial causal attributions. Within this context, the concept of malediction (*malédiction*) appeared to be an important cause of the symptoms. Moreover, the disrespect of ancestors and failure to honor ancestral spirits was another important cause for symptoms of PTSD. These findings are largely in line with past research on explanatory models of mental illness in other conflict-affected African communities and asylum-seeking populations from Sub-Saharan Africa, which documented a failure to honor ancestral spirits and curses to be an important causal attribution (46, 50). Another important causal factor in explanatory models of PTSD was the enormous social pressure to adhere to implicit and explicit family assignments and obligations to send remittances to serve the family interests. The dilemma between the migrants' precarious situations in Europe and the high expectations was reported to be an important source of mental distress, which could lead to complete separations from families. This finding should alert therapists to develop a critical awareness of migrants' transnational family contexts and the tremendous social pressures and obligations inherent therein (7).

Furthermore, Cameroonian migrants with a precarious residency status placed resilience and cure for trauma and PTSD within a family context highly intertwined with spiritual, religious, and traditional practices, and receiving blessings (*la bénédiction*) from parents and the family elders was stated as the most important source of resilience. In this regard, abundant research documents the powerful influence of spiritual beliefs and practices for recovery and resilience (52, 74), and the importance of family cohesion has been described as a crucial element of resilience and recovery in immigrant and refugee populations (75–78). The religious and spiritual conceptualization of family relations in Cameroonian migrants provides a strong sense of cohesion and sense of belonging. Members are able to perceive the experience of forced migration, however painful and uncertain, from a broader perspective that creates a sense of events and fosters hope (52). However, still little is known about what happens to the family remaining in the country of origin. Future research might engage in binational studies in order to assess conceptualizations and perspectives of those members of the same family who stay behind (9). Moreover, it might be interesting to investigate lay representations and explanatory models of trauma and PTSD, as well as family conceptualizations among migrants with a regulated residence status in order to further explore the influences of the precarious living situation.

The present results demonstrate that on the one hand family is experienced as supportive in Cameroonian migrants with a precarious residency and can promote resilience. On the other hand, family can be perceived as a burden due to the feeling of responsibility toward ancestors or feelings of guilt toward family members who have stayed behind. In future quantitative research, it might be interesting to explore individual differences linked to own stressful experiences among a larger group of participants. Moreover, it might be interesting to explore whether subjective explanatory models open scope for a specific way of coping, such as praying or creating individual meaning, in contrast to the peritraumatic and often re-enacted powerlessness and helplessness, which are frequent symptoms in treatment.

Our results suggest that the Western psychiatric perspective on post-traumatic stress and the individual patient-centered approach employed by Western-trained psychotherapists might conflict with traditional, religious, and spiritual practices in the context of family conceptualizations of Cameroonian forced migrants with a precarious residency status in Europe. Accordingly, an increased awareness among healthcare providers of how family context and the intersection with religious and spiritual belief systems impact the mental health of migrants is needed (26). Clinicians might respectfully inquire about the meaning and importance of religion and spiritual beliefs and practices in the individual and family life, explore spiritual and family sources of distress, and identify spiritual and religious resources (52). However, many Western therapists feel that their training leaves them ill-equipped in this regard and find it uncomfortable to address transcultural, religious, and spiritual topics (52, 79). Thus, our results uncover the need for culturally relevant tools for screening and addressing the mental health needs of patients from different cultural backgrounds. However, on the one hand scholars have criticized that the assessment of explanatory models has not yet been integrated into routine clinical practice, regardless of its importance for the improvement of cultural competency in assessment, diagnostic validity, and the therapeutic relationship (35, 80). Moreover, the majority of published guidelines on cultural and spiritual assessment and interventions are designed predominantly for individuals, and fail to differentiate between individual and family spirituality (81). On the other hand however, it should be noted that in view of the frequency of trauma-related disorders in asylum seekers and forced migrants, this demand might often represent an excessive requirement for clinicians and psychiatric institutions. Therefore, clinicians should adopt an attitude of cultural humility (82, 83), were practitioners have an interpersonal stance that is other-oriented rather than self-focused, characterized by respect and lack of superiority toward a patient's socioeconomic and cultural background (83). In this regard, clinicians should show interest in the patients' assumptions about their illness and see themselves as non-paternalistic learners. In this way, distrust can be reduced, misunderstandings can be prevented and a discourse creating coherence on different disease concepts can arise without running risk of cultural stereotyping.

LIMITATIONS

While interpreting the present results, some limitations and methodological considerations should be taken into account:

In the present study, we combined data of two samples of Cameroonian migrants (asylum-seeking vs. undocumented) residing in two different European countries (Germany vs. France). While we did not find any differences with regard to the conceptualizations of family and its role in explanatory models that could be traced back to the migrants' legal status or their country of residence, an influence of these two factors cannot be fully ruled out. Although there are striking similarities in the relationship of the two host countries with Cameroon (the colonization of Cameroon first by Germany and subsequently by France), there appear to be some major differences as well (e.g., in terms of the extent of the colonization and the decolonization process that followed).

Moreover, we used different qualitative methodologies for the data collection, combining data generated from interviews and focus group discussions. While we did not find any differences with regard to the conceptualizations of family and its role in explanatory models within the data, critics have argued on the one hand that data yielded by focus group discussions are often influenced by social dynamics and frequently describe what people assume they should think, rather than what they actually think (46). However, on the other hand, past research has pointed out that compared to individual interviews, several types of sensitive and personal disclosures were more likely to be reported in a focus group setting, and that some sensitive themes only occurred in the focus group context (84).

We used a general population approach by applying a case vignette design. A disadvantage of this study design is that information about conceptualization of traumatic stress is taken from a third-person perspective. While widely used in transcultural research, vignette methodology is limited in its generalizability to real clinical situations [see also (57)]. Moreover, it is important to point out that not all described symptoms are specific to a diagnosis of PTSD and can also occur in other mental disorders, so that the statements in the case vignette can also be applied to other mental disorders or mental distress in general. Furthermore, we did not particularly assess participants' psychopathological status. Readers should be mindful about the fact that individual psychopathology might shape the interpretation of the presented vignette and even conceptualizations of symptoms of PTSD, whereas severely traumatized persons might differ in their interpretations.

Another important limitation of the present study is the small sample size, which leads to a limited generalizability of the present results. Due to the limited number of participants, caution is warranted in drawing conclusions about the impact of culture on participants' conceptualizations of traumatic stress. Furthermore, we do focus on a particular group of Cameroonian migrants, i.e., those with a precarious residency status who took the Mediterranean route. In general, the aim of qualitative research designs is to investigate a specific phenomenon in a certain population, with a focused locality in a particular context. Therefore, the generalizability of our findings was not an essential attribute (85). Moreover, participants within the present sample highly differed in terms of their educational and socioeconomic background. While analyzing the data, we did not find any particular differences between the participants in this regard. However, we cannot fully rule out an influence of the educational background on conceptions of family and explanatory models of PTSD. Thus, our results represent an important contribution to the present understanding of conceptualizations and explanatory models of symptoms of PTSD, but are only paving the way for future research including larger sample sizes, clinical populations, Cameroonian migrants with a regulated residency status as well as native comparison groups.

Furthermore, data collection and moderation of interviews and focus group discussions were conducted by a white, female researcher, which might have led to a selection bias. Some men might have been reticent to share their opinion due to a feeling of social desirability, or due to differences in gender, social class, and cultural background.

As our sample consisted of only male participants, the present findings represent a male point of view. Thus, an influence of gender on the conceptualization of family and its role on explanatory models of trauma and PTSD can be assumed. This might be of special importance, as the Cameroonian society is highly patriarchally organized, and women might have very different perspectives on family structures and transgenerational obligations. Therefore, future studies may wish to consider investigating female samples in particular.

Even though we focused on migrants from Cameroon, we recognize that countries are rarely homogeneous societies with unified cultures (58). As such, it should be kept in mind that Cameroon is one of the most diverse countries in Sub-Saharan Africa in terms of geography, language, ethnicity, and religious affiliation (4). While we took the ethnic, religious, and geographical diversity of participants into account when analyzing the data, particular conceptualizations of family and its role in explanatory models might still vary between different cultural and ethnic groups of Cameroon.

CONCLUSION

The conceptualizations of trauma in Cameroonian forced migrants with a precarious residency status were based on a collective family, religious, and spiritual level instead of an individualized illness-centered perspective, challenging the narrow conceptual framework of PTSD. Thus, the Western psychological and medical perspective on traumatic stress might conflict with traditional, religious, and spiritual practices in the context of family conceptualizations of Cameroonian migrants with a precarious residency status. When working with traumatized migrants from Cameroon, health professionals need to use a broad and flexible multifocal lens (6). It is necessary to acknowledge the diversity of belief systems and attitudes within cultures and to attempt to understand each individual context as embedded within a culture-specific family context and a particular demographic situation. Clinicians working with traumatized Cameroonian migrants with a precarious residency status can respectfully address patient's cultural needs by assessing the family history and exploring the intersection with religion and spirituality.

European health care systems need to take into account the changing demographics of populations and family configurations, and provide appropriate mental health care for the growing number of forced migrants and migrants with a precarious residency status (3, 14, 86). Moreover, mental health care providers require skills in trauma-informed and transcultural care in order to meet the complex needs of populations from diverse cultural and demographic backgrounds. The training of Western clinicians and health care providers working with migrants from diverse cultural backgrounds should incorporate knowledge about explanatory models and specific cultural, religious, and spiritual characteristics. Furthermore, therapists must pay attention to the complex interactions within family systems and even develop transnational collaborations in order to help their patients (10). Future research might stimulate new theorizing about definitions of family life, how relationships evolve at long distance, and about how to develop systemic and even transnational interventions for separations (10). Finally, family therapists should prioritize the study and treatment of transnational families and consider family members across national borders (10).

DATA AVAILABILITY STATEMENT

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

ETHICS STATEMENT

The study was reviewed and approved by the local review board of the Department of Psychology, University of Marburg, Germany. The participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

FG analyzed and interpreted the data and was a major contributor in writing the manuscript. SS and MM contributed to the interpretation of data and critically revised earlier versions of the manuscript. RM was the senior principal investigator of the study, gave feedback to the analyses and the interpretation of the data, and was a major contributor in writing the manuscript. All authors read and approved the final manuscript.

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Couples Coping With the Serious Illness of One of the Partners

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Chronic kidney failure is a serious somatic disease. Addressing the issue of living with a chronic disease means fully considering the patients' entourage, their families, and those close to them, especially their children and spouses.

Objectives: The present paper focuses on the couple's psychological experience when one of them suffers from a chronic disease, in this instance kidney disease. In particular, how is the spouse affected by the treatment provided? The aim is not only to see how care for sick people can be improved, but also, more specifically, how relatives and especially partners can receive attention.

Methodology: A qualitative approach is not only adopted, being based on the psychotherapeutic follow-up of the partners of patients with chronic kidney disease, but also of the patients themselves, addressing the matter of their life as a couple. Three couples were considered, and two case studies are presented here. The issues that cut across these different situations are examined.

Results and Discussion: Some couples show considerable resourcefulness. However, over the years, that capacity for adaptation and inventiveness can also be interrupted by the periods of greater suffering and even despair, especially when the somatic pathology becomes chronic. Many spouses talk about how living with a sick partner weighs down on them, causing severe fatigue. Some aspects of the illness can also become traumatic. The disease regularly disrupts the daily life of the couple and the family. This leads to a reworking of family relations. Each couple has its own history with the condition. As it emerges, it can disrupt the bonds of filiation, especially when the illness is hereditary. Making psychological care more accessible to the partners involved constitutes a major challenge for our hospital care systems.

Keywords: serious somatic disease, chronicity, spouse, partner, couple, reworking of family relations, transmission, filiation

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INTRODUCTION

Major challenges currently exist in Europe and indeed worldwide to provide better management of patients suffering from chronic and/or noncommunicable diseases, whose numbers are constantly on the increase. "Noncommunicable diseases (NCDs), including heart disease, stroke, cancer, diabetes, and chronic lung disease, are collectively responsible for almost 70% of all deaths worldwide."[1] The available definitions focus mainly on the duration of the disease. According to the World Health Organization (WHO), chronic diseases are long-term conditions that generally progress slowly and require long-term treatment and care.[2] However, definitions may vary from country to country and according to the underlying national objectives.

The proposed work aims to reflect on the couple's psychological experience when one of them suffers from a chronic illness, in this instance kidney disease. People with chronic kidney disease and their partners will be more specifically considered. However, a significant part of our study is also relevant to couples with one partner suffering from another chronic disease. The pattern that emerges is one where those close to people suffering from such diseases still receive insufficient attention, with little or no support even when they feel the need for it. It is clearly essential to review practices in health services and to give consideration for the sick person as a whole, both somatically and psychologically, as also their family and friends.

Chronic kidney disease is a serious somatic disease characterized by impaired kidney function. As the kidneys no longer effectively filter the blood, the patient has to undergo dialysis or receive a kidney transplant. As treatment regimens improve, it is becoming increasingly common in the course of care for patients to go through both dialysis and transplantation. "We do not always realize it, as its work is so silent, but the kidney is an essential organ, and when it no longer functions, when we are, like me, in acute renal failure, all the other functions are distressed: if we do nothing, we die of poisoning" is how the novelist Nathalie Rheims so appositely described her condition (Rheims, 2019, p. 18).

People with the disease suffer from a chronic and potentially fatal illness. They can no longer "self-preserve" (Cupa, 2007). This is a "clinic of reality" (Raimbault, 1982). That one's very survival depends on bringing a machine or someone else's organ to intervene in the body is a staggering realization. A number of authors have stressed this (Becker et al., 1978; Carbonell, 1978; Cupa-Pérard, 1985; Cupa, 2000, 2002, 2009; Causeret, 2006; Riazuelo and Cupa, 2013; Riazuelo, 2016, 2020; Paumier-Bidault and Michel, 2018). The three weekly sessions of dialysis provide an incessant reminder of possible death.

The risks of depression are regularly highlighted in the international literature, both at a medical level and in the field of health psychology. There are numerous references in this field (some recent ones being Bonenkamp et al., 2020; Nair et al., 2020; Schouten et al., 2020 etc.). These studies seek to establish scales (of depression and anxiety in particular) and relevant and operative measures, particularly for preventive purposes, or to provide a comparative analysis of the treatments proposed (hemodialysis in the center or at home, peritoneal dialysis, before and after a transplant, etc.).

At a more psychodynamic level, Marty (1980) writes of "operative thinking" anchored in the factual. A lack of affect and a modification of the representational framework (in the sense of A. Green) can be observed as feelings and emotions no longer interconnect. J. MacDougall speaks of these somatic manifestations as "theaters of the body" as "crushing" these patients and "of their emotional state in the face of almost any situation capable of mobilizing emotionally charged performances. The curtains were somehow tightly closed on the psychic stage, no sound reached the ears of those outside, and yet a drama was played out on the inner stage of the one whose very life was threatened" (MacDougall, 1990, p. 15). They are regularly caught up in the present and enduring reality of the illness.

Medical progress has pushed back the limits of mortality. This is all about growing up, living, and aging while striving to survive a serious illness. The question of the entourage of sick people, their families, those close to them, children and spouses, then arises. The bonds with others are central to everyone's lives. Maintaining them involves investing in one or more other people who invest in you in return. It is all about the friendly, loving, and family sphere that brings what is needed for a rich emotional life. This takes on its full meaning when the vicissitudes of life render one more vulnerable. The strength of such bonds can take on an essential and sometimes vital dimension (Bacqué, Baillet, 2009). It should be emphasized that the relationship with the medical and care teams is central to day-to-day care and treatment and, more generally, to the relationship between sick people and their illness.

The importance of the relational realm of the friendly and loving environment for patients emerges chiefly in research focused on the quality of life of sick people (Cupa, 2002; Morelon et al., 2005; Belasco et al., 2006; Draskic et al., 2011; Czyzewski et al., 2018; Schouten et al., 2020). Some works focusing on the relatives of patients with chronic kidney disease have also been published (Kaye et al., 1989; Devins et al., 1997; White and Grenyer, 1999; Gee et al., 2005; Belasco et al., 2006), and there has been a succession of further articles in recent years (Roques and Proia-Lelouey, 2015; Gilbertson et al., 2019; Jean-Dit-Pannel and Thomas, 2019 among others). These studies describe how the sick person not only finds support from their partner, contributing to their well-being, but also underline the draining effect this can have on that family member (Kaye et al., 1989). Conversely, some patients insist on the overbearing nature of the role their spouse takes in daily life and care, which can undermine the relationship within the couple (Devins et al., 1997). Multiple scenarios arise. In some instances, the partner becomes a kidney donor for his or her partner. Each couple has its own history more or less directly relating to dialysis or transplantation. Some patients and couples choose to "leave the illness behind in the hospital." Dissension too may emerge. Despite the multiplicity of situations, all the authors consulted describe a situation that can be extremely distressing for relatives (White and Grenyer, 1999; Ekelund et al., 2004; Gilbertson et al., 2019).

The past few years have seen an emergent literature on "carers" and "family carers." The term is being used increasingly, often to refer to those looking after people with a severe motor impairment, a severe psychiatric disability, Alzheimer's (Schuster and Pellerin, 2019, for example) or cancer (Jarrossay and Paternostre, 2020, for example). These people come in on a

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[1] https: //www.who.int/health-topics/noncommunicable-diseases#tab=tab_1
[2] idem.

regular basis to help in a non-occupational capacity with the activities and tasks of daily life. Their workload is gradually being recognized in many countries.

In the medical field, and more particularly in nephrology, Gilberston et al. identified 61 studies in 2019 that focused on the issue of family caregivers of dialysis patients. This figure is interesting in light of the fact that just 10 years ago; such research was still extremely limited. When carrying out this systematic review of the literature, they noted the difficulties involved in making comparisons given the extreme diversity of the methodologies adopted. However, they point out that they regularly identified a number of salient features. Firstly, the quality of life is worse among these carers than in the general population but still remains comparable to that of carers devoted to other chronic pathologies. Workloads are also heavier. This improves when the patient is transplanted. However, depression is less common among carers than among those suffering from kidney disease. Meanwhile, the cases of depression are regularly comparable or slightly higher for carers than for the general population. It should be noted that caregivers are most often married women.

These observations are interesting and help to contextualize our arguments. Above all, the concern is to clarify the experiences of family carers of people with chronic kidney disease by looking at what they can deliver and develop during psychotherapeutic follow-up. The aim is to adopt a psychodynamic approach to investigate some of the complex aspects of these situations and what lies at stake in the couple's relationship.

METHODOLOGY

The methodology adopted was qualitative. The clinical material derived from several psychotherapeutic follow-ups with a psychoanalytical orientation. These follow-ups were conducted in a nephrology department within the framework of the Nephrology Psychosomatic Unit.[3] Follow-up programs were initiated for three partners (wives in the present instance) in response to their request for psychotherapeutic assistance. Their husbands or partners were dialysis patients at the center. The carers did not remain at the bedside during hospital treatment sessions although they participated actively in at-home dialysis. We met them alone and took detailed notes on what they reported as they talked about their relationships.

In each case, the support lasted at least 3 years. The sessions were regular, with one session per week or every fortnight for the third. Each situation was considered as a case study and cross-cutting themes were identified between them. For ethical reasons, all situations are made anonymous.

The following **Table 1** gives a summary at start of psychotherapeutic follow-up:

Attention here will first be devoted at greater length to two psychotherapeutic follow-ups. The first case was that of a woman whose husband had been suffering from chronic kidney disease for several years while the second concerned a dialysis patient who regularly talked about his couple during interviews. These two individuals' narratives provide a valuable insight to help better understand their individual experiences in that clinical situation, giving the complementary perspectives of the spouse on the one hand and the sick person on the other.

CLINICAL RESULTS

"Time Goes by, and Who Am I? Just Another Carer"

Nicole requests a psychological consultation when her husband has already been on dialysis for many years. She arrives very tired and depressed. She says she knew about her husband's kidney problems from the early days of their married life. Gradually the disease took hold and dialysis became inevitable. She had been alongside him from the start, supporting him at each stage, managing the medication, organizing appointments, and resolving travel issues. She also oversaw a large share of their daily life. She relied heavily on assuming her role as a grandmother, relishing her grandchildren's laughter echoing around the house. There was no real respite, but at least the children's presence boosted her.

Her reasons for asking to meet a psychologist were largely due to her feeling unable to imagine her future without being overwhelmed by anxiety. She felt that even the slightest mishap might lead to total disruption. She became obsessed with this fear. The trepidation relating to the illness meant she no longer

TABLE 1 | Some data regarding subjects we met.

Partner	Age	Living as a couple since	Medical follow-up time	Session frequency	Partner's type of medical treatment	Partner's dialysis duration
Nicole	65 years	42 years	5 years	Every week	Dialysis centre	6 years
Séverine	62 years	38 years	3 years 8 months	Every fortnight	Dialysis centre	15 years
Marie	58 years	27 years	3 years	Every week	Dialysis centre	2 years
Patient	**Age**	**Living as a couple since**	**Medical follow-up time**	**Session frequency**	**Type of medical treatment**	**Dialysis duration**
Paul	75 years	33 years	3 years 4 months	Every fortnight	Dialysis centre	10 years and a half
Alexandre	52 years	8 years	3 years 6 months	Every week	Dialysis centre	30 years
Louis	55 years	30 years	4 years 3 months	Every week	Dialysis centre	7 years

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[3] The Nephrology Psychosomatic Unit (AURA APP) is a team of four part-time clinical psychologists offering consultations for people with kidney disease. It also caters for the family and friends of patients followed in the unit, especially their partners.

dared make plans for travel or home improvement work. Even suggesting that they take a weekend off together from time to time proved impossible for fear of being turned down by her husband. This led to her just living despondently from day to day. Her discourse over the months revolved around the drudgery of their daily life with nothing positive to add except to say that she knew her husband did all he could, that the disease had "struck him" and that he was in no way responsible. Her own good health became a source of guilt and she often had to rein in her own aggressiveness, finding it difficult to put words to her pain, all the more in so far as she regularly had the feeling that she had been reduced to simply being the servitor to a sick person. Nicole felt less and less listened to: "At least we take care of him, we take his pulse, we listen to his heart… But nobody's there for me. I do not even have the right to take a break." She told me, for example, that she had recently accompanied her husband to a consultation with a specialist and that when she entered the surgery the doctor welcomed them in and pointed to a chair saying "Here's the seat for the carer." That short phrase had echoed back to her over and over, summing up the level to which she had been reduced. She was no longer really "Nicole," "Mrs T." or even "the wife of" but merely the helper of a sick partner. Then, indulging in a swing of mood, she explained to me that she did not consider herself as a caregiver. She could not bring herself to do so. Knowing all the doses of medications by heart, taking his blood pressure, managing certain dressings, and so on she was able to find a place alongside her husband, almost forgetting her role before the disease invaded their lives. She reflected that she had just become one of her husband's caregivers. This was sometimes tinged with a hint of rivalry. The impression of being in control of the disease gave her the impression that she was somehow mastering the situation in the face of certain anxieties, especially relating to death.

Over time, she found that the disease invaded what bound her to her husband. There was never a break and there would never be a cure as such. The treatment allowed her husband to survive and would always be necessary. She felt caught up in this helping relationship. She came round to thinking, on some days, that she was sacrificing herself and would never be able to get out of that relationship that she described as a "stranglehold." How could her life be summed up that way? She also stressed that being just a caregiver also meant reducing her husband to being a sick person only. She realized that she was adopting a relationship of overprotection which, combined with the absence of any sex life and the decline of her sick partner, was almost reminiscent of the bond between mother and child. She added that with the disease she no longer recognized her husband's body. She sometimes feared "damaging" that body already weakened by illness. That illness was omnipresent in their intimacy. Sexual relations had become increasingly rare, frustrating and then non-existent. From the onset of the disease, their sex life had been undermined, as has been observed for so many couples (cf. Ekelund et al., 2004). Nicole not only talked about the waning of desire but also about the fear, sometimes as a form of reaction, of further harming his sick body. She remained frightened after her hand accidentally brushed the fistula and she distinctly perceived his pulse throbbing on the surface of his skin. She struggled not to reduce her husband to that sick body. Sometimes she found herself fixated on certain scars, remembering how he had found the will to fight back against the disease. That heroic dimension enabled her, then, to continue investing in that body, in the hero facing off the disease.

Suppressing her emotions so as better to support her husband as she thought, she gradually isolated herself in her distress. She slowly became depressed, withdrew socially, without being able to talk about her fears, her anxieties and what made her aggressive. She had moments of anger that helped her to fight off depression but that also made her feel guilty, further depressing her. She felt caught up in a vicious circle. The first consultations were essentially devoted to letting that pent up frustration find expression. Gradually, she came round to talking about herself, telling her story. In a game of disinvestment and reinvestment, she was able to resume certain leisure activities, see her husband a little differently, even though any somatic problem that arose would open the way for diffuse anxieties to affect them both, each of them mirroring the other.

"Everything Against the Other"

Paul was a 75-year-old patient who had been on dialysis for just over 10 years. Psychiatric consultations had lasted a little more than 3 years with one session every fortnight. His wife had not received any special attention from the Dialysis Unit but had been very much present alongside her husband. She was seen to accompany her husband for each of his treatments at the Unit. She prepared his dialysis bag for him and provided him with a book, food and a blanket. She would leave after his being connected to the machine and having received a text message from him telling her that everything was fine, coming back 4 h later to pick him up. Sometimes she stayed in the waiting room throughout dialysis. During those periods of separation, they phoned each other or sent text messages.

During our consultations, they would sit next to each other. As I moved over to greet them, they both stood up together. She helped him a little while he leaned on her and in turn helped her to her feet. I sometimes had the feeling that she was somehow entrusting her husband to me. She settled down to wait for him, filling in time by doing crossword puzzles. He took a long time before letting her go from him, even for the short time of a simple consultation. When separating, they were attentive to each other and rushing them was clearly not an option. Our conversations led to Paul telling me a lot about his wife. He first met her quite late in life at a business meeting outside his company. He had been sharing everything in life with her for more than 35 years. They had gone through the announcement of the disease together. Dialysis after dialysis, she was the one who placed the anesthetic patch on his fistula, for example (arteriovenous access for dialysis), to reduce the pain on the needle site. In the course of the interviews, Paul stressed how meeting his wife, willing and able to protect and care for him, was so vitally important to him. He explained to me that he had previously lacked real attention and "true care." He added that he too was very much present alongside his wife. Their relationship was fusional.

After more than a year of consultations, he brought up the matter of separation in the waiting room. At first, he smiled at the idea, depicting that eventuality as a moment in suspension. He talked about it gently and tenderly, insisting on the solidity of their couple, the attentiveness they afforded each other. At times, a sense of unease laden with anxiety became apparent as he explained how it was important to prepare for the moment when they would have to take leave of each other for good. Discussing the matter of the disease, the guilt he felt for putting his wife through the trials of his illness and the likelihood of a fatal outcome were central to our discussions. He told himself that 1 day he would have to pluck up the courage to talk to her about his worsening state of health and the inevitable fatal outcome. They both followed changes in his condition together, reading the medical reports together, but never talking about it. "The matter of the illness and the background of my death became taboo," he told me that "too painful even to contemplate." During consultations that moment in the waiting room when they let go of each other's hands with great delicacy to take leave of each other, and in a way put the issue of separation to work, came up regularly. Paul also made a connection with the care given him by his godmother when, as a child, he arrived at her home weak and undernourished and how during a walk to strengthen his muscles, he was able to let go of her hand and make his own way proudly and confidently. He also confided that he had been talking about his fears with his son and how he was counting on him to take care of his mother should anything happen to him.

DISCUSSION: THE COUPLE COPING WITH CHRONIC ILLNESS

These two series of consultations shed light on the complexity of what plays out within a couple when one of them is seriously ill.

In a cross-cutting manner (concerning six follow-ups, three partners and three people suffering from nephropathy), let us emphasize that a number of couples were seen to have demonstrated a considerable capacity for adaptation and inventiveness over the years. Some periods were clearly more painful and a source of suffering, especially when the somatic pathology worsened. The loneliness experienced by some partners was regularly expressed. While early on they said they felt supported, they found themselves being given less and less attention as time went by.

Furthermore, as outlined in the methodology, it was noted that over more than 20 years of clinical practice in a nephrology department and having followed several relatives of sick people, those coming in for psychotherapeutic care consultation were mainly wives. The literature too reveals that family carers are regularly wives. Gilbertson et al. (2019), who carried out a broad review of the literature on the situation of carers of people undergoing dialysis, found 61 studies on this issue, where the group identified were wives of patients (72.3% of hemodialysis patients and 20.6% of peritoneal dialysis patients).

The way the disease is managed can also vary. Many of the patients' partners were heavily involved in the local community. This also provides another way of understanding the disease and feeling active. However, even though I only met female partners, it did not seem appropriate to confine my comments to them alone. Certain lines of thought and experiences are cross-cutting, shared, regardless of gender, when faced with a serious and chronic illness. The following are the main points.

Guilty of Being in Good Health, Guilty of Being Sick: in Silence

Sometimes feeling guilty for being in good health, partners can enter into a sort of spiral, where they come to accept all the patient's demands. In such moments, emotional distress can arise. They refrain from speaking out, avoiding even minor clashes that could mildly hurt the feelings of the sick partner. This was especially the case for Nicole. She wanted to be absolutely perfect, attentive to every detail, throwing herself into everyday tasks. She was the "good mother" who cared whatever she might be going through. There was no question of any form of self-indulgence, no other options were available to her as she kept telling herself, paradoxically sinking into passivity in her relationship with her husband, never answering back or refusing him anything. But there were times when she could hardly bear the state of dependency in which her husband regularly found himself. After a few months, she realized that she could also maintain this dependency herself. Her husband may regularly be exhausted by the illness, but gradually they would find common ground on what could be managed by one or other of them.

As she devoted herself to this care work, she managed to explain to me that while never overtly expressing her feelings, especially her ambivalence and aggressiveness, these could find indirect expression when dispensing care. For example, she sometimes went through the motions too fast, ripping off the armband of the blood pressure device, thus hurting her husband. The unconscious desire to assault her partner, urged on by death wishes, can overwhelm the spouse who then feels a painful sense of guilt. A guilt that can resonate. Paul too, for example, felt guilty toward his wife for being a sick husband.

Some partners regularly talked to us about their weariness, their sense of guilt at being exhausted and being unable to bear the place the illness occupies.

Containing Diffuse Anxieties

In *Les Reins et les Cœurs*, N. Rheims narrates her experience. The narratives of this French writer provide, particularly, enlightening insights. She is currently undergoing a transplant as a result of kidney disease and her mother and grandmother also suffered from the same condition. "I can hear the regular noise of the machine filtering me like a sponge. I follow the path my blood takes. It leaves me, passes through the artificial kidney, then comes back, through the same orifice, into my veins, cleaned, washed out. Impossible to imagine this return journey between the inside and outside of the body without having gone through it. You also have to get rid of all that water that makes me a monster of the depths, something you hardly think about either. Dying submerged by your own fluids is like returning to the fetal stage, floating in your mother's womb, but to drown there" (Rheims, 2019, pp. 77–78). The author captures the complexity of the treatment and how it chronically stretches the boundaries of within and without.

A similar picture emerged from the interviews. The difficulty of containing one's anxieties, those that remain diffused in the space of the couple and the family, were mentioned repeatedly. The inevitable transformation imposed by dialysis can be experienced as a catastrophic change in the sense of W.R. Bion, where the patient feels powerless and overwhelmed. Commencing dialysis requires an intrapsychic and intersubjective reorganization. This means looking at oneself and one's life without overly denying the loss of oneself. Faced with this complex situation, patients will use more or less onerous and effective strategies depending on their personality. At times when somatic disorders intensify, when complications suddenly arise or when pain builds up, the partner is largely drawn in to take on some of the burden, helping to contain the effects alongside the sadness, the fears and anxieties. The recurrent themes evoked related to anxieties of being drained (fear of the extra-corporeal circuit and that the inside will flow out) and those relating to death. These are often the most psychologically disturbing. That suffering can become unbearable when fear of dying becomes daily, coming in to undermine and subvert the continuity of daily life. The state of passivity, or even passivation, the dialysis patient is forced into can lead to dangerous forms of regression and pathological mourning. With the supportive partner too, there is a need to take an interest in the most basic forms of distress, to listen to the most primitive anxieties. They may be a depository or be traversed by formal signifiers (Anzieu, 1987) and archaic anxieties. The partner may be confronted with a sick person whose somatopsychic limits are threatened. They are, as it were, dislocated, pierced by the repeated drawing off of the blood, which then circulates outside the body. The phantasm of a "flayed body" emerged several times in interviews with Nicole.

Trauma Transmission

There is also the matter of mental paralysis and traumatic metaphoric "break-ins" in the couple and/or the family. One author, E. Reinhardt, recounts his personal experience and the illness of his wife, suffering from cancer, in one of his narratives. The somatic condition is different but similarities can be drawn, especially in terms of the families' experiences. He writes: "I told myself that the worst was not so much the illness, which was now being treated by the doctors, but the fear, the anxiety, the devastating panic. I was afraid she would give in to her illness" (Reinhardt, 2017, p. 12). Nicole evoked the same pervasive anxiety that her husband would let go and no longer fight back against the disease. A fear and distress she sometimes recounted repeatedly in a traumatic manner.

Nicole also recounted how she sometimes found her husband in such a state of distress that she was unable to find sufficient resources to calm him down. She ended up putting cool refreshing cloths on his face or simply holding his hand and talking to him gently. After that, she would take a while to calm down herself, repressing her inner turmoil for hours on end. Listening to Nicole, the notion of primary distress (*désaide*) came to mind, a prototype of traumatic situations, resulting from the inability to satisfy one's needs without the help of the object (Laplanche and Pontalis, 1967).[4] There is not only the idea of the subject's inability to help themselves but also the lack of internal resources to deal with what they are experiencing. The dialysis patient may experience states of distress close to that of an infant unable to survive alone. It is commonly observed that when the disease has irreversibly taken hold and when death becomes imminent, those first infant relationships return to the forefront. "When death comes, the balances implicitly constructed and elaborated in what remains unspoken of the respective deficiencies and strengths will find themselves stripped, sometimes reinforced and sublimated, sometimes corroded and annihilated, but always disrupted. The exceptional and the unexpected disturb and upset, harass and erode the very roots of the relationship, in an ultimate explosion that everyone feels, though never willing to name it" (Ruszniewski, 1999, p. 89).

Containing anxieties, stemming the pain from time to time or on a daily basis is a daunting task that can weigh heavily on partners. This can be a strain on some couples, but others, like Paul and his wife, grew closer together. Multiple situations clearly arise.

Rearrangements within the family are significant and the children are particularly affected by this. The anxieties are pervasive, especially those relating to death, regularly breaking in on the couple or the family. The possibility of passing on the trauma is regularly there in the background. Relatives, spouses, and also children regularly conceal all that they themselves are going through, how they are challenged, sometimes made distraught, in order as they believe, to protect the sick person they love.

A number of kidney pathologies are hereditary (polycystosis, for example) and the matter of the disease arises in filiation, with the additional pain this entails. Returning to N. Rheims, she explains how the women in her family were all affected by the disease and unable to escape from it: "We had seen our mother on dialysis for 25 years. This was no illusion. She was receiving visitors at home, in her bed, hooked up to her machine. How could we forget this? How could we fail to imagine that it would affect us too? Our mother held the record for longevity in dialysis. I had also seen my grandmother, Alix, whom I adored, die of this terrible disease, and her sister Minka, who died a few months later, struck down by the same illness" (Rheims, 2019, p. 10).

There are so many different situations that cannot all be addressed here. The people we meet tell of the stories of couples who, despite the ordeals of the disease, stay together. Nicole sometimes brings up the possibility of a separation when some days turn out to be extremely heavy, but she regardless stays by her husband's side. However, it should be remembered that some couples separate.

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[4] The term appears in his correspondence with Fliess, first in Manuscript G, 1895 and then in *Entwurf einer Psychologie* (Freud, 1895). It is used further in *Inhibitions, Symptoms and Anxiety* (Freud, 1926).

Traumatic elements can weaken even the most united couples, break the family apart. The anxieties (in particular, the anxieties of death) are regularly pervasive and can upset, manhandle the closest relatives. It can also be a matter of patients who tell how they feel, find themselves progressively "damaged" by the disease and who say that they are gradually being withdrawn by their husband or spouse. However, it should be added that there are also couples younger than those mentioned above who refuse to have biological children so as to avoid taking the risk of passing on the disease. The illness emerges while they are still young and they make the often painful decision to make sure it ends with them. Others try and try again to have a child but the infertility caused by the pathology often leads to the couple remaining childless. The issue of fertility can be at the heart of couples' concerns when the illness occurs at an age when they wish to become parents.

CONCLUSION

In conclusion, one should bear in mind that renal disorders involve severe and constraining therapy. People with kidney disease have a special need to build on the relationships they have with others. This can hold in and contain the patient, maintain their somatopsychic limits that have become so uncertain, and remind them that those close to them hold them dear. This is part of a movement on the side of life.

This support provided by loving relationships helps to alleviate the deadly loneliness that the patient experiences at times. Partners play a major role in rehabilitation, care, and assistance for their sick loved one. Opening out to more psychological and psychotherapeutic consultations for partners and other family members is becoming essential in facilitating their access to psychological care. In consultation, there is a need to be attentive to the slightest movements from which the psyche emerges under the shadow of illness and death. Emotions gradually emerge, pockets of anger and sorrow which, when they do not unravel, can gradually link up in the space of psychotherapeutic work. The partners may also feel psychologically worn down by a reality that is just too burdensome. The work of hospital clinical psychologists is then to support the bond within the couple and be able to offer a supportive environment for the carers to work things out. If the place they occupy in daily life is based on guilt, a kind of assignment and obligation, this can tend toward a risk of collapse.

Lastly, let us conclude with a further quotation from N. Rheims, where she rebounds, finding renewed strength and turns again to life: "It is in the depths of this fatigue, unlike anything previously experienced, that I discover an unsuspected residual strength, that which makes us cleave to life, whatever the circumstances" (Rheims, 2019, p. 84).

DATA AVAILABILITY STATEMENT

The original contributions presented in the study are included in the article/supplementary material; further inquiries can be directed to the corresponding author.

ETHICS STATEMENT

Ethical review and approval was not required for the study on human participants in accordance with the local legislation and institutional requirements. The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

The author confirms being the sole contributor of this work and has approved it for publication.

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ORIGINAL RESEARCH
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"We Thought We Were Alone": The Subjective Experience of the Siblings of Anorexic Adolescent Patients

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Objective: The siblings of patients suffering from Anorexia Nervosa (AN) are potentially affected by a disturbed emotional experience that often remains undetected. In order to bring them a psychological support, the Maison de Solenn proposed a support group program for these siblings. The current research explores their mental representations of AN and their emotional experience in the support group named "sibling group."

Method: This exploratory study is based on a phenomenological and inductive qualitative method. Four girls and three boys aged between 6 and 19 participating in the "sibling group" were included in a one-time focus group session using a semi-structured interview guide. The thematic data analysis was performed by applying the methods of interpretative phenomenological analysis.

Results: Themes that emerged from the interview fall into four categories: AN explained by siblings; the individual emotional experience of siblings; the family experience of siblings and the experience inside the "sibling group."

Discussion: According to our participants, the "sibling group" thus functions as a good compromise between keeping an active role in the anorexic patient's care and taking a step back to avoid being eaten up by the illness. Sibling-group participants retrieved a sense of belonging, which is normally one of the functions of being a sibling. It is important to note that the "sibling group" is part of the comprehensive (or global) family-based approach included in an institutional multidisciplinary integrative care framework.

Keywords: anorexia nervosa, siblings, mental representations, support group, group program, family approach, qualitative research

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INTRODUCTION

Anorexia Nervosa (AN) is a psychiatric pathology characterised by food restriction behaviours, leading to insufficient body weight, intense fear of getting fat, and changes in the perception of body image. Epidemiological studies have shown that AN is more frequent among girls aged 15–19 with a prevalence rate of 0.3% and an incidence of 8 cases per 100 000 per year in the general population (1–4).

This disorder often starts during adolescence, with prolonged evolution and a non-negligible risk of chronicity. Besides individual somatic and psychiatric complications, which can lead to life-threatening situations, there are also major psychosocial and familial repercussions that lead to a deterioration of the patient's and the family's quality of life (5–7).

Numerous reports and a wide body of research have shown that chronic pathologies have deleterious repercussions on family functioning and on each one of its members, including siblings, who are constantly concerned by the upheavals linked to the occurrence of a chronic illness (8–14). In the case of AN, professionals have in the last few years developed family-centred approaches, providing care to anorexic children or teenagers alongside support for the parents, but neglecting care toward the brothers and sisters, whose emotional experiences have long been ignored (15–18). This exclusion is also reflected in the medical and psychological literature, where there is very little information or research devoted to the impact of AN on patients' siblings (19–25).

In the first studies that focused on assessments of siblings' personal experiences, brothers and sisters expressed themselves along these lines: "knowing what's going on, being a little more active, it would have helped me not to feel so left out" or: "as for me, I'm transparent, apparently not interesting." The comments that were collected from the brothers and sisters of anorexic patients in a study on support for families of teenagers with an eating disorder clearly showed their feelings of exclusion and powerlessness.

A study of siblings' coping strategies for dealing with their sister's AN reported 22 different coping strategies, including fourteen emotion-focused, five problem-focused, and three support-seeking strategies. Among the emotion-focused strategies, "empathising with my sister, forgiving her behaviour," "distancing from negative affect" and "developing cognitive reconstructions, making meaning," were some of the emerging themes (20–23, 26, 27).

Siblings can also experience feelings of guilt, worry, fear, and pain, but also difficulties in tolerating separation on the occasion of hospitalisation of a brother or sister. These emotions are often hidden and experienced alone by siblings, who do not take it upon themselves to ask for help from their family (20, 23). On the other hand, they may feel obliged to take care of their anorexic brother or sister and to give their parents emotional support; paradoxically, so as to avoid any conflict, they avoid telling their parents about any pathological behaviour they have witnessed (20, 21, 28).

A recent meta-synthesis of qualitative studies concerning the experience of "caring for or living with someone with an eating disorder" reported that siblings describe AN as having a pervasive and all-encompassing impact on their daily lives. There is some evidence that this may affect their mood, identity, body perception, attitudes to food, family relationships, home life, school functioning, and motivation. Siblings feel obligated to care for their ill sibling and support their parents, who ignore their concerns about eating disorders (29).

This distressing and potentially psychologically harmful personal experience generally goes unnoticed; brothers and sisters find themselves powerless to cope with the incomprehension surrounding the illness (23, 30).

Because of the clear impact AN has on the dynamics of inter-sibling relationships and on their psychological state, a support group or "sibling group" was set up in the adolescent multidisciplinary department of the "Maison des Adolescents—Maison de Solenn" (31), to address the need to support the siblings of anorexic patients. The objective is to let them express themselves and give them the support they need in their personal experience, which can be overwhelming, painful and incomprehensible to them.

This initiative was started at the behest of some parents who had taken part in a parental exchange group at the time they were confronted with their child's anorexia, a discussion group created in 2005 at the "Maison des Adolescents—Maison de Solenn." Parents reported on the siblings' worries concerning their brother's or sister's state of health, and the feeling that they were being left out and excluded from any form of care. Furthermore, these parents were worried about these other children, their well-being and their development when faced with the family upheaval necessarily triggered by the illness. Moreover, they themselves felt caught up in their child's illness and felt they were not available enough to provide support.

This "sibling group" is based on different studies that have been conducted on the need and the advantages of including siblings in the care provision for patients with chronic somatic or psychiatric pathologies (8, 12). These studies are all the more relevant in the field of eating disorders because the occurrence of such disorder changes and questions family functioning. Family relationships are in many authors' view paramount to understanding AN, whether for its genesis, its maintenance or its treatment (30). There is a need to pay attention to family bonds, which are seriously undermined by the illness, through regular family interviews, and in some cases family therapies.

Providing care and trying to relieve these siblings' painful experiences is one of the first aspects of the support group program that is presented here. But this group also has a place in the overall therapeutic process of the family approach, which designates the family as a therapeutic resource to combat the illness (32–35).

The "sibling group" meets on a monthly basis for 1-h sessions. It is led by a doctor expert in eating disorders and adolescent medicine, a child psychiatrist and a clinical psychologist. The group is open to anyone and the number of participants may vary, as sessions are not compulsory.

The sessions are structured with a first part devoted to free talk, where no subject is imposed. The participants are invited to suggest a topic freely, so that shared reflection can emerge from the group. This joint reflection leads the participants toward a common elaboration of their experiences of having an anorexic brother or sister. In a second part, a ludic support is suggested to help the participants to express themselves. Professionals offer adolescents different types of mediation including role playing, drawing, writing, photolangage. Indeed, the use of mediating objects can help to shape subjective experiences and supports the psychic process of subjectivation (36).

In this research, one of the issues concerned the ideas, feelings and perceptions the group participants had about anorexia. We also sought to cast light on their personal emotional experiences, as well as their degree of motivation for taking part in the group sessions, the advantages felt by each of them and their assessment of the ludic supports.

To address these various questions, it was decided to run the research with two main objectives:

- To explore representations the sibling-group participants had of AN.
- To assess the personal emotional experiences concerning the "sibling group" allowing feedback from the siblings on the proposed group therapy system in order to improve our practises.

MATERIALS AND METHODS

This study was observational and exploratory, based on an inductive, phenomenological, and qualitative approach. A qualitative methodology was chosen since it helps to understand subjective perceptions, and the significance and the meaning of a phenomenon on the basis of detailed narrative reports (37, 38). A qualitative methodology was particularly suited to the complexity of the study subject. A phenomenological approach was thought to be the best adapted to study experiences of suffering (39, 40). It also took the subjective and constructivist aspects into account, where knowledge is the fruit of a shared construction between the researcher and the participant (41–43). This method thus enabled the participants to take on the role of experts on their own personal experience (44). Concerning the qualitative methodologies, we have chosen to refer to a method of discourse analysis: the Interpretative Phenomenological Analysis (IPA) technique, which will be presented in more detail below.

Sampling

The sampling was reasoned and the selected subjects represented typical cases (45). The subjects were recruited among sibling-group participants between 2017 and 2019. They were therefore brothers and sisters of all ages of adolescents with AN who were currently or had been treated at the "Maison des Adolescents—Maison de Solenn" (Cochin Hospital, Paris, France). As the sibling group is an open group, siblings may have regular or occasional participation over a period of time. This disparity in the regularity of participation in the support group reflects the heterogeneity of the sibling group in clinical practise, so we decided to include in the research siblings who had participated in the sibling group even for a short period.

Data Collection

For the data collection, a socio-demographic datasheet was used, as well as a one-time focus group session structured by an interview guide and two ludic supports.

Socio-Demographic Datasheet

The socio-demographic datasheet collected information on age, gender, address, school level, rank among the siblings, family composition, date of entry in the "sibling group" and the number of participations at sibling group sessions.

TABLE 1 | Thematic guide for the semi-structured interview during the focus group.

1. **Representation of the illness:** Report on the descriptive and conceptual aspect of the illness.
- What do you think anorexia nervosa (AN) is?
- How would you describe a person with anorexia?
- What do you think people think about anorexia?
2. **Emotional Experience**: Explore the emotions associated with ill siblings.
- How do you feel when you think about your sibling?
- What feelings would you like to express to your sibling?
- Can you think of a scene with your sibling that was difficult for you?
- Can you think of a scene with your sibling that was enjoyable for you?
3. **Siblings' place in the family:** Describe siblings' experience based on their place in the family
- How do you feel about your family?
- How do your parents or other family members experience your sibling's anorexia?
- Could you describe a family meal?
- Could you tell us about a family scene that particularly affected you?
- Are there any differences between your family and a family not affected by anorexia?
4. **Impact on the adolescent process:** To explore the influence of the illness experience on sibling adolescence
- Do you think your adolescence was influenced by your sibling's anorexia? Why or why not?
- Do you think your adolescence would have been different if your sibling did not have anorexia?
- Do you think that your brother's or sister's illness has influenced the way you are?
5. **Free expression**
- Are there any feelings that you experienced during this interview?
- Is there anything you would like to add about your experience?

Focus Group

This technique of group interviews allows a structured exploration of the participants' different points of view on a subject. It is based on group dynamics and provides opportunities to collect experiences, needs, expectations, and representations. These interactions and feed-backs encourage the emergence of knowledge, opinions and experiences as a chain reaction as a result of the meeting of a wide range of personalities which encourages the expression and discussion of controversial opinions. The researcher is like an explorer, he may know part of the subject but will also discover unknown areas. Methodological thoroughness is essential as much for the data collection as for its analysis (46–49).

Procedure

To organise a the focus group session, a semi-structured interview guide was created by the authors, defining two categories (**Table 1**):

- Representations of anorexia: this aimed to give an account of the ideas and feelings concerning AN disease, the patient suffering from AN, the family and the experience of having brother or sister with AN. These representations were then assessed to see how they had changed over the course of subsequent sessions of the "sibling group."

- The participants' emotional experiences in the "sibling group": this aimed to explore the participants' subjective experiences in the group during the sessions, through the emergence of affects, the participants' level of motivation and their perceptions of the group's dynamic but also but also the opinion of brothers and sisters on the ludic tools being used during the support sibling group.

Two ludic group activities were offered to mobilise participants' emotional expression and symbolic abilities. These mediations helped the participants clarify their ideas of their own representations and to put them into words during the session:

- Emoji cards: a set of 25 cards representing emotional states in the "emoji" format. The instruction was to choose the cards that best represented the emotions they experienced during the sibling group sessions.

- A wish-list: participants were asked to draw up a list of ideas to improve the group session program. Participants were also invited to write down their wishes or suggestions for the following year in anonymous manner.

All the brothers and sisters who agreed to take part signed informed consent on a form explaining the objective and the nature of the study. Each participant's data was stored in a socio-demographic data file. The focus group took place during an hour-and-a-half group session in the "Maison des Adolescents—Maison de Solenn," which was audio-recorded. It was conducted using the interview guide (**Table 1**), which was the main thread for the whole session. Three researchers (AP, SG, and CB) conducted the interview.

The framework and objectives of the focus group were clearly stated to the participants. We also explained that in order to guide our discussion, we would use an organised semi-structured interview guide and two ludic supports that were offered in the middle and at the end of the interviews. We made it clear that each participant was entitled to his or her own way of expressing feelings, points of view and personal experience. Finally, we insisted on the rules of respect for each other's opinions and confidentiality. All datasets (generated and analysed) for this study are included in the manuscript and the tables.

Data Analysis

Data analysis was carried out according to the Interpretative Phenomenological Analysis method, which enables the study of the meanings subjects build from personal experiences (50–52). A meticulous analysis of the interviews, as they took place enabled a set of super-ordinate themes to emerge, which were themselves linked to several themes describing all the narrated experiences. The themes were not only chosen on the basis of their prevalence in the data. Other factors, including, in particular, relevant passages casting light on the themes, and the way different themes helped to shed light on other aspects of the narrative, were also taken into account.

Once a the focus group session was recorded, it was transcribed in full. The analysis of the material was obtained from meticulous scrutiny by three researchers (AP, CB, and SG) of the transcription content. First of all, each researcher independently identified themes that they considered best represented the content of the interview. Then the three researchers compared their results and agreed on a common analysis.

The methodological criteria were retrospectively verified according to the COREQ (COnsolidated criteria for Reporting Qualitative research) checklist (See **Supplementary Material 1**).

Ethical Considerations

Participants in the "sibling group" were invited to take part in the study completely freely. The care provided to the anorexic brother or sister was not in any way conditioned by their participation in the research.

All the participants were informed of the research objectives in an informed consent form. For minor participants (under 18 years old), a consent form for minor participants allowing them to take part in a study was signed by the parents and their child/adolescent. In both documents, the framework and objectives of the study were clearly explained. All subjects (siblings and their parents) gave written informed consent for the research and for the publication of the datasets (social and demographic characteristics of the study population and direct quotes from the participants) in accordance with the Declaration of Helsinki.

The group interview was recorded with agreement by all participants. It was retained solely for the purpose of transcription. Once the material had been transcribed, the audio tape was destroyed. The resulting written material remained confidential and was used solely by the research team for content analysis. All interviews have been anonymised to get the datasets non identifiable.

This study was carried out in accordance with the recommendations of an appropriate ethics review board ("Comité de Protection des Personnes—Ile de France," ref. CPP: 2016-A00818-43, 3426). The protocol was approved by the ethics review board "Comité de Protection des Personnes—Ile de France."

RESULTS

Population

The participants in the research included 4 girls and 3 boys who had attended a sibling-group session at least once. Their ages ranged from 6 to 19. Their characteristics are summarised in **Table 2**. The participants' brothers or sisters were all treated at the Maison de Solenn.

Thematic Analysis

From analysis of the data with the IPA method, 4 meta-themes were suggested: AN as explained by the siblings, the siblings' individual emotional experiences, the siblings' family experiences and their experiences in the "sibling group." These categories provided a way of organising, understanding and reporting the experiences that the participants were able to express during data collection. The first three meta-themes refer to the first objective of the study: exploring the siblings' representations of anorexia. The last meta-theme is related to the second objective, which aimed to evaluate the experience of the siblings within the proposed group setting: the "sibling group."

TABLE 2 | Characteristics of the study population.

Participant	Brother 1	Brother 2	Brother 3	Sister 1	Sister 2	Sister 3	Sister 4
Age	11	13	19	7	12	12	15
Group participation (months)	2	24	7	2	6	1	24

AN Explained by Siblings

This category focused on the way brothers and sisters understood anorexia, on the basis of their ideas, perceptions, and hypotheses about the illness.

It Is Like Imprisonment

The siblings focused on the idea that the illness leads anorexic patients toward regularly withdraw, which excludes them from interpersonal contacts. This isolation prevents them from feeling happiness and vitality, thus leading them to a feeling of solitude.

Brother N° 1: "it's like being unable to feel anything that brings happiness… you don't see anyone anymore, you shut yourself up, inside your own bubble, it's like feeling that everybody's attacking you. As if you were truly alone…"

Brother N° 3: "It'll be hard for them to keep their friends, they lock themselves up inside their own delusion, it just goes round in circles…"

There Is a Need to Self-Harm

For siblings, anorexic children deliberately try to self-harm because they deserve it and it gives them a certain satisfaction.

Sister N°4: "she did like - self-mutilation… (she) feels she deserves it, and so the fact of inflicting that sort of thing on yourself, it gives you a good feeling, in the sense that you deserve it… As if it was a punishment… because you need to harm yourself…"

It Never Gets Completely Better

The siblings did not believe that a full recovery was possible in the end. For them, there would always be internal signs and after-effects from the illness.

Sister N° 4: "I don't know if you get cured from this illness… you can manage… well… to overcome things, and so on, but there's a special relationship with food. There will always be signs… more on the inside with the after-effects. Because on the outside, they can be wiped out if you want…"

The siblings seemed to think that cure is synonymous with going back to a previous state.

Brother N° 1: "Well, there'll be problems, but there are problems more or less everywhere… There will always be memories of this time… you never get back to your previous state, maybe a little bit below that… Body-building, drawing… it makes you forget, but as soon as you sit down for a meal and you have to eat, doesn't it (the illness) come back to you?"

The Siblings' Individual Emotional Experiences

This category gives an account of the brothers and sisters' emotional experiences associated with anorexia.

We Do Not Understand Why

The siblings expressed their difficulty in understanding the causes of the illness. Unlike other organic illnesses, there is no concrete explanation about its causes and no details on its treatment.

Sister N° 4: "We often ask ourselves "why", but there is no particular reason. It's not like an illness where you've got this or that germ… It's complicated. There are many different factors… We try to understand, but we don't know anything, so we feel ill at ease."

We Are Powerless

Powerlessness is a feeling that comes from the inability to contribute to the cure of anorexic siblings, if only because of the restricted verbal communication. The participants felt that the support they had to offer did not have any real impact.

Brother N° 3: "In fact, what's important is to accept the fact that there are moments when there really is a sense of powerlessness."

Brother N° 2: "You can't do anything to cure them, apart from talking to them… we are powerless because we can't talk to them… you can't say to them "why can't you do it? What's the matter?""

We Feel Angry

The siblings felt angry toward their anorexic brother or sister, as well as with themselves. Behind this feeling is the idea that anorexic adolescents are responsible for their illness.

Brother N° 3: "Feelings of powerlessness can sometimes turn into feelings of anger… We can also believe that they are responsible for what's happening to them… that they're doing it on purpose."

Brother N° 2: "You can't talk to them, you feel angry and sometimes you swear at them… You say that maybe it's their fault… Sometimes you get angry at yourself."

The Siblings' Family Experiences

This category concerns the way the siblings experienced the family upheavals triggered by the illness.

It Is Hard for the Parents

The siblings realised that the illness made things difficult for the parents, who first of all seemed to react through denial. The siblings pointed out that the parents' role was undermined by systematic, generalised refusal on the part of their anorexic child.

Brother N° 3: "We lie to ourselves. We say to ourselves "he's not anorexic". The child finds it hard to accept, in fact… for the family, it's really hard to accept".

Brother N° 1: "it's really hard when he says "no, no" and he pushes people away…for example: "do you want to go for a walk?"… "No, I don't feel like it" and it's always the same… "Have you eaten your watermelon?"… "No, I haven't"… There it is… he refuses everything… they (the parents) are a little bit all over the place, they try to, they really do try to free the child from anorexia, *to help the child. Er… and it's really hard because… the anorexic child refuses. So, they don't know how they can help…"*

We Try to Help

The siblings try to give a helping hand in the family, which potentially leads to ambivalent feelings, between gratification and suffering. To do this, they try to find certain strategies to prevent their brother or sister from getting angry or feeling guilty or in distress, or to avoid any conflict with them.

Sister N°2: "We act as if it was our duty to help our sister… it makes us feel good inside, but at the same time, it destroys us… With my sister, you can never talk to her after dinner because she's inside her own bubble… she blames herself and she gets angry."

Brother N°2: "We ask questions "how was your day?" just small talk… Then, we ask questions like "what's the matter with you?"… We try to make a little more progress, to have fewer taboo subjects, so as not to shock him of course."

Brother N°1: "What I'd say to my anorexic sister if I hadn't spoken to her in a long time is "nice to see you". But not "how are you" or anything like that. Because it might give her a shock"

We Keep Our Distance

Finally, the siblings also keep their distance in order to deal with their own feelings and protect themselves.

Brother N°3: "My sister (non-anorexic) was a little angry with my brother (anorexic) because she thought he was in a way responsible for what had happened to him… As for me, I tried to keep my distance."

We Have to Stay Out of It, Without Leaving Them Completely in the Dark

According to the siblings, anorexic children need the presence of their family, but at the same time need to keep their distance. Patients have to learn to become autonomous. However, this balance seems difficult to find. The siblings can feel they are abandoning their anorexic brother or sister.

Brother N°3: "At the same time they (the patients) need a family presence… and they also have to fend for themselves. They have to break away… to feel they are independent in relation to the family."

Brother N°1: "I agree, but not entirely, because you can't leave them in the dark… they are lost… that way."

Experience Inside the "Sibling Group"

This category gives an account of experiences of the "sibling group" participants during the session and their perceptions of this support group program.

We Were Able to Express Things

Participants felt supported by the other brothers and sisters who shared the same experiences. It enabled them to express themselves without being bothered by the judgements of other people with no experience of the illness, and without being afraid of hurting their parents when recounting their own experiences. It also enabled them to feel less alone.

Brother N° 3: "it helps to put thoughts that we usually keep to ourselves into words… it's a change from other people we meet… who lecture us … when they know absolutely nothing. I prefer to hear about other siblings' feelings… it's a lot more authentic. And in the end, I find it a lot more interesting…"

Brother N°2: At first we thought we were the only ones. But as soon as we were here, at the Maison de Solenn, we felt less lonely. We were able to talk about things."

Sister N°3: "It's also about… being able to talk, in the end, without hurting other people. Like our parents."

Attending the Group Sessions Enables us to Keep Our Distance and Provide Help at the Same Time

Participation in the "sibling group" allowed the participants to feel less trapped in the family dynamic, whilst keeping an active role. It helped them understand and deal with the illness better.

Sister N°4: "This is exactly why there are institutions like this one. So that we can get away from the family but continue to be able to help."

Brother N°1: "At the beginning, I didn't know what to do… er… I knew nothing about the illness and then, er… well, I started to know things about what I should or shouldn't do."

Sister N°4: "I don't think that it changed anything, but perhaps we understand things better… And then, we manage to deal with it better…"

Brother N°3: "I thought that my brother would be pleased to see that his brothers and sisters were also part of the Maison de Solenn in some way."

Fear, Sadness, and Difficulty Talking, but Also Happiness (Table 3)

Through the ludic supports used during the focus group, participants were able to express feelings that had not been mentioned previously. These feelings were fear, sadness, difficulty talking or listening to other siblings' experiences, but also feelings of relief, to be able to express themselves and the joy that their brother or sister was still alive (**Table 3**).

Brother N°2: (he selected cards with expressions of panic, sadness, anger, fear and joy) "he's desperate, and because he's desperate, he's crying. Because he's crying, he's afraid. Because he's afraid, he's angry, because he can't do anything. But afterwards, he's all right. He says he feels good nonetheless… because he (the anorexic brother) is still here."

Sister N°3: (She selected cards with expressions of disgust, sadness, anger and joy) "I don't really want to know, because it saddens me… I'm sad, because we're talking about it, because my brother, well, he's still hospitalised. It's a little embarrassing… but I'm glad we can talk about it a little."

We Want to Talk About Subjects That We May Not Have Thought About (Table 4)

Finally, the participants wanted to go deeper into subjects that had not been broached until then in the group. The experience of an outsider to the group could thus help to open up exchanges on this kind of theme. They seemed interested in an account given by an "expert" patient who had gone through the different phases of the illness (**Table 4**).

Brother N°3: "I would have liked to talk about more complex subjects that we might not have thought about… let's say, for

TABLE 3 | Analysis of the ludic support: ≪ Set of Emoji cards ≫.

Participant	Chosen cards
Brother 1	1. Surprise: "He's surprised." 2. Joy: "He feels ready and he doesn't feel bad. There's no real stress." 3. Euphoria: "This is where I am, he's happy to go there… really happy."
Sister 1	1. Falling asleep: "He's asleep."
Brother 2	1. Panic: "He's desperate." 2. Sadness: "Because he's desperate, he's crying" 3. Fear: "Because he's crying, he's afraid." 4. Anger: "Because he's afraid, he's angry because there's nothing he can do." 5. Joy: "But after that, he's ok…" He says he feels good even so… because she (the anorexic sister) is still here, isn't she?."
Sister 2	1. Refusal to talk: "I prefer to listen to how the others are feeling." 2. Sadness: "It makes me sad to see that we feel we're, er… in the same situation." 3. Joy: "It's also good to talk."
Sister 3	1. Refusal to listen: "I don't really want to hear because it makes me sad." 2. Sadness: "I'm sad because we are talking, and because, well, my brother is still hospitalised." 3. Anger: "It's a little embarrassing." 4. Joy: "But I'm glad to be able to talk about it a little."
Brother 3	1. Refusal to talk: "He doesn't want to talk about certain things. And I understand that." 2. Anger: "During the last session, there was someone who was so rude, I thought it was a shame that he wasn't put back in his place. The session was completely ruined… What he had to say had nothing to do with the spirit of the group. I also thought he showed no respect for anyone." 3. Joy: "He's smiling because the activity gave me confidence to be able to express myself… and in different ways."
Sister 4	1. Refusal to talk: "We don't really know how to talk and we don't necessarily want to talk either." 2. Panic: "We talk about things and we don't know how to react to these things…" 3. Refusal to listen: "I don't particularly want to hear things, sometimes it's a bit complicated…"

Participants chose the Emoji cards that best represented their emotional state during the "sibling group" sessions. They then commented on their choice and gave more in-depth answers. Overall, the participants chose images representing the following states: surprise (1 participant), joy (5 participants), euphoria (1 participant), falling asleep (1 participant), panic (2 participants), sadness (3 participants), fear (1 participant), anger (3 participants), refusal to talk (3 participants), and refusal to listen (2 participants).

TABLE 4 | List of wishes in the second ludic support.

- Suggest several activities for a session and let people choose.
- Suggest a few sessions closer to one another.
- Intervention from a former anorexic patient or an expert patient.
- Explanation of certain aspects of the illness from the professionals' point of view.
- Talk about more complex subjects.
- Invite people to talk about their own experience if they want to.

In this support the participants provided the following suggestions.

instance that you… you talk about someone else's experience. These are subjects that we don't always think about…"

DISCUSSION

Siblings Take on the Role of "Translators" of the Illness

This exploratory study aimed to explore the representations that siblings of anorexic children had of AN and how far they were able to give form to these representations through their participation in the group, to know whether their participation enabled any psychic elaboration to take place. The second objective of this exploratory study was to assess the personal emotional experiences concerning the support group program.

First of all, we observed that the representation the participants had of AN was completely that of a psychological subjective experience. Indeed, the brothers and sisters explained AN in terms of imprisonment, isolation, absence of joy, distrust of the external world, and repetitive delusional behaviours. These representations showed that their approach was obviously more emotional than rational or theoretical. In other words, the siblings seemed to put themselves in their brother or sister's position to try and understand what they were going through from a relational and affective viewpoint (53).

We could thus suggest that the "sibling group" participants attempt to understand AN through their own interpretation and deduction of the emotional states of their suffering brother or sister. This interpretative approach of the siblings could be associated to the concept of mentalization whereby individuals are able to interpret their own's and other people' actions by basing themselves on mental states, such as personal desires, needs, feelings, beliefs and reasons (54). Siblings thus try to attribute mental and emotional states to the patient's pathological behaviours. It could provide them with some explanation of what anorexic symptoms can express through the attack on the body, the psyche and interpersonal relationships. We believe that this type of elaboration, is related to the fact that AN does not have a single identified aetiology unlike most somatic diseases and cannot be explained or treated like them.

However, this effort of mentalization could also be considered as an attempt to compensate the failure of the anorexic sibling's ability to mentalize. The lack of mentalization in anorexic patients has already been mentioned and explained by similar concepts like "reflexive function" or "social cognition." According to these concepts, AN is associated with a dysfunction of the psychological processes underlying the construction of mental representations and to a poor emotional mental state inference. The representation ability of patients with AN would not be able to contain an experience. Instead, the representations are assimilated to "presentations," which are experienced as concrete facts in the here and now. These "pseudo-representations" are described as "concretised metaphors" in which a feeling of control can refer to an empty stomach, or a firm, slender body can be equated with a feeling of purity, for example. Similarly, in terms of lack of social cognition, self-starvation and purging behaviour may serve as inappropriate strategies to cope with impaired recognition of other people' emotions (55–57).

Therefore, it could be said that siblings assume the role of "translators" of the disease, by attempting to put themselves in the place of the anorexic sibling, inferring their thoughts and emotions, building mental representations of their interpersonal relationships, giving deeper meaning to symptoms that would otherwise be not understandable and transforming a concretised mode of expression into a language of representation, full of meaning, emotions, and metaphors.

As an example, in this study the siblings used the metaphor "self-mutilation" to explain anorexic behaviour in terms of the need to self-harm. In this case they talked of mutilation as an analogy, which could at least partially explain the patient's fundamental motivations. They consider that anorexic patients seek to self-harm because they feel they deserve it and it somehow gives them pleasure.

This work of understanding of the psychic states could be also related to the Bion's notions of "reverie," containment and the alpha function (58). This concept designates the mother's capacity to receive her small child's projective identifications, to use them as communication and to return them in a modified form. Thus, containment is the capacity to receive the unelaborated and rejected contents of someone else, to experience them, to transform them and to return them to the subject in a modified form with signification (59).

Making an analogy with this model, siblings attempt to metabolise anorexic patients' raw psychic contents (beta elements) through their own ability to daydream. This process consists in giving anorexic patients' behaviours and feelings meaning, in order to metabolise and transform them into thought activities (60). By giving anorexic symptoms meaning, the siblings change an invasive illness into an emotionally charged phenomenon for their anorexic brother or sister.

It was also noted that the siblings were unwilling to spontaneously share their representations of AN with their family. They feared that their way of interpreting the illness might be difficult to understand for those who were not in the same elaboration process. Consequently, the siblings felt that their family's judgemental reaction could be violent and sanctimonious. This fear is all the more intense when siblings imagine that the expression of their emotions could hurt their anorexic sibling and their parents. In this case, the feeling of guilt would make their own personal experiences even more painful.

This guilt may also be related to the desire of adopting a "care giver role" in the family. The persistent failure of sibling strategies to support and soothe the emotional state of the ill sibling and his or her parents may develop into a sense of self-blame, powerless and anger. Cook-Darzens (30) refers to this type of sibling as a "pseudo-parent" because they try to care for and protect the anorexic child. This role may be triggered by a desire to compensate for their parents' weaknesses and to inhibit their own aggressive tendencies.

When faced with this emotional experience, siblings could choose to distance themselves from their family in a radical way, in order to protect themselves from this painful and disturbing situation. Yet this distancing increases their feelings of guilt and worry concerning their sibling (22, 61). This crossroads leads to ambivalent feelings between remaining in close contact with anorexic siblings, thereby maintaining their role of translator and helper, or staying away from them and preserving themselves. The presence of ambivalent feelings can also be observed when the siblings express opposite feelings such as joy and sadness, or fear and relief.

Thus, the siblings seem to be at higher risk of finding themselves alone in a very demanding psychological elaboration process in relation to the brothers and sisters with AN, dealing with their own feelings of uncertainty, fear, guilt, anger, powerless and ambiguity, without the containing function of the family.

The "Sibling Group:" a Good Compromise to Find the "Right Distance"

Our participants felt the need to find the "right distance," allowing them to avoid any excessive contact with their anorexic brother or sister. That way, they had a sense of independence and at the same time provided their anorexic brother or sister with affective support and presence. This position enables siblings to protect themselves from excessive proximity without having the feeling of neglecting the anorexic sibling. On the basis of this notion of the "right distance," we could hypothesise that siblings are conscious, to a certain extent, of the risks of the dynamics of a symbiotic relationship. Indeed, on the basis of what the siblings said, families should not function in an overprotective, idealised and intrusive way. It has been shown that this type of family functioning damages the process of identity development, in an attempt to protect families from conflict, aggression and traumatic events in their intergenerational storey (62).

Of course, this balance between presence and distance is not easy to reach. It requires elaboration, and challenges intra-family roles. The space where siblings can take a step back in relation to their family, whilst remaining faithful to their feelings, representations and behaviours within the family dynamics, might therefore be found in the "sibling group."

According to our participants, the "sibling group" thus functions as a good compromise between keeping an active role in the anorexic patient's care and taking a step back to avoid being eaten up by the illness, which overturns intra-familial relationships. Inside the group, siblings find a place to express themselves outside the family on what is happening inside it. Their feelings of guilt are alleviated, which enables emotional expression, without any fear of hurting their parents or their anorexic brother or sister with bouts of anger, powerlessness or frustration.

Similarly, siblings seem to be supported by the idea that in the group "we are all living through the same thing," which allows them to feel confident enough to share their representations. In this notion of shared experience, participants retrieved a sense of belonging, which is normally one of the functions of being a sibling (63), but which was undermined by the illness. Through the links woven between the participants in the "sibling group," their lack of identification references in the family thus seemed to have found a way forward for elaboration.

Finally, it was confirmed that the introduction of playful ludic supports was preferable to an approach that was solely verbal in the "sibling group." This allowed the siblings to set free their expressions and their emotions, even the ambivalent ones that oscillated between joy and sadness or between the need to talk and the refusal to talk. A solely verbal approach seemed to us insufficient to tackle this kind of emotional complexity, particularly when these emotions were re-enacted during the sessions.

Study Limitations

One of the limitations of our study was the small number in the sample. A study with a larger number of participants could provide results that could be more readily generalised.

We are also aware that the differences in the participants' ages played an important role in the analysis of the results. Indeed, the understanding of the experience by a 6 year-old participant is different from that of a 19 year-old young adult. It is therefore difficult to talk about a completely homogenous experience for the group as a whole. It is important to remain cautious and take each participant's individuality into account.

One other aspect of this individuality was the variability in participation in the "sibling group," which was an open group. Our study participants did not taken part in the group program with the same regular attendance nor from the same starting date.

Patient gender but also sister or brother gender could have an influence on the sibling experience of anorexia nervosa, particularly during the adolescent process where identity issues are very common. Only one of our patients suffering from anorexia nervosa was an adolescent boy. This is consistent with epidemiological data reporting a sex ratio of 1 male to 10 females (64), although the prevalence of eating disorders in boys may be underestimated.

Finally, the absence of a control group was a limitation in our study. It would have been interesting to compare the participants' experiences among our sibling-group subjects with the experiences of siblings who did not take part in this group, either by choice or because it was inaccessible, in order to observe the effects of the group program on the different types of representations of anorexia, the participants' abilities for psychic elaboration, their styles of emotional expression and their personal experiences concerning family relationships.

CONCLUSIONS AND PERSPECTIVES

From this research, we were able to observe that the "sibling group" allowed the participants to benefit from a remedial experience. Through the group dynamics, siblings found identification elements, enabling them to have a sense of belonging. This gave them enough confidence to express their anxieties, as well as their ambiguous and aggressive feelings.

We were able to observe the fact that the brothers and sisters were able to have enlightened opinions concerning the family dynamic. They were able to detect the need for the right distance between the members of the family, which made the relationships more balanced. It is important to be able to develop the siblings' therapeutic potential within their family. Their ability to elaborate and the richness of their personal experience could prove beneficial for the patient in a family therapy framework, or during regular family interviews. By providing some support for identification, by confronting similarities and differences and by making emotions communicable, the "sibling group" acts as a prop to the siblings' subjectivation. This process, as well as being individual, can also have an impact on the family, particularly on relationships. Through the group intermediary, siblings could enable the family system to open up to new information and multiple interactions (32).

It is also important to note the institutional aspect of the "sibling group." This program is part of a wider care provision integrated into the family approach, including direct care of the anorexic patients and their parents. This institutional environment seems to provide a very important containing function for the siblings, who feel they are involved in an overall treatment program.

We can thus confirm that siblings of anorexic adolescent patients require specific care, taking account of their individual and subjective way of understanding the family, with their own ideas, analogies, and emotional elements. Care solely centred on information communicated by professionals in charge of patients with AN to the siblings could be seen as detached from the affective and idiosyncratic aspects. It would be good to communicate this approach to teams dealing with adolescents suffering from AN, and alongside to be able continuing this work with a wider study including a larger number of participants and a control group as previously mentioned.

DATA AVAILABILITY STATEMENT

The original contributions presented in the study are included in the article/**Supplementary Material**, further inquiries can be directed to the corresponding author/s.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by Comité de Protection des Personnes - Ile de France III, réf. CPP: 2016-A00818-43, 3426. Written informed consent to participate in this study was provided by the participants' legal guardian/next of kin. Written informed consent was obtained from the individual(s), and minor(s)' legal guardian/next of kin, for the publication of any potentially identifiable images or data included in this article.

AUTHOR CONTRIBUTIONS

AP and CB contributed to conception and design of the study. AP, SG, and CB conducted the interview and analysed the interview to optimise the validity of the results. AP wrote the first draught of the manuscript. AP, SG, CB, and MM wrote sections of the manuscript. All authors contributed to manuscript revision and read and approved the submitted version.

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SUPPLEMENTARY MATERIAL

The Supplementary Material for this article can be found online at: https://www.frontiersin.org/articles/10.3389/fpsyt.2021.664517/full#supplementary-material

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Multifamily Therapy for Adolescents With School Refusal: Perspectives of the Adolescents and Their Parents

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Introduction: School refusal is an important public health concern in adolescent psychiatry increasing over the past several years (5% of child and adolescent psychiatry consultations in France). Multifamily therapy has developed over 30 years. Its efficacy is validated in adult, child and adolescent psychiatry, including for children at risk of school exclusion. In this study, we aimed to explore the adolescents and their parent's experience of a multifamily therapy treatment of school refusal with a qualitative method.

Materials and Methods: This qualitative study is based on an Interpretative Phenomenological Analysis approach. We conducted 15 semi-structured interviews, participants were adolescents ($n = 6$) and their parents ($n = 9$) who experienced multifamily therapy in an adolescent department in Paris. Data analysis was performed independently by two researchers.

Results: For the six families, school was a source of suffering, system paralysis and social exclusion. Families reported painful emotions and separation anxiety. For teenagers, multifamily therapy increased self-confidence and allowed group experience. For parents, it gave support and relieved from feelings of stigmatization and guilt. Parents became more aware of their adolescent's suffering and their insight. They all considered that multifamily therapy improved intra-family communication and expression of emotion. Participants highlighted the benefits of intergenerational interactions, activities, group and guidance from therapists.

Discussion: Multifamily therapy uses therapeutic tools from both family therapy (joining, resonance, family competence, and metacommunication) and group therapy (use of media, identity device, and mirror reactions). Parents expect school solutions from multifamily therapy and question how psychiatric treatment can deal with school, school refusal being therefore understood as a social functioning disorder.

Keywords: school refusal, multifamily therapy, qualitative research, adolescents, family therapy, school phobia, group therapy

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INTRODUCTION

School Refusal, a Major Public Health Issue

School refusal is a worldwide current public health issue (1, 2). It increased over the past years and concerns 5% of consultations in preadolescence and adolescence psychiatry in France (3–5). First named "school phobia" by (6), school refusal is distinct from others forms of school attendance problems (SAP), such as truancy, school withdrawal, and school exclusion. In truancy, reasons and motivations of school missing are different (positives rewards). Anxiety is not present, and absenteeism is frequently hidden from parents. Young people are not willing to go to school. Finally, truancy, as school exclusion, are more often associated with behavioral disorder and oppositional defiance disorder (2). Berg's consensual international definition of school refusal relies on four criteria which are the following ones (7). The young person is reluctant or refuses to attend school, in conjunction with emotional distress that is temporal and indicative of aversion to attendance (e.g., excessive fearfulness, temper tantrums, unhappiness, unexplained physical symptoms) or emotional distress that is chronic and hindering attendance (e.g., depressive affect; sleep problems), usually but not necessarily manifested by absence (e.g., late arrivals; missing whole school days; missing consecutive weeks, months, or years). The young person does not try to hide associated absence from their parents (e.g., they are at home and the parents are aware of this), and if they previously hid absence then they stopped doing so once the absence was discovered. The young person does not display severe antisocial behavior, beyond resistance to parental attempts to get them to school. Finally, the parents have made reasonable efforts, currently or at an earlier stage in the history of the problem, to secure attendance at school, and/or the parents express their intention for their child to attend school full-time. The existence of reasonable parental efforts is important to assess school refusal. Neither DSM 5 (Diagnostic and Statistical Manual of Mental Disorders) nor ICD-10 (International Classification of Diseases) recognize school refusal as a diagnosis, underlying the social and educational issues at stake.

The diagnosis is done on clinical criteria and can be assessed by the School Refusal Assessment Scale (SRAS) developed by (8). School refusal can be divided into different subcategories: school refusal associated with anxiety separation, school refusal associated with anxiety (including social anxiety), school refusal associated with specific phobia related to school (tests, teachers), school refusal related to depression (1). School refusal concerned two main ages: childhood (first primary classes) and adolescence. Prevalence in adolescents appear to be higher than in childhood (1). Prevalence does not vary according to sex, socioeconomic background or intellectual level. Half of school refusal appear in the form of somatic complains (headaches, abdominal pains, nausea, sleeping disorders) (1, 9).

School refusal is associated with several comorbidities. Half of patients suffer from anxiety and depressive disorders (10). Short term consequences are weak academic performances (31%), impacts on peer relations (34%), family conflicts (43%), school leaving (25%) exclusions from peers, risky behaviors (addiction), and suicide attempts (11–14). Thirty to 50% of these adolescents still have psychiatric disorders when they are adult (anxiety, depression, personality disorders) (6, 15). They stay longer at their parents', have less children, consume more psychiatric care and suffer from more professional failure (16). As a result, some authors state that back to school is only one prognostic element among others according to the ability of general adaptation (17).

Thus, school refusal is a major issue and its treatment is a priority. Early intervention is required, and prognosis depends on how much school the child misses (1). The first objective is the back to school. According to the school refusal severity, adolescents can benefit from outpatient cares, a day hospital or a complete hospitalization. Cares are multidisciplinary. An individual psychotherapy is always proposed- cognitive-behavioral therapy (CBT) has shown positive outcomes (18). Medication is proposed when required (anxiolytic or antidepressant) (6). Working with families and school is also essential.

Family Involvement in School Refusal Treatment

Working with families appears to be a crucial element in child and adolescent psychiatry (19). School refusal has a major impact on families, and may stretch the parents' vulnerability (20, 21). Moreover, the degree of commitment of school personnel toward children with school refusal largely depends on their parents' attitudes (22). The first family therapy for school refusal is described by (23, 24). Several studies have since evaluated and confirmed the efficacy of family adjunction in therapies (12). In their qualitative study about the Experience of Psychiatric Care of Adolescents with School Refusal (25), Sibeoni et al. showed that expectations were different between adolescents and parents. Adolescents considered their suffering as the principal difficulty—suffering which parents, relatives and even health professionals could underestimate. School was not seen as the source of their discomfort—rather the place where that discomfort could be expressed. On the contrary, parents focused on their children being back to school which remained the central issue- psychiatric care had to resolve this difficulty. They worried about their child's future in school, repetition and school system rigidity. They were also worried about their child's social isolation, seeing the hospital as a mean of sociability. Parents perceived their child's internal discomfort at a later stage and sometimes after professional explanations. In addition, they attributed their child's progress during treatment (improvement in psychiatric disorders, better self-confidence, and maturity) to the development of adolescence more than to psychiatric care. Intra-family and peer relationships was also emphasized, as adolescents may say that changes in family relationships were beneficial. Thus, expectations of parents and adolescents differed. On one hand, adolescents focused on taking charge of their internal discomfort and the importance given to time, while parents were focused on the return to school- being synonymous with recovery-, and the need to find quick solutions. As a result, involving families in school refusal treatment appears to be quite challenging. Family adjunction improve therapeutic outcomes including long term outcomes (especially for behavior and cognitive therapy) (12, 26–29). Carr showed that family therapies improved symptoms (anxiety and school leaving) in more than 2/3 of school refusal patients, thus being more efficient than individual therapy (30, 31).

Multifamily Therapy

Multifamily therapy (MFT) first appeared in United States in the 1960's (32). Based on family and group approaches, MFT proposes to several families, who have a member affected by the same disease—originally schizophrenia—to help each other in a "caring community (33, 34)." Through the exchange of ideas and experiences with other relatives and members of other families, participants can compare notes and learn from one another (34). Intra- and inter-family interactions are "intensified" (35) in a group setting where parents and children are participating in different exercises. Participants not only examine their own interactions but also those of others families and their individual members. The creation of multiple perspectives, which is much harder to replicate in individual sessions, is associated with change (36). MFT has largely spread these last 30 years and has gained empirical supports with no clear contraindications (37). It is currently used in adult psychiatry and in child and adolescent psychiatry (e.g., for ADHD, learning disorders and others) (37–41). It has been well-described that MFT is as efficient as and less costly than family therapy for anorexia nervosa. It has also been used for social issues, such as for families with abused children. In 1977, Dawson and McHugh developed the "Family School" in the Malborough Hospital department. The "Family School" gathers several children at risk of exclusion from school and their families and teachers, using MFT (42, 43). Its efficacy was validated by Morris et al. (36). They found positive effects on child and family social, emotional and behavioral functioning. These effects lasted up to 12 months after the end of the therapy. Thus, MFT seems to be an interesting therapy for school refusal (36).

The Present Study

To our knowledge, no international nor national studies have evaluated multifamily therapy in school refusal. Moreover, few data are available on the perspectives of adolescence and their parents on their experiences of school refusal and family therapy. The objective of the study was to explore experiences of a MFT treatment of school refusal among adolescents and their parents. We aimed to study the expectations, the lived experiences, the improvement and the critics and unfulfilled expectations. We wondered if MFT had an impact on school refusal and more broadly on individuals and on intra family interactions. To this aim, we chose a qualitative study design based on interpretative phenomenological analysis. Indeed, qualitative methods seek to describe and understand in depth a complex phenomenon. They were a tool of choice for focusing on the views of patients, including adolescents and families (25, 44).

PARTICIPANTS AND METHODS

Procedure

Since 2019, adolescent department of Cochin hospital has been providing a MFT program to adolescents attending the department for school refusal and their families.

This MFT program was based on five sessions, each one lasted 3 h, took place once a month and gathered 5–7 families. There were 4 therapists, trained in systemic family therapy—APRTF (Paris Association for Research and Work on Families), and in MFT by Asen (33).

The program content was developed by the Multifamily Therapy Team, supervised by Cook-Darzens (45) and Asen, based on the specific needs of families of adolescents with school refusal.

This MFT program had 6 main goals:

- improving anxiety manifestations to help adolescents going back to school,
- avoiding chronic school dropout,
- improving communication between adolescents and their families,
- developing the skills and resources of families,
- fostering a place for exchange for families facing the same problem,
- and breaking the feeling of isolation of families.

The content of the five sessions was manualized. For each session, the objective of the session and several alternative exercises were specified.

Sessions Description

Each session began with a sharing of the participants' mood of the day, then began the first part of the session. Activities could take place in the whole group or in parents, mother, father or adolescent subgroups. They could use different media, such as photos, drawings, role play, sculptures or speech. Feedback took place at the end of the activity, in whole group or in sub-groups. A break marked the end of the first part. The second part proposed another activity and ended with a feedback of the whole group session.

Each session worked on a theme:

- 1st session: meeting and creating the group alliance (photolanguage, cross presentation)
- 2nd session: outsourcing and providing information on the school refusal (problem drawing, expert intervention)
- 3rd session: change motivations (sub-groups, social network map)
- 4th session: family resources (cross presentation, role plays)
- 5th session: working on change and focusing on the future and the family's resources (role-playing, sculpture).

We conducted an Interpretative Phenomenological Analysis (IPA) study among adolescents and their families of the first MFT group which occurred from May to August 2019.

Ethical Standards

This study was carried out in accordance with the recommendations of an appropriate ethics review board

(Inserm ethics review board, IRB 20151300001072). All patients and their parents provided written consent before inclusion in the study. The semi-structured interviews were all audio-digitally recorded and anonymized.

Sampling and Participants

Sampling was exhaustive since all the participants of the first session agreed to be recruited. The inclusion criteria were families with an adolescent aged from 12 to 18 years, with school refusal resulting in complete school disconnection for more than 2 weeks and <18 months, attending the adolescent department for school refusal and living in Ile de France. Diagnostic was assessed in team according to the Berg criteria. Adolescents had all a DSM 5 diagnostic. They had no mental deficiency and no neurodevelopmental disorders (autistic disorders, learning disorders, behaviors disorders). They used to be in regular school with an average academic level.

Data Collection

Data came from semi-structured interviews we performed at the Cochin adolescent department. Participants were contacted by email or by phone. Each family was interviewed and parents and adolescents were interviewed together. Each interview lasted from 60 to 90 min. They were conducted by two researchers (AR, an adolescent psychiatrist and CG, an adolescent psychologist) from September to November 2019. The interviewers used an interactive conversational style and sought to explore experience of the participants, their feedback on the content of the sessions and the proposed activities, as well as the perceived changes in the family system and for school refusal (**Table 1**). The interviews, which have been anonymized, were recorded and transcribed word-for-word, including the participants' expressive nuances. The transcript thus obtained was then analyzed.

Analysis

We performed a thematic content analysis according to the principles of IPA (46). The IPA allows for an in-depth analysis of the subject's subjective perception and the meaning given to lived experiences. IPA has three principal epistemological underpinnings: phenomenological- to understand how a phenomenon appears in the individual's conscious experience—, hermeneutic- dual process in which the "researcher is trying to make sense of the participants trying to make sense of what is happening to them"—and idiographic—a deep understanding of each case from the perspective and within the context of the individual (46). In practice, five subsequent steps have been followed (**Table 2**) (47). Each interview was analyzed in detail, then a transversal analysis was carried out in order to develop the final themes and sub-themes and organize them. Data analysis was performed independently by two people (AR and AH, two adolescent psychiatrists) so that the themes identified did not reflect the unique vision of a single researcher. Triangulation of the analysis, which guarantees the quality of individual coding, took place during monthly meetings of our research group (AR, AH, LB, JS, and MM, all adolescent psychiatrist).

TABLE 1 | Interview guide.

1	Taking news on the current situation.
2	Can you describe your experience in the multi-family group?
3	What were the most common emotions and feelings (anger, sadness, anxiety, relief, joy, fed up, etc.)?
4	What moment(s) during the therapy was (were) the most memorable? Describe this or these moment(s).
5	What changes has multifamily therapy made possible?
6	What hasn‘t changed with multi-family therapy?
7	In the proposed activities, did any of them seem relevant (interesting)?
8	In the proposed activities, did any of them seem uninteresting or unsuitable?
9	In multi-family therapy, what moves the problem forward? (What are the elements that you find the most useful in moving forward with the problem?)
10	What were your expectations from multifamily therapy before starting the group?
11	Did multifamily therapy fulfill your expectations?
12	What changes would you suggest for the next groups?
13	How would you explain multi-family therapy to someone who hasn‘t participated in it?
14	Visual analog scale from 0 to 10 to describe whether they are happy (10) or not (0) with their experience.

RESULTS

Sample

This study included 15 participants who attended the first session: 6 adolescents, 6 mothers and 3 fathers. Five of the 6 adolescents were girls. Half of the parents were together. All the adolescents had fully left school at least since 5 months. They all had psychiatric co-morbidities (anxious and depression disorders) and they all had psychiatric care. **Table 3** summarizes their characteristics.

The results captures three superordinate themes:

1) Before: From School Refusal to MFT
2) The Living Experience of MFT
3) After MFT: Outcomes and Expectations

Table 4 summaries the thems and sub-themes.

Relevant quotations from the tran-scripts are presented within the results, they have been translated into English for the sole purpose of this article.

Before: From School Refusal to MFT

Academic Issues Are Major

In these families, academic and social success issues seemed to be major. Grades were a central element with strong pressure, pressure from adolescents who inferred their intelligence to their academic level and pressure from parents (Q1). Success must be academic and academic failure was a loss for both parents and adolescents (Q2). Performance anxiety was strong (Q3). Teenagers described their parent's expectations as a heavy weigh to bear (Q4). School was perceived in very negative terms: a cemetery (Q5), a brake and a hindrance. Adolescents were frightened and experienced a deep unease at

TABLE 2 | The five steps of analysis data.

	Activities	Rationale
Stage 1	Repeatedly read each transcript, as a whole	Obtain a global picture of the interview and become familiar with the interviewee's verbal style and vocabulary. Each new reading of the transcript might also provide new perspectives.
Stage 2	Code the transcript by making notes corresponding to the fundamental units of meanings.	Make descriptive notes using the participant's own words.
Stage 3	Make conceptual notes through processes of condensation, abstraction, and comparison of the initial notes.	Categorize initial notes and reach a higher level of abstraction.
Stage 4	Identify initial themes. Provide text quotes that illustrate the main ideas of each theme.	Themes are labels that summarize the essence of a number of related conceptual notes. They are used to capture the experience of the phenomenon under study.
Stage 5	Identify recurrent themes across transcripts and produce a coherent ordered table of the themes and sub-themes.	Move from the particular to the shared across multiple experiences. Recurrent themes reflect a shared understanding of the phenomena among all participants. During this more analytic stage, researchers try to make sense of the associations between the themes found.

school (Q6). Schooling affected the family atmosphere, provoked misunderstandings (Q7) and family conflicts (Q8).

Q1 Mother 5: "She came very happy with a math homework graded C. I looked at the column next to it, the class average was B and I didn't value that."

Q2 Father 1: "She wants to succeed, and she has largely the capacity for. It would be a shame if she stayed by the side of the road"

Q3 Mother 1: "For her, repeating a year, that was a shame, it means she was stupid"

Q4 Teenager 5: "Because, suddenly, children would have in their heads the expectations that parents have of their children and that can put a lot of pressure."

Q5 Father 6: "On the way to school, there was the cemetery [...]. Yes, in the drawing, they put hell in it."

Q6 Teenager 3: "I was scared of high school and all that."

Q7 Mother 5: "Teenager 5 thinks that, for a long time, I put pressure on her, real or unconscious, or that I have wanted to compare her to others."

Q8 Teenager 3: "Let's say it was usually my daddy who came in with his big hooves, who asked me the question he shouldn't ask and suddenly I would go straight and it ended badly."

Families Experience Deep Suffering and Paralysis

School refused generated violence, suffering, fear and hopelessness (Q9). It produced a deep feeling of helplessness and loneliness without support and without a concrete solution. Families described themselves as wandering and lost (Q10). It was a daily struggle (Q11). These families also experienced great guilt, searching what role they had in the school refusal development and what they had missed (Q12). Mothers described themselves as not enough good mother. Some parents had even not told their relatives about it (Q13).

Q9 Teenager 5: "Yes, violence and even hatred that we can have inside us, frustration, something that is really present when we can't go to school, when we are not well [...] even parents."

Q10 Mother 1: "As parents, we are lost. I mean lost, we have to research, we have to find [. . .] we, parents, have to do everything."

Q11 "Father 6: Here we faced a system and we defend ourselves."

Q12 Mother 5: "I wonder, I search, how this situation happened, what are its causes, what part, what role I might have played"

Q13 Mother 3: "I didn't tell my parents anything. So it had been 2 or 3 years or so, I didn't say anything to my parents."

School refusal paralyzed daily life with no temporal landmarks anymore for teenagers (Q14). Families were stunned by fear and shock. The disease became all-powerful and tyrannical, locking and imprisoning the adolescent and his family (Q15). Paralysis hardened, no more moves were possible. Acting or speaking could worsen things.

The family system was paralyzed with no emotion shared (Q16). The family was divided by major differences between parents and adolescents experience, especially between parents stunned by anxiety and adolescents who experienced daily school refusal (Q17). Parents didn't understand their children behavior anymore, nearly with a feeling of lost.

Finally nothing happened no more, everything was frozen. Imagining a future was impossible (Q18). More than future, school refusal paralyzed the development and arose death anguish. Thus, death theme appeared throughout the interviews in a use of a vocabulary close to the act of execution or through metaphors: tunnel, drowning (Q19).

Q14 Teenager 1: "I hadn't any reasons to wake up, I have nothing to do"

Q15 Mother 1: "And then I couldn't go because, as soon as I went outside for 5 min, she beeped me 'Mummy, mummy, come back, come back, I have dark thoughts.' So, we left everything. Now it's okay I can go out."

Q16 Mother 3: "And then we have to keep quiet. When we are in family meetings, we can't express ourselves, tell what we feel, because we have to resist for others. But that's what is difficult, because you can't show anything [. . .]. And you build a wall."

Q17 Teenager 3: "Parents arrive with their big hooves to tell us that and put it all in our heads, that totally ends the conversation [. . .] it was not that we didn't want [...] it was really something we couldn't do."

TABLE 3 | Participants' characteristics.

	Family 1	Family 2	Family 3	Family 4	Family 5	Family 6
Age	15	16	16	15	17	14
Sex	F	F	F	F	F	M
Academic level Repetition/passing a class)	2nde general	1re STMG	1re general	3e general	1re general arrangement with school then CNED	3e general
Class dropout	4e then in 2nde	2nde	3e	4e	2nde	3e
Class dropout duration	Some months in 4e then arrangement with school ; full since 9 months	18 months	Part-time since 3 years; full since 6 months, with CNED	Part-time since 1 year and 5 months; full since 5 months	Since 1 year and a half; full since 5 months	Since 6 months
Harassment	Yes, in 4e		Yes, during school	Yes, during school		
School change	Current demand			Change between 4e and 3e	In 2nde	
Next year plan	CNED	Bachelor's degree in 2 years	CNED	Repetition and CNED	Care and study hospital	
Social life	Preserved		Preserved (a boyfriend)	Social networks (a boyfriend)	Preserved	Any
Comorbidities	Anxiety Panic attack Major depression	Depression	THC addiction Scars Depression Anorexia nervosa	Scars Anorexia nervosa	Scars TAG Panic attack Depressive disorders Mix anorexia nervosa ADHD	Suicide ideas
Psychiatric history	CMP care in 4e	Psychological care at CMP during 7 months in 2018	Psychological care since 2017 then followed at MDA Hospitalization at MDA from May to June 2019	Psychopraticien in 2017	Hospitalization Day hospital from January to June 2018	
Family history	Brother: school anxiety Mother: depression		Father: anxious disorder		Mother: depression	Father: school leaving in 2nde Depression
Current psychiatric history	Psychological care since September 2018 Adolescent psychiatric care	Psychotherapy CBT since April 2019 Adolescent psychiatric care	Adolescent psychiatric care	Day hospital since September 2018 Adolescent psychiatric care	Psychological care Adolescent psychiatric care Family therapy since April 2019	Psychological care
Treatment	Sertraline prescribed not taken	Deroxat 20 mg	Sertraline 100 mg	Any	Sertraline 150 mg	Any
Brotherhood	1 brother (18 years old) Brothers and sisters in law	2 brothers in law	1 brother (19 years old)	2 brothers in law	Single child	1 brother of 20 years
Parental situation	Parents together	Parents divorced	Parents together	Parents separated	Single	Parents together
Living place	At her parents' with her brother	At her mother's	At her parents' (brother doesn't live anymore)	At her parents'	At her mother's	At his parents' (brother doesn't live anymore at home)
MFT Participation	Parents and teenager	Mother and teenager	Parents and teenager	Mother and teenager	Mother and teenager	Parents, teenager, brother

STMG, management science and technologies; CNED, national center of distance learning; CMP, medical and psychological center; THC, tetrahydrocannabinol; GAD, generalized anxiety disorder; MDA, house of adolescent; CBT, cognitive behavioral therapy.

TABLE 4 | Summary of themes and categories.

Themes	Categories
Before: from School Refusal to MFT	Academic issues are major
	Families experience deep suffering and paralysis
	Stigmatization and search for identity
	Anxiety from school remains overwhelming
	These families experience great separation anxiety
The living experience of MFT	Description of the MFT device by the participants
	Experiencing generational diversity safely
	Getting involved in activities
	Belonging to a group
	Therapist as a security figure
	A Deeply Emotional Trip
	Emotional catharsis
	Group connection
	Awareness
After MFT: outcomes and unmet expectations	Empowered Families
	More liberated adolescents
	Breaking the Taboo of School Refusal
	Relationships with others
	Unmet expectations

Mother 2: “I understand now how my daughter works and why we are here.”

Teenager 3: “I had the feeling that MFT was much more demanding for you, parents, than for us. We, about school refusal, we are already inside”

Q18 Teenager 5: “Imagining myself years later is something I can’t think of.”

Q19 Father 3: “It’s true it was gut-wrenching for me [...] skinned themselves.”

Mother 3: “We were at the bottom of the tunnel about everything, in a general sense.”

Mother 1: “Finally, we take our heads out of the water [...] there is no life belt.”

Stigmatization and Search for Identity

Families experienced a strong societal and school stigmatization. School refusal was unknown and not recognized, and thus generated a triple exclusion. Exclusion from peers, pupils, parents, families (Q20). Exclusion and abandonment by the academic and teaching system (Q21). Exclusion by society and the state (Q22).

Q20 Teenager 1: “With others pupils, we are often afraid of being judged because we know it’s hard for them to understand the difference.”

Mother 3: “Because when we say ‘Don’t go to school,’ some people, who don’t experience what we do, say “she is lax, they accept everything from their daughter!.””

Teenager 3: “There was mother 2, her family, they didn’t get anything, they weren’t understanding about what was happening and she was getting a lot head over heels about her daughter. Mother 1 too.”

Q21 Father 3: “That means that high school dropped us. Them, it’s a situation they refuse, something they ignore.”

Q22 Mother 1: “Children like ours are misunderstood by the system and the society. These children are children who get into troubles.”

Living this exclusion, families seemed to search for an identity that school denied them. They appeared to be ambivalent toward school refusal, hardly naming school refusal and using terms as “problem,” “problems,” “problematic,” “situation,” “particularity” (Q23). Likewise, depression and care were rarely named and difficulties were minimized (Q24). This ambivalence appeared in the participants expectations toward MFT: for adolescents, to be with others peers or to make their parents becoming aware; for parents, to find solutions for their children (Q25). Care did not appear in their expectations.

School refusal was a special way of being, which must be understood and supported. An enigma they were looking for (Q26). Their adolescent behavior even became a higher non-standard one. Thus, school refusal proved this identity. It wasn’t their children who had a disorder, it was the academic system which didn’t recognize and fit to their particular and gifted teenagers (Q27). School refusal offered them an identity to belong (Q28).

However, return to school still remained an ideal to achieve, identifying intelligence and adolescent normality, fitting thus a social norm as exemplified by the road metaphor throughout the research (Q29).

Q23 “When you say ‘the problem’, is it?

Mother 4: The anxious refusal of Teenager 4.”

Q24 Mother 2: “It’s a disease in quotes”

Q25 Father 6: “The first thing, we did it for Teenager 6 [...] to get better, finally a tool, to be better equipped, both to understand the origin of the problems and to correct problems”

Teenager 6: “Meet other people”

Q26 Mother 4: “It’s a better understanding of this functioning [...] Teenager 4 is overwhelmed by it.”

Q27 Mother 5 “[...] set up with a sophrologist, specialized in orientation for children with particularity, dys, ADHD, etc. [...] we look for other possibilities since we have to step outside the box.”

Q28 Teenager 1: “School phobia is very specific [...] there are many others who are different like us.”

Q29 Teenager 1: “Well, I know where I’m going. I have a specific goal now.”

Anxiety From School Remains Overwhelming

Schooling was overwhelming. Nothing existed apart school, families only spoke about school and couldn’t speak of others topics. Even when they were asked for personal news, they answered with schooling (Q30).

Q30 “And how are you at home?”

Mother 4: “Uh, it’s okay. Well, it was a bit complicated with the CNED (national center of distance learning), it got me a little bit over ... I think it still stress us out, bored and stressed us too [...] here we are, things are moving forward.”

Nothing else could be thought. Painful emotions were avoided and couldn’t be shared or showed in family (Q31). These families got difficulties to identify their emotion and to name them (Q32). Introspection was hard and some families preferred hiding behind science and theory more than experiencing emotions (Q33). They were affected by the emotion expressed by other participants but not by theirs (Q34). Parents described themselves as inhibited, avoiding oral situations where they could be in danger. For these aspects, MFT was frightening at the beginning (Q35).

Q31 Mother 6: "I'm not saying it's good, but that's how it is. I consider that I don't have to let it go [my emotions]."

Q32 Father 3: "I had a lot of emotions, which I was trying not to show [. . .]. It's the emotion of someone watching other scenes, I was embarrassed."

Q33 Father 6: "So [...] to scientificize a problem which, at the beginning, is very emotional."

Q34 Mother 3: "I find it hard emotionally because there were parents. . . . Above all about parents and even children."

Q35 Mother 1: "Initially, I didn't really want to go, I didn't want to show my life and I don't like to talk about it"

Adolescents appeared to be in great difficulties when they were asked to think, as if they preferred taking no risk to think or act by fear of being wrong. They were marked by a first astonishment of thought as soon as they were asked a question (Q36). Language production was difficult, even absent. They answered mostly with sentences as "I don't know." Emotions were also difficult, whether their access, their identification or their naming (Q37). They were also adolescents marked by an excessive fear of other judgments and they were paralyzed by social anxiety. They didn't have confidence in themselves and were afraid of doing wrong. The unknown, especially the changes, scared them (Q38). They therefore needed security and landmarks.

Q35 "Did you keep relationships after the group?

Teenager 6: I don't understand the question."

Q36 Teenager 3: "When we say: 'Things are not going on 'or' I'm tired,' we have to develop it, to say why. Me, it makes me stuck"

"What were you feeling?"

Teenager 3: "I don't have any idea [. . .]. It was pretty neutral."

Q37 "What were you afraid of, do you know?"

Teenager 4: "Just the fact that it was new and that I didn't know."

These Families Experience Great Separation Anxiety

We noted on several occasions an absence of mother/daughter differentiation. This lack of differentiation even crept into the speech, where mothers intervened, added, supplemented, and thought for their adolescent (Q39). Mothers also seemed to be ambivalent toward adolescent's autonomy, both wanting them to be empowered and finding hard at the same time to let them empowered (Q40). Adolescents delegated their thoughts and words to their mother (Q41). This fusional mother-daughter relationship appeared ideal and idealized (Q42). There seemed to be no apparent problem in mother-daughter communication and the disorder brought them together and strengthened family ties (Q43).

Conflict was difficult, if not impossible. Thinking differently could mean rejection and exclusion (Q44). Identity exists only through fusion- fusion with others, peers, parents, adult referent (Q45). We could see it in the use of the pronominal "we" instead of "I."

Separation with the therapists was difficult at the end of the session and parents expressed the feeling to be "drop out" (Q46). Nevertheless, relations between the participants didn't last after the end of MFT as if this idealized band couldn't exist outside of the therapy space (Q47).

Q39 Mother 1: "She's always glued to mom, too."

Q40 Mother 1: "There, it's still the little girl, my little baby, but no [. . .]. By saying to myself: well no, they don't think like us."

Q41 Teenager 2: "It's not me you should ask, I wouldn't know at all how to explain, that's why when my mother says things I say it's all the same because that's exactly what I'm thinking so here's to you."

Q42 Teenager 5: "Yes! Just, I noticed once again during these sessions that we were still very close and very fusing, and everything that goes with it [. . .]. And besides, I had a lot of comments about that, like, "It must be too good to be this close to your mom like that, you're too lucky." I thought it was cool!"

Q43 Mother 2: "We talk a lot with Teenager 2 [...] the fact that she is experiencing this brought us together a lot and that we communicate a lot."

Q44 Teenager 1: "I, initially, I was good. Then it was complicated with Teenager 6 and Teenager 4 because there was some trouble and everything. So that made me a little bit sick of the stuff."

Q45 Mother 1: "Ah yes, her psychologist, yes."

Teenager 1: "My model of a woman. Sorry mom!"

Teenager 1: "My second female model."

Q46 Father 3: "Last session, I think everyone would have liked, not to have others sessions, but at least having the possibility to keep being guided by you occasionally. Because everyone seemed to feel we were now let down."

Q47 Mother 6: "So far, we haven't done anything. Maybe someone needs to provide the impulse."

The Living Experience of MFT

Description of the MFT Device by the Participants

Experiencing Generational Diversity Safely

The families were very sensitive to the fact that MFT mixed two generations. They valued that different points of views could be expressed with confrontations, disagreements, and debates (Q1). This diversity allowed a horizontalization of the relationships and gave a voice to the adolescents (Q1). Adolescents thus became experts of their own disorder, with a modification of the usual family dynamic. Parents saw their children from another perspective, in "real condition" with other adolescents (Q2). MFT brought also a diversity of roles with the sub-groups, adolescent sub-group, mothers sub-group and fathers sub-group, allowing a better cohesion, providing different expressions and pooling different resources. Diversity was also illustrated by families who were at different stages of school refusal and reflection (Q3).

Q1 Teenager 1: "It creates debates too. To see that sometimes we have as much voice as adults. It gave us confidence, whereas it's sometimes what we are blamed at high school for or that kind of thing. There, it feels good to be at the same level."

Q2 Mother 5: "But in the end we have never experienced a situation like this, to be in a group, where you talk about a theme. I also discovered my daughter."

Q3 Mother 6: "We were a bit of neophytes on the subject, whereas there are people who had thought about it a lot more."

Getting Involved in Activities

Adolescents and parents emphasized five activities: problem drawing, sculpture, photolanguage, role-playing, and imaging the future with masks accessories. These medias expressed what speech couldn't. Serious things and emotions were shared by an imaginary and symbolic language (Q4). These activities made participants think and question themselves, but in a twisted and playful way (Q5). These exercises must be done by both parents and teenagers in order to compare different perspectives. Exercises put parents and teenagers on an equal footing (Q6). Parents perceived the experience of their teenager both through the activities and their explanation by adolescents. This was very striking for adults and adolescents, whose speech became strengthened, legitimized and shown. Their suffering, their experience was no longer heard but watched, furthermore by their parents (Q7). Through this look, it became real. In contrast, some activities were utterly not named, as the blazon one which worked on family resources, and the backpack which worked separation issues.

Q4 Teenager 5: "By activities, we really can express things otherwise than with words. Precisely, to bring out things that come from our imagination and all that, it's something that brings out the real emotions much more."

Q5 Teenager 4: "I would say we don't have too much to think about. Finally it made you think but not too much and it was still a pleasant moment."

Q6 Father 6: "The moment when, symbolically, the problem was drawn by the parents on one side, by the children on the other [...] both sides of the same coin that really highlighted the different vision of the same problem."

Q7 Teenager 1: "It felt good to show to parents, to put our fears into words."

Belonging to a Group

Group was noticed by all the participants as a major and supportive element: MFT group, parents group, adolescent groups, and subgroups (Q8). Relationships happened once more. By its kindly holding, its motherly matrix, group enabled speaking, emotion releasing and emotion flowing (Q9). Adolescents expressed themselves with a single voice, almost in a single body; their voice became legitimized and powerful, heard by their parents (Q10).

Group was an entity whose members experienced the same things, belonging to a single and merging collectivity (Q11). For some adolescents, it was the first time they met others teenagers suffering from school refusal. The group had to be preserved whatever the difficulties were, in a group illusion. Violence or family conflicts had not their place. Participants were excluded if they didn't share this single thought (Q12).

Q8 Father 2: "I think this is what makes this thing so strong, it's the fact that there is a group."

Q9 Mother 6: "Maybe to be in a group too, maybe there are things we say differently. I think we don't feel the same when we are several as when we are alone. I think it's a good way to get some things out."

Q10 *Mother 2: "What really strikes me is their total agreement, they had the same living, the same feelings and that really strake me....because they didn't know each other, they've never seen each other and when they presented their activity well, they were always in unanimous agreement, and that really struck me."*

Q11 Teenager 1: "Yeah, we made a single unit in an hour, but before we didn't know each other and it was the perfect square."

Q12 Teenager 1: "It was just that the affinities were made at the start and then it just got worse. Suddenly, we just weren't compatible [...], she didn't come back to me."

Therapists as a Security Figure

Therapists were deeply invested. They settled the frame in a reassuring way (Q13). By their holding and their welcoming, emotions could be released. Unlike others therapies where therapists are more leading, they stepped aside for participants to become co-therapists (Q14). One mother expressed that if therapists had participated too much, she would have felt paralyzed (Q15). On the contrary, half of the parents found that therapists were not enough interventionists. These latter parents seemed to be looking for reassurance, security, confidence, and renarcissization of their parental or family functioning. It echoed parental regression toward the therapists. For them, therapists were the ones who got solutions, possessed the knowledge and knew the appropriate behavior parents should have (Q17).

Q13 Mother 5: "I found that you have been able to create an atmosphere, for people to feel confident and that enable it [...]. As a secure framework."

Q14 Teenager 3: "In the end, it guides us toward solutions, which leads us to do some thinking alone. It's still really interesting for us to lead the session a bit ourselves, still being guided not to go anywhere."

Q15 Mother 3: "I, if I may add, if you had intervened, personally, I would have stopped talking because we would have felt judged, analyzed."

Q16 Father 3: "By the way, if I have a criticism to make, I find that you did not intervene much."

Q17 Mother 6: "When you said: 'we're filming,' I say to myself: wow, they must have analyzed things, they saw: there, he ticked, there, he did something. I, I don't know how to analyze."

A Deeply Emotional Trip

Emotional Catharsis

Participants described an emotional catharsis, feelings restrained which could eventually/finally be released in the group, because the group welcomed and greeted them (Q18). These emotions flowed in a dual circulation, the participants being both depositories and receptacles (Q19). Therapeutic work was enabled (Q20). Participants described an emotional range and thus experienced emotions once more (Q21). Even though speaking of and feeling these emotions was painful, participants explained that it was necessary. They were relieved and even proud of themselves (Q22). Intimacy was exposed Q23).

Q18 Mother 3: "[…] and you are given the opportunity to open the floodgates, that was my thing. There you are in a group where everyone has the right to express themselves. So automatically, barriers you put up to hold out fall."

Q19 Mother 3: "So there were a lot of emotions, often it was a parent and then at another session another parent. It was spinning."

Q20 Father 6: "Once again, group time is therapeutic, emotional, it works."

Q21 Teenager 5: "We went through all the emotions, I would say between us."

Q22 Father 3: "I was struggling and still struggling. It is true that it took me to the guts. But I felt it was necessary."

Q23 "Mother 2: "we bare with people we don't know."

Group Connection

Participants experienced deep connection between each other. They felt strongly connected in their experience of the difficulties (Q24). Some personal history echoed strongly between parents and teenagers (Q25). In addition, some participants used the word mirror: mirror as a reflection which enabled a questioning, and mirror as a multiplier medium that strengthened the therapy work (Q26).

Q24 Mother 2: "Compared to what others might experience, feeling their experience [...]. I had resonance with some people."

Q25 Mother 1: "My problem was uprooting […] it was Ado 5 experience, which also upsets me a little [...] to be like that, cut off from its roots, of its origins."

Q26 Father 3: "Because there is a mirror effect, that is to say that we see other parents playing teenagers, we see teenagers playing parents and there, we understand things better."

Q26 Mother 5: "Me, I would say that it has a mirror effect, it multiplies. Instead of seeing only you in the mirror […]. So that's just as much power."

Awareness

Parents described a true awareness of their teenager experience (Q27). It was a revelation of their adolescent autonomy, maturity and lucidity (Q28). Some parents even spoke of bewilderment. This awareness was seen in certain terms used, such as "struck," "marked," "questioned," "percussive."

Q27 Mother 4: "This stress, this look is so deep, I hadn't understood enough before, this fear to make a mistake, the look of others, it is so strong. I understood that a lot more with the multi-family group. I hadn't realized that."

Q28 Mother 4: "It was really interesting and with a clarity, a clarity… Yes, I think we were all stuck, in any case the parents, I find we were much more draft, whereas they were very clear, precise, they knew where they were going, they really have an awareness of what they are going through and they know how to put words."

After MFT: Outcomes and Unmet Expectations

Empowered Families

MFT was an extremely invested therapy by the participants (Q1). MFT partly relieved parents and adolescents from their guilt (Q2). It offered them other ways of proceeding and solutions (Q3). They better understood school refusal. Going back to school was no longer a goal for some parents (Q4). Intra-family communication was improved (Q5). Participants understood that part of the solution was inside the family system (Q6).

Q1 Father 3: "I didn't think MFT would offer me so much."

Q2 Mother 5: "Yes, I also told myself that I had a part of guilt I could leave."

Q3 Mother 3: "We hear other ways of acting, saying: well, maybe I will try, it will maybe improve things, help him a little more. We found other solutions finally.

Q4 Father 3: "Back to school? I had it before, now I understand that it's not necessarily ..."

Mother 3: "We accepted the situation. We even told Teenager 3: "Going to school might be not worthy if that makes you feel stressed""

Q5 Father 3: "We question ourselves. I listen more to my daughter, I try to listen to others a little more, I see that she has less difficulty speaking, even with us."

Teenager 3: "It also allowed more communication."

Q6 Mother 4: "I don't know, it's not individual, it's not a case, a single case. I think it's interesting in itself to see other families. For me, it's a structure. If I move, things will also change with Teenager 4 or the opposite. In any case, we are not isolated individual, everything is connected."

More Liberated Adolescents

MFT brought adolescents a liberation and a relief (Q7). Adolescents experienced a certain authenticity in relationships in MFT thanks to the absence of peer judgment and therefore experienced a peaceful relationship with their peers (Q8). They had more confidence in themselves (Q9).

Q7 Teenager 5: "It allowed me to open doors, to be less stuck on school refusal or even anxiety, things like that."

Q8 Teenager 5: "I felt comfortable, not misunderstood. I had less this feeling of wanting to be superior to others […]. I felt in my place […]."

Q9 Teenager 1: "You are going to go to a group where there will be lots of people like you. Suddenly, it gave us confidence, we are able to do it."

Breaking the Taboo of School Refusal: Acceptance, Talk About

School refusal was finally accepted and told to others (Q10). Participants have been able to talk freely about it. MFT provided them answers (Q11). Participants admitted school refusal (Q12)

Q10 Mother 3: "Me, I hadn't told my parents. There, I said to myself: now you're going to say it and then we'll see."

Q11 Teenager 5: "I think it helped me on a lot of questions I was asking myself"

Q12 Mother 2: "She's going to be able to tell it even to people she doesn't know."

Relationships With Others: Socialization, Communication, Differences

Participants felt less lonely (Q13). Absence of judgment and sympathy were two major elements (Q14). MFT allowed to have new contacts and to face others perspectives in safety. The community and its plurality of perspectives helped each other (Q15). Thus, each participants became co-therapists. Moreover, seeing others reaction made some participants question their behavior and change it afterwards (Q16).

Q13 Mother 5: "It already made it possible to see that we were not alone. It's comforting to know that we are not alone facing things."

Q14 Mother 3: "Not to be judged. This is also what is important, no one judges the other."

Q15 Father 1: "We are all together with our own problem, helping each other to find a solution together."

Q16 Father 3: "It's the mirror phenomenon, I said to myself: hey, the guy doesn't have a good attitude. And then I understood that I was doing the same."

Unmet Expectations

Parents didn't see results about school refusal (Q17). They would have liked more practical solutions to be provided. Some families would have liked feedback from therapists, and even made it one of the goals of MFT; they missed feedback and interventions (Q17).

Q17 Mother 5: "I haven't seen too many effects on 'Avoiding chronic school leaving' and 'Improving anxiety manifestations'."

Q18 Mother 6: "I found that it lacked feedback."

DISCUSSION

The aim of this study was to explore the experiences of adolescents and their parents of the MFT in school refusal. We aimed to explore the adolescents and their parents perspectives, the relevant improvements and the unfulfilled expectations. We explored reported changes on individuals and intra-family interactions. We also studied if what was described in MFT theory was found through families reported experiences, and if it was relevant for school refusal treatment.

Families Experienced MFT as a Therapy Between Family Therapy and Group Therapy

Our results suggest that MFT provides families with reassuring environment, group connections, empowerment and various perspectives. This echoes several aspects of systemic family therapy.

One of the key objectives for family therapists is to "join" the system in order to be able to work with its members. To do so, they must understand and respect the rules and organization of the family system (48). In our results, therapists joined the multifamily system by understanding the implicit rules of the group and of its family sub-systems- including the fear of direct confrontation, either to psychiatry, other people, or to their own emotions. Moreover, each participant affiliated each other, thus strengthening the joining procedure.

Moreover, our results suggest that the resonance phenomena occurred and was particularly strong between participants, who thus became co-therapists. Resonance states that, in a system, one member's experience- toward an emotion or an event shared or expressed in it- has a function for the system (49). The resonance phenomena is part of the family therapy.

Further, MFT seems to use the family competence as a therapeutic tool. Family competence is a concept developed by G. Ausloos who states that families have already the solutions to their problems, but they do not know it yet. Therapists only guide families to find it (50). In our study, participants not only valued their own family unit's competence but also the competence of other families. The group appeared as a larger family, where each family unit was able to provide solutions. In addition, according to G. Ausloos, families became active agents of their own change. They are included in the therapeutic process and relieved from their guilt. In our results, the participants described those two specific aspects.

Finally, in some families, communication has reached a dead-end: the same interactions are repeated over and over, in an endless game. Each apparent solution fails to provide a real change, "doing more of the same thing" (51, 52). Family therapy, through therapists, brings other new perspectives (53). Our results suggest that metacommunication was occurring in our study. Each family brought another perspective and became thus co-therapists. This change of perspectives and roles is described by E. Asen as a "greenhouse effect": participants are "in perpetual motion" within their family and the MFT group, having to adopt a multitude of roles and perspectives (34).

Families included in the study also underlined several aspects of group therapy, such as activities, group experience as a belonging place and a safety framework, and eventually mirror reactions.

Media such as activities, drawings, role playing and sculptures enables adolescents to make up with their thoughts passing by imagination (54). Indeed, while the blank sheet of paper astounds, media allows liberation. In ours study, imagination- so crucial to the transformation process occurring at adolescence- was paralyzed by school refusal and was particularly unleashed by activities (55, 56). Furthermore, through activities, adolescents were at the same level as their parents, in this horizontalization process allowed by MFT. By using their language and their expression code, MFT allowed their integration and involvement into the therapeutic process. Their words became heard. They became therapists, experts of their disease and valued. They, who suffered from school refusal and anxiety, deadlocked in daily life and in their families, became active agent of their change. They reappropriated their thinking from their parents who all expressed their surprise facing the lucidity of their teenagers's words. MFT thus allowed progressive empowerment of thought and differentiation from parents.

Further, the group gave to adolescents a new and transitory support of identity (57). The sense of belonging to this "perfect square" allowed them to face anxieties of fragmentation and of identity loss. The group was the basis of a neo-identity, a "prosthesis" which helped supporting their failing feeling of their own personal identity (58). Shared perception of schooling or of school refusal provided support to face differences. Adolescents could give up some defensive attitudes (59). As Teenager 5 pointed out, MFT became a place where she could be more genuine without trying to be superior. Adolescents could re-experiment the community experience and interactions with peers. They surrendered their social anxiety, their fear of judgment and their experience of exclusion.

Moreover, the group device, with its frame and sympathy, held emotions and anxieties (60, 61). *Holding* was also set by therapists and their special positioning in group therapy. Indeed, they did not have the classic leader role and acted as benevolent observers who provided care function- as "co-pilots"- making families active agent of their own change (34, 62).

Last, the mirror reaction was widely noticed by participants. Foulkes describes it as the patient's awareness that other individuals have morbid anxieties, which allays anguish and guilt (62). Mirror reaction also includes the personification, the incarnation of a character in which participants can recognize themselves or discover- through their reactions to him- an unknown part of themselves.

MFT: A Relevant Therapy for School Refusal

Between family therapy and group therapy, MFT appears in our results to be truly relevant for school refusal management.

Emotions, experiences and feelings could be expressed in families where they were precisely locked in. Emotions and speech were eventually released and flowed. This emotional update created a real "sensitive period" mobilizing new representations of oneself, of others, and of the interactions in the family (63). MFT restored moves and circulation in families paralyzed with an injunction of impossible motion. This flow of emotions even went beyond the intra-family nucleus to outreach the extended family, as exemplified by Family 3 whose maternal grandparents "evolved."

Emotion was released in safety, allowed by MFT device. By the frame, the holding, the therapists positioning and the activities, intimacy could be shared without threat. The benevolent needs of adolescents were thus fulfilled.

In addition, for these families characterized by separation anxiety, working precisely in family was probably a major element, enabling autonomy in safety. Adolescents could be with peers under their parents "look" who saw their offspring evolving in a micro-society of peers. As noticed by Mother 3, it was the first time for many parents that they experienced their adolescents evolving with other teenagers.

Besides, in MFT, attachment issues, attachment to the therapists and to the other participants occurs regularly. J. Byng-Hall defines the concept of "family security basis" which allows in family clear communication, open feelings expression and the ability to recruit outside help from extended family, as resource persons or therapists (64). In MFT, the therapists and other participants became substitutes and temporary family security basis in this group, which became a meta-family (65).

It is interesting to note that the positioning of the therapists confused and made half of the parents felt insecure. The end of MFT was difficult for all parents, as if the separation was impossible. But, as a paradox, seeing each other after MFT could not happen, as if the transition to reality was impossible. We can hypothesize that if the group is therapeutic as an identity, seeing itself outside would be too intrusive with a threatening reality.

Further, for these families who experienced exclusion and stigmatization, MFT allowed enrollment in a system of peers: group system, school refusal system, MFT system, adult system, teenagers system. Rejected by "a common enemy," searching for a validation and a legitimacy of their abnormality, participants found in MFT a place to belong. It enabled them to go back to the institution, whether for an individual therapy, a family therapy or day hospital care.

Finally, MFT works on belonging and identity issues in a system where filiation and affiliation axis co-exist, which is unusual (66). This appears all the more relevant for this problematic which itself is not recognized as a psychiatric disorder and which does not clearly belong to a diagnostic entity "without affiliation, without socialization, and almost without perception of its limits [of existence] (66)."

School Refusal Gets Health Professional to Work With Community

Very few participants, especially parents, clearly used the term of school refusal. They spoke of problems, anxious refusal, and social anxiety. Similarly, they neither talked about depression nor unease. While for other psychiatric disorders, adolescents consult a doctor to recover, here solution should come from school. While adolescents came to MFT for their parents to understand their disorder, parents went to MFT in order to help their children, wishing a return to school after the therapy. This difference of expectations recalls Sibeoni study (25), where adolescents wanted peer relation and going back to education more than going back to school.

The specific place of this disorder can be seen in family ambivalence toward school refusal- which marked an identity, an extra-ordinary identity. It is also seen in MFT expectations, which should bring "educational guide." We could wonder whether the difficulty was the school refusal or the inability of the academic system to adapt to these "extra-ordinary" pupils. Parents thus seemed to come to MFT and to the hospital, another state institution, in order to find the help and support that school was unable to provide them. A cleavage appears between the hospital, the good one, and the academic system, the bad one, in a disorder at the crossroads of these two entities. MFT became "a last resort" and carried the unfulfilled expectations.

Further, as we introduced, school refusal does not yet appear in international classification, neither in the DSM 5 (Diagnostic and Statistical Manual of Mental Disorders) nor in the ICD-10 (International Classification of Diseases). If the DSM-5 includes school refusal in "anxiety disorders of childhood and adolescence linked to separation anxiety" and distinguishes two forms- the first classified among the symptoms of separation anxiety and the second classified in within social phobia (DSM-5)-, the ICD-10 classifies this disorder as "phobic anxiety disorders" (ICD-10). It seems to suggest that psychiatry community considers that school refusal is a social functioning disorder, explained by social and academic reasons. Besides, for parents, school responsibility is often essential if not exclusive and the care offered by the psychiatrist enters into competition with the return to school and to normality (54).

These results raise several questions. First, what would mean a return to school: a recovery? A return to normality? Would it be a criteria for the recovery of a psychiatric disorder? Can it really be a therapeutic goal? It highlights the question of care and its limits- in families where it is probably easier to talk solely of school issues.

Furthermore, this study questions the place of education in families and, more broadly, in society itself. The solution must consider this societal dimension, and first and foremost this third protagonist, school. It seems necessary either to invite the school to MFT or to go to meet the school. We thus better understand parents' expectations from MFT, which appear at first sight unsuitable to MFT (bringing concrete solutions, making the link with the academic system).

From the psychiatric community to the "network therapy," working with- even in- the community is an important issue in psychiatry. In the 1970s, Cooper (67) founded the Philadelphia Association for developing original places, as Kingsley Hall, for patients suffering from schizophrenia. Patients were taking turns for caring for each other, the group regulated itself and controlled the delirium of its members. Likewise, Speck (68) developed a new professional role, a mediator one between the schizophrenic family and the therapist, between the therapist and social organizations or society, and between family and society. "Network therapy" uses the patient's network for care, a network in the broad sense (which can go up to 40 people): nuclear family, extended family, friends, and neighbors (68). The "Family School" developed by Dawson and McHugh's team at Malborough Hospital falls into this tradition in order to work with, even in the community and not in the institution (42, 43). In France, Prof. Baleyte, head of department of the 5th sector of child and adolescent psychiatry at the intercommunal hospital of Créteil, has developed since 2018 a mixed and mobile school intervention unit, the UMMIS, which relies on the tools of multifamily therapy (69). UMMIS is a multidisciplinary mobile team that works in several schools in the city of Créteil to prevent from dropping out of school. It relies on the commitment of three stakeholders: the school, the pupil and his family, and UMMIS.

We could thus reflect on the opportunity of such a device in the management of school refusal which would include families, teachers and therapists. One of the longer-term objectives would be to develop a joint network with education in order to be able to quickly take care of patients suffering from school refusal who often arrive too late to the care.

Finally, this study only included a few sessions, and the beneficial effects could be impacted. More sessions have been added to the next ones (8 sessions). The results of this exploratory study were considered to improve the content and form of the following groups. Other groups will start in other units and we hope to be able to consolidate the results.

Strengths and Limitations

Our study had several strengths. First, to our knowledge, this is the 1st study, and the 1st qualitative one, exploring MFT experience of families facing school refusal in adolescents. This was the first group of MFT and school refusal organized in France, making this study a pioneering one in that field. Moreover, the rigorous IPA-based analysis was most appropriate to its topic.

Nonetheless, some limitations must be taken into consideration.

First, it took place in France, and caution is required in transposing our results to other places because psychiatric care depends strongly on the organization of the medical system as well as on the country's economy. Second, the population of adolescents was recruited in a specialized department of adolescent psychiatry.

One might argue that the sample size is too small to allow transferability of the results and that data saturation was not reached. However, this small homogenous sample is in line with IPA guidelines, and the concept of data saturation is not relevant within IPA methodology (46).

One methodological limitation is the jointly participation of adolescents and their parents during the research interviews which might have inhibited adolescent expression.

Finally, as only one brother came to only one session, we didn't include the siblings in the research but further research should include their perspectives.

Conclusion

This research highlights several elements.

On one hand, families' experience of MFT seems to confirm its anchoring in both group therapy and family therapy. Indeed, it takes root in family therapy, as it leverages systemic concepts such as resonance, affiliation, family competence and metacommunication. It also borrows from group therapy the use of a medium, the group device- which composure help create a safe environment-, and the role of therapists- who leave the participants active agent of their change. The MFT group thus becomes a large system, a meta-family whose members, individuals or families, become co-therapists, disorder experts and agents of change, by mobilizing their family or even meta-family resources.

On the other hand, MFT appears to be quite relevant for school refusal management, a paralyzing pathology, where emotions and thoughts cannot be expressed. It allows working on separation issues in families where it seems difficult to empower oneself. In addition, it is a pathology at the crossroads of care and education, and which gives rise to great stigma. MFT group thus appears particularly relevant since it offers participants a new affiliation and a relief from their guilt.

It is interesting to note a certain resonance between school refusal and MFT since they both are two fairly recent entities whose identity is not clearly defined.

Finally, this study questions the role of school in therapy. MFT has its origins in community psychiatry and it seems important to have a reflection on how we can work with this third protagonist in order to fulfill families' expectations for a disorder that appears to be deeply rooted in society.

DATA AVAILABILITY STATEMENT

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by Comité d'évaluation éthique des projets de projets de recherche en santé non soumis à CPP N° IRB: 20151300001072. Written informed consent to participate in this study was provided by the participants' legal guardian/next of kin. Written informed consent was obtained from the minor(s)' legal guardian/next of kin for the publication of any potentially identifiable images or data included in this article.

AUTHOR CONTRIBUTIONS

The study was designed by AH. The interviews were independently coded by two researchers (AR and AH). Codes were discussed during group meetings (AR, AH, LB, JS, and MM) to enable triangulation, which both enriches the analysis and serves as a quality control process. All authors contributed to the article and approved the submitted version.

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The Search for Origin of Young Adoptees—A Clinical Study

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In the current area of social media propagation, the adoptees' search for the birth family is increasingly reversed: more and more adopted adolescents are contacted directly by their birth parents, even if they did not search for them. This study explores the impact of these new forms of contact between adoptive family members and birth family members, through the qualitative analysis of clinical protocols of five adoptive families that sought counseling in a clinical setting devoted to international adoption. The interpretative phenomenological analysis revealed three themes. Two of them shared by the parents and their children: the feelings of anxiety and intrusion, as well as the feelings of guilt and debt. The last theme concerns only the parents: feelings of endangered family relations and can be divided into two sub-themes: feelings of threat by the birth family, feelings of an undermined parental role. Nevertheless, these new kinds of confrontations with the children's origins bear a potential of renegotiating adoptive family relationships and positive effects on mutual feeling of filiation. Exploring the impact of the search of adoptees by the birth family enables professionals involved in adoption to improve preventive and supportive work in the adoption process.

Keywords: adoptive family, adoptees, birth family, search for origin, social media, interpretative phenomenological analysis

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INTRODUCTION

Young adoptees have been the subject of an increased interest in research in the last decades. A first research field focused on their mental health and risk of psychiatric illness. Many adoption studies have showed that adoptees are overrepresented in diagnosed people with a psychiatric disorder and in outpatient clinical settings (Hjern et al., 2002; Juffer and van Ijzendoorn, 2005; Wicks et al., 2010). A meta-analysis, conducted in 2016 (Behle and Pinquart, 2016) presented evidence for an increased risk of adoptees, compared to non-adoptees, for experiencing psychiatric disorders, contact with mental health services, or treatment in a psychiatric hospital.

These results were put in perspective by other authors (Miller et al., 2000; Harf et al., 2006). This overrepresentation of adoptees in outpatient clinical settings can be explained by the adoptive parents' propensity to more readily use mental health services, even in early stages of symptom-development.

Adoption-research is also interested in the impact of pre-adoption experiences on the children's social and emotional development (Verhulst et al., 1992; Rutter, 2005), but also on their family relations and the filiation process. Adverse pre-adoption experiences such as maltreatment by families of origin or neglect during institutional care in orphanages prior to adoptive placement, increase the risk of post-adoption psychosocial maladjustement, specially with externalizing problems (Gunnar, 2000; Wilson, 2003; Juffer and van Ijzendoorn, 2005; Tung et al., 2018). But post-adoption experiences, such as quality of parent–child relationship mediate these pre-adoption experiences to produce different outcomes (Howe and Fearnley, 2003; Skandrani et al., 2019). Post-adoptive family relationships represent therefore a protective factor on the adoptee's emotional and social development (van IJzendoorn et al., 2005; van IJzendoorn and Juffer, 2006). In this regard, an interesting field of research focuses on the parent-child relationship in adoptive family and the understanding of adoption.

Increased Family Contacts in the Adoption Triad

Since the mid-90', adoptions have become increasingly open in the UK and the United States (Black et al., 2016; Farr et al., 2018), even if it concerns especially domestic adoptions. In this context, child adoption is understood as an extended kinship network, including, the adopted children, the adoptive parents and birth relatives (Reitz and Watson, 1992; Grotevant and McRoy, 1998).

Despite this trend in both countries, controversies surrounding birth family contact persist (Grotevant, 2012; Siegel, 2012). Research in this area highlights different benefits to increased openness in adoption (Berge et al., 2006). Contact between the adoptive family members and birth relatives is generally associated with positive outcomes in adjustment and relationships among this adoption triad (Grotevant et al., 2007, 2013; Siegel, 2012) and with satisfaction (Grotevant et al., 2007, 2013; Vandivere et al., 2009; Brodzinsky, 2011; Brodzinsky and Goldberg, 2016; Farr et al., 2018). Adoption-related communication promotes a positive identity development among adopted adolescents and emerging adults (Grotevant et al., 2007, 2013). Yet, contact and adoption communicative openness are not related to adoptees' externalizing behavior in adolescence or emerging adulthood (Grotevant et al., 2011).

In spite of these results in favor of an increased openness in adoption, uncertainty remains about how this should be achieved. The complexity of the process of renegotiating the boundaries of kinship following adoption for all those involved is not enough recognized (Jones and Hackett, 2012). A qualitative study with adolescent adoptees whose voices are usually less heard, suggest that some of them are satisfied without having contact with their birthmother (Berge et al., 2006). Although a majority of adopted adolescents desired more contact with their birthmothers, not all of them had this desire for more openness (Grotevant and McRoy, 1998; Berge et al., 2006).

However, these general results in favor of an increased contact between adoptive and birth families were mostly reported in the context of American and Britain domestic adoption. In contrast, the traditional model of adoption as a form of family substitution is still dominant in France, where closed adoptions are the norm (Skandrani et al., 2012). They imply a permanent and total break of the filliation's bond with the birth family. In comparison to the American adoption context, a second point is further noteworthy: In France, children are mainly adopted from abroad (421 adoptions in 2019[1], primarily from Vietnam, Columbia, Thailand, Haiti, and Congo. These two observations highlight a different adoption context in France, which determines a different adoption practice, especially concerning the contact to the birth family, the adoptee's cultural belonging and their search for origins (Skandrani et al., 2012).

Controversies Surrounding the Search of Origin

In France, the discussion about an increased openness in adoption takes place *via* controversies regarding the benefits and drawbacks of the search of origins in adoptive families. Some adoption professionals (Lévy-Soussan, 2002; Soulé and Lévy-Soussan, 2002) defined the search of origins as a never-ending search for affection and love. Those engaging in such a path are trying to compensate the loss that they have incurred through their adoption. Instead of enabling a process of grief and a positive identity development, the quest for the birth parents would obscure the real psychological challenge: the need of separation–individuation during adolescence. In contrast, other researchers support the understanding of the search of origin as a search of personal history (Delaisi de Parseval, 2002; Golse and Moro, 2017). The studies in this area revealed the importance of acknowledging the specificities of the adoptees' adoption story. Considering the birth and cultural context reflects one way to deal with the question of origin (Harf et al., 2015). Considering the birth family story and even the adoption-related losses can constitute an opportunity to integrate them in a coherent life narrative (Skandrani et al., 2019).

Increased Contact Through Social Media

Contact is currently also becoming more common in international adoption with the enhanced use of internet and social media of birth and adoptive family members (Roby et al., 2005; Black et al., 2016). Adoptive families are increasingly confronted with the possibility of contact with birth family members, a contact sometimes initiated by the latter. Boundary challenges (Black et al., 2016) and concerns arise with these developments (Goldberg and Smith, 2011; Grotevant et al., 2013). Ambiguities, miscommunication (Hertlein, 2012; Black et al., 2016) and concerns about potential intrusion by birth family members into the adoptive private family lives (Neil, 2009; Goldberg and Smith, 2011; Black et al., 2016) can be consequences of social media contacts. This is even more a concern, when adoptive families are directly contacted by adoptees' birth relatives without having themselves reached out for them (Skandrani et al., 2020). This contact initiated by the birth family doesn't fall into the category of what could have been an open adoption. In the latter, the relation arrangements between the birth and adoptive families are determined in advance during the adoption process itself.

These new ways of contact in the adoption triad, i.e., contacts initiated by the birth relatives *via* internet and social media, remain mostly unstudied. In the situations at stake here, the contacts couldn't be anticipated and prepared by the adoption family members. Understanding their complexity is the goal of the present clinical study.

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[1] Government source: https://www.data.gouv.fr/fr/datasets/adoptions-internationales-pays-dorigine-zone-geographique-tranche-dages-et-procedures/

MATERIALS AND METHODS

The study explores the impact of new forms of contact between adoptees and their birth family, through the qualitative analysis of clinical protocols of five adoptive families.

Data Collection

In a clinical setting devoted to international adoption (Harf et al., 2013), adoptive families searching for psychological counseling are received by two psychologists, a psychiatrist and a psychology trainee for a preliminary evaluation, before being referred to a specific therapeutic setting. This evaluation process consists of three sessions, occurring once a month. Each step of this evaluation process takes place with the whole family, i.e., with the adoptee, his/her adoptive parents and his/her siblings if he/she has some. In this clinical setting, the adoptees' ages range is between 3 and 20 years.

A series of specific topics are systematically raised as part of the evaluation process. First, the different family members are invited to narrate the adoption procedure as well as the first encounter between parents and children. They are questioned about their past and current contacts with the birth family members, about eventual pre-adoptive arrangements, about their relations and their personal experience in this context. They are also encouraged to expose their current concerns about the family relations, the adoptive children's psychological outcomes/adjustment and their understanding of the difficulties that are faced. Each session is transcribed *in vivo* by the psychology trainee, after obtaining the family's agreement.

The family's questioning around the child's origin, especially during adolescence becomes often apparent during these sessions, addressed by the children themselves or by their parents. This clinical experience showed an enhanced parental concern about contacts with the birth family through the social media and their questioning about boundaries (Skandrani et al., 2020).

To further study the implications of these new forms of contact with the birth family on the family dynamic and the adoptee's psychological development and adjustment, the transcripts of this evaluation process were analyzed as part of a research protocol.

Participants

Five families seeking clinical counseling in adoption participated in this clinical study. In all five families the couples were married. Parents' ages ranged from 35 to 49 years at the time of their children's adoptions and at the time of the interview from 47 to 60 years at the time of the interview. Parents lived in urban areas of France. All of them were college-educated professionals.

Each family has adopted one child: three were from Tahiti, one from Ukraine, and one from Haiti. Three were girls and two were boys. At the time of their adoption, their ages ranged from 1 day to 5 years. At the time of the clinical interviews, they were aged 9–16 years (see **Table 1**).

The reasons reported by the families for reaching out for adoption professionals were relationship difficulties in the adoptive family ($n = 5$ families), as well as adoptees' internalizing problems: anxiety ($n = 5$), sadness ($n = 3$), and suicide attempt ($n = 2$).

Each family came three times in clinical counseling. The sessions took place over a period of three months. After the evaluation process, all the families were referred to a specific clinical setting devoted to international adoption, for therapeutic support. Further, four of the adoptees (except the 9 years old Paul) were invited to seek individual psychotherapy.

Each session was transcribed during the clinical encounter. A total of 15 sessions were then analyzed.

Data Analysis

These 15 clinical transcripts were analyzed by two independent researchers (who were different from the professionals involved in the clinic setting), according to the Interpretative Phenomenological Analysis (Smith and Osborn, 2008).

This qualitative research method allows the exploration of the adoptees' and adoptives parents' personal experiences and unique representations of the question of origin as well as of their contact with the birth family, through a detailed examination of their personal perceptions and lived experiences. Hence, an in-depth qualitative analysis was conducted. Through an iterative inductive process, the researchers proceeded to a detailed case-by-case study of each clinical transcript. They began with several close, detailed readings of each clinical transcript to gain a holistic perspective, noting points of interest and significance. Through a step-by-step analysis, analytic themes emerged, which were described, as well as their interconnections, while keeping a link back with the original clinical transcripts. This process produced a coherent and ordered table of emerging themes. This data analysis procedure was inductive, since the analysis of the international literature on this specific subject was performed in the aftermath.

The sample size was determined by meaning saturation: we stoped including new families, when no additional information emerged from the data (Wilson, 2015; Hennink et al., 2017). We used this type of data saturation, as we aimed for an in-depth understanding of the phenomenon under investigation—i.e., the search of origin, when initiated by the birth family—from the perspective and experiences of adoptees and adoptive parents. Clinical transcripts ensure to gather deep, rich, detailed, and relevant data. Thus, the meaning saturation was reached, when no further insights were originating from our data.

Validity

The researchers involved in this study are specialized in international adoption, family therapy, and trauma. The researchers codings were compared in order to insure the validity of this research.

Two trained researchers (SS and AH) independently coded and interpreted the clinical transcripts. The emerging codes were repeatedly discussed with another research team member (MRM) who had read the transcripts. These discussions allowed to identify additional themes in the data that might not yet have been described in the codes. It enabled the researchers to complete or modify the coding in order to increase the consistency and coherence of the analysis. It was thus ensured

TABLE 1 | Participants' description (All names have been changed).

Name	Age	Age at adoption	Country of origin	Type of contact
Diana	16	1 month	Tahiti	The biological sister contacted the adoptee through social media
Pierre	15	1 day	Tahiti	The biological sister contacted the adoptee through social media
Marie	15	6 months	Tahiti	The biological sister contacted the adoptee through social media
Daria	14	4 years	Ukraine	The biological sister contacted the adoptee through social media
Paul	9	5 years	Haiti	The biological mother contacted the adoptive mother through social media

that the themes were accurately identified and reflected the data. Through this process, systematic differences, due to variations in interpretation, were eliminated. Validity was also enhanced by clearly distinguishing between the patients' discourse and the researchers' interpretation (Smith and Osborn, 2008).

Ethical Statements

A clinical study such as this raises many ethical issues for consideration. Ethical approval was given by the Comité d'Evaluation de l'Ethique des projets de Recherche Biomédicale (CEERB) du Groupe Hospitalo—Universitaire Nord, on the 29th of March, 2011 (Institutional Review Board N° IRB00006477).

Parents and adoptees were fully informed about the voluntary nature and the goals of the study. Written informed consent was obtained from all participants included in the study before recording the sessions und using the transcripts. Participants were informed that all responses would be confidential, that the transcripts would have no identifying information, and that they would be free to withdraw at any time, without any incidence on the process of clinical counseling they were involved in. All identifying informations were removed from the transcripts, and participants' anonymity further ensured through disguising or withholding descriptive data.

RESULTS

Four adoptees in our clinical study were contacted by their biological siblings *via* social media. In one family only, the mother was the one contacted directly by the birth mother. These contacts took place either in French (Haiti and Tahiti) or in English (Ukraine).

Three themes emerged from the interpretative phenomenological analysis of these 15 clinical protocols: overwhelming feelings of anxiety and intrusion, feelings of guilt and debt, parental feelings of threat and insecurity (see **Table 2**). These themes will be illustrated by patients' quotations.

Overwhelming Feelings of Anxiety and Intrusion

The first emerging theme concerns the feelings of anxiety and intrusion experienced by the adoptees after their birth family and especially their birth siblings reached out for them.

The adoptees reported being overwhelmed by the suddenness of this contact with their birth family, especially as they did not seek for them.

TABLE 2 | Themes and sub-themes.

Themes and sub-themes extracted from the analysis	Adoptees	Adoptive parents
Overwhelming feelings of anxiety and intrusion	5	10
Feelings of guilt and debt	5	10
Feelings of endangered family relations	–	10
Parental feelings of threat by the birth family		10
Feelings of an undermined parental role		10

> "Before, I didn't think of meeting them or even looking for them. I am here, I mean, my life is here" (Marie, 15).
> "She [the older biological sister] contacted me… Just like that. And she told me my story. I mean, I knew the story, my parents told me, but she told me other stuff… And then my mother, my birth mother called me. It was…" (Diana, 16).

Diana can't continue her story, she is overwhelmed by her emotions. Even 2 years after this first contact and its persistence since, she can't talk about it without this overflow of emotions. Especially as she wasn't prepared for this virtual encounter. She was not, or not yet, thinking about her birth family.

> "I mean, I was not thinking about them (the birth family). Sometimes we talked about going there, with my parents, some day. Sometimes I wanted to go to Tahiti and sometimes not. But I was not thinking about them."

Diana's mother remembers that her daughter was "dazed" afterward and "chocked." And she didn't know what to do.

> "But I think afterwards it became difficult with Diana, she started fighting with us. And I think it's related." Diana nods to her mother's description.

Pierre (15) reported a suicide attempt close after the first contact with his biological sister from Tahiti.

> "I tried to kill myself, because my girlfriend broke up with me… Especially since my sister contacted me *via* facebook. She just said that she is my sister. I learned then that our father, i mean my biological father, just died too."

Pierre was completely unprepared for this contact and even more for the announcement of his biological father's death. In this context, the breakup with his girlfriend was a trigger for the expression of his overwhelming anxiety.

Daria was adopted in Ukraine when she was 18 months old, after her mother died. When she was 13, she was contacted by an elder biological sister *via* facebook. Her parents and her brother reported her being afterward "outside of reality." She started going to an elder neighbor, spending all her time there and telling her lies about her parents' behaviors toward her. She alarmed her neighbor so much that the woman reported Darias parents to the social service for abusing Daria. A subsequent social investigation shed light on Daria's lies about her parents' behaviors. Thereafter, the whole family agrees that Daria was very disturbed by the contact with her biological sister.

> "She [the older sister] broke into my life. After that, everything went upside down."

All five families reported not having been prepared for these contacts. The adoptive parents report having always been open to discuss with their children their pre-adoptive history and to share with them what they knew about the birth parents. But they had no active contact with any member of the birth family since the adoption.

> "We have a flexible brain and a flexible heart" (Pierre's mother).

But when the link to the birth family was created, without them—neither the parents nor the children—seeking for these contacts, they experienced the latter as intrusive and even invasive.

> "It's too much. I mean, she [the elder biological sister] is always coming virtually in our family. That does not help Daria to make plans here, to concentrate on her future school choices. How to stop her?" (Daria's father).

Feelings of Guilt and Debt

The analysis of the clinical protocols revealed feelings of guilt and debt, experienced by both the adoptees and their parents.

After acknowledging his birth father's death, Pierre expressed a feeling of guilt toward him. In his adoption story, this man was held responsible for his abandonment and adoption. That's why Pierre was always angry with him, until he brutally discovered his death.

> "I mean, when I found out, I couldn't go and piss on his grave."

Suddenly feelings of debt toward this man who gave him life, are experienced by Pierre and led to much anxiety.

Daria is very concerned with the life of her biological sister: she is pregnant although still very young, she is beaten by her boyfriend and living in very precarious life conditions. The 14 years old Daria tries to give her advice regarding her pregnancy and her life, is always very anxious when she hears about the couple's fighting. She even tries to contact the boyfriend to tell him to stop harming her biological sister.

> "For me, life is simple. But for her, everything is difficult. I want to help her, I want to be there for her."

She is experiencing feelings of guilt for her "better" life conditions, even if she is herself in psychological distress—she is very anxious, sometimes even hurts herself. Her sister's alarming situation is too heavy to bear for a 14 year old girl.

Paul's mother was contacted by her son's biological mother *via* facebook. She is very worried that this woman could ask her for money, although the biological mother didn't say anything in this regard.

> "I don't want to begin such a relationship. But I can understand. I mean, she doesn't have anything, she must be so poor, but we aren't."

Through her worries, she is expressing her ambivalent feelings regarding what she owes to this birth mother. This contact situation that her family didn't seek reveals her feelings of debt toward her.

After the contact with her birth family has been set through her biological sister, Diana now wants to travel to Tahiti. She is working to pay for her airplane ticket. To her parents, who are trying to postpone the trip, she answers:

> "It's urgent. I can't prepare for the trip, you can't prepare yourself for such an encounter. It will be associated with a lot of emotions, it's logic, you can't avoid it."

Encountering her birth family is "urgent" because she owes them a lot and this contact has reminded her of that. That's why it is so important for her to pay for the trip by herself and also to go there by her own.

Now that she has a regular though virtual contact with her biological sister, Marie wants to go and visit her in Tahiti. Even if she will only be graduating in at least 4 years, she is already planning to move afterwards to Tahiti for a few months to help the people there through a humanitarian internship.

> "I want to give a little bit of what I have. And to my sister too."

What does she want to give to her sister? Why does she want to give her something? Through this imprecise sentence "And to my sister too," she is expressing indirectly her feelings of guilt and debt toward her.

Feelings of Endangered Family Relations

The third emerging theme concerns only the parents. They experience and perceive the contacts initiated by birth family members as endangering their relations to their children. Their narratives reveal a difficult coexistence for them, of both filiations—the adoptive and biological one. The two kinds of relationships are experienced as competitive. This theme can be divided into two sub-themes: Parental feelings of threat by the birth family and feelings of an undermined parental role.

Parental Feelings of Threat by the Birth Family

The birth family, breaking in the family life without warning nor preparation or desire to let them in, was experienced by the parents in our clinical sample as a threat.

Paul's mother felt endangered by potential demands of the biological mother, even if the latter didn't make them: requests for money but also for help to come to France for example.

When Pierre's birth mother contacts him to criticize his misbehavior at school and with his peers, his mother intervenes:

> "She should mind her own business! If she gives him [Pierre] away, she gives him away, it's no longer her business."

Even if she agreed to this contact, initiated by the birth family, she experiences it in the long run as intrusive and threatening. She needs to warn her son:

> "Nobody is waiting for you at the other end of the world. Everything is taking place here."

Diana's father is fearing the negative effects of the relation with the biological sister on his daughter. Even if Diana denies it, he thinks that she is disturbed by this contact. He even makes it responsible for the psychological distress his daughter is experiencing since several weeks.

Daria's parents have a similar opinion: all the family's dysfunction began after the relation with her biological sister started. This passively experienced contact had a shattering effect on their family. The parents felt they almost lost their daughter, after a social investigation took place, as Daria pretended being abused by her parents.

Feelings of an Undermined Parental Role

The feelings of endangered family relations are linked to a second sub-theme, which also concerns the parents only: their loss of confidence in their parental function and, in this context, their feeling of insecurity.

Paul's parents fear not being able to protect their son from all the harm he could experience in the outside world. This anxiety is related to the biological mother's search for them.

> "It's difficult to accept that we aren't able to protect Paul from all the dangers in the outside world. He is rejected by his peers, even his teachers are not very nice to him. And when his biological mother contacted us, we were not able to avoid this neither."

Pierres' father expresses a similar feeling: he failed in his parental role—screening the informations given to his son by the birth family.

> "The brutal announcement of the death of his biological father, we were not able to avoid that. But we should have been."

Faced with this parental insecurity, some adoptees try to reassure them.

In Diana's opinion, her parents are opposed to her trip to Tahiti because they feel insecure concerning their relation to her. They would worry that their bond will be undermined by the bond between her birth family and herself.

> "My parents fear losing me. They fear that I won't come back. That's why my mother wants to come with me. But I want to go alone. As my birth mother searched for me, my mother thinks she wants to keep me now."

She tries to reassure them concerning the strength of their relation.

> "I didn't grow up with my birth family. They don't know me, they weren't there for me. It's completely different from my adoptive family."

Marie's parents regret that they weren't capable from preventing a contact with the birth family. Otherwise, they think, their daughter wouldn't have wanted to go to Tahiti. In this context, Marie tries to convince them about their essential role in her life.

> "Yeah, I didn't want to go to Tahiti, before my sister reached out to me. But now I want to go, but I will come back. My life is here, with them [the adoptive parents]. [She turns around smiling at them] Don't worry!. "

Through their narratives the parents are expressing their anger toward the birth family members as well as their fear of losing their children and their bond with them, as if both relations—to the adoptive family and to the birth family—couldn't coexist.

DISCUSSION

The interpretative phenomenological analysis revealed three themes. Two of them shared by the parents and their children: the feelings of anxiety and intrusion, as well as the feelings of guilt and debt. The last theme—feeling of endangered family relations—is experienced by the parents only.

The Emergence of Birth Family

In our clinical experience, the contacts *via* social media initiated by the birth family take place more and more often. In these situations, the quest of origins is reversed, as it is not started by the adoptive family or the adoptees themselves but by the birth family. In the adoptive family, this initiative can be experienced as intrusive and even invasive, since it was not prepared. The adoptees are alone, in front of their computer or phone when the message suddenly pops up. This lack of preparation has therefore an important impact on the way the search of origin can be deployed.

In all adoptive families, the question of origin becomes at some point an issue for the adoptees themselves and/or for their adoptive parents (Skandrani et al., 2020). Many studies (Grotevant et al., 2007, 2013; Hawkins et al., 2007; Le Mare and Audet, 2011; Siegel, 2012) show the positive effect of an open discussion or at least the possibility to address this subject in the family. Some adoptees will ask questions directly concerning their birth mother or birth family, others will address them indirectly through an interest in the culture of origin (Harf et al., 2015; Benoit et al., 2018). Other adoptees will take a trip to the country of origin, visit the orphanage or the location of their abandonment; or just plan the trip and always postpone it (Mazeaud et al., 2019). The quest of origin can thus only be fantasized, without never taking place through direct action.

These different ways of approaching and integrating the question of origin in the adoptees' identity construction are impaired when a contact is initiated by the birth family and is taking place through social media. The adoptees have no longer the possibility to confront this question of origins at their own pace, in discussion with their adoptive parents but also with others, like siblings, peers or adoption professionals.

Moreover, adoptees cannot prepare themselves for the emotional overflow they might experience or protect themselves from it. They are put in a passive, even helpless, position, a position that bears the risk of a shattering and dazing effect on them. This sudden emergence of birth family members through social media brings up the issue of its traumatogenic effect on unprepared adoptees (Skandrani et al., 2020). This applies even more in a context in which openness in adoption is rare if not non-existent, such as in the French context. Cultural differences in the representation and process of adoption between different countries are reported in several studies (Rushton and Minnis, 1997; Skandrani et al., 2012; Harf et al., 2015). Contemporary child adoption in the UK and USA has been conceptualized as an extended kinship network of adopted children, birth relatives and adoptive parents (Reitz and Watson, 1992; Grotevant and McRoy, 1998). This contrasts sharply with the French model of adoption as a form of family substitution. The absence of open adoption in the French context and the subsequent lack of approaches to think and deal with relations with the birth family deprives the adoptees and their parents of possibilities to make sense of these new experiences.

In our clinical study the adoptive parents worry about birth parents interfering in their parental role. They express feelings of anxiety, insecurity, and even threat. They worry that these contacts confuse their child, undermining his/her emotional well-being but also their protective role as parents. They feel neutralized in their parental function of introducing the world to their child in small doses, according to his/her needs and possibilities (Winnicott, 1957), of screening the child's relation to the outside world, of protecting them if necessary. The adoptive parents cannot support their children and walk them through their, often necessary, questioning concerning their origins. Their function as supportive and protective environment for their children is impeded (Winnicott, 1957). As our clinical study showed, they lose confidence in their parental abilities and experiences and become insecure in their relation to their children. The intensity of these feelings of helplessness seems specific to these contact circumstances, as parents don't express the same level of intensity in other situations, neither in real life nor on social media. Sometimes the adoptees must reassure them regarding the continuity and stability of their relationship. It seems that it is not only the contact with the birth family that is responsible for this insecurity but also the way it took place and its meaning for them. Our clinical results showed how this passive, even helpless position can trigger feelings of intrusion and threat by the birth family. These contacts initiated by the birth family are experienced by the parents as a danger for their family relations, as both filiations seem unable to co-exist for them. As stated above, this is probably even stronger in the French context in which the adoption model of family substitution is dominant, depriving adoptive parents of relationship models between the birth family and the adoptive family (Skandrani et al., 2012; Harf et al., 2015).

The new kind of relation to the birth family exposed here has the potential of disrupting the relations in the family and the roles of the children and their adoptive parents. Moreover, the virtual aspect of this beginning relation, taking place exclusively or for a long time through social media only, deprives everyone of the supportive, warm, real aspect of relations. The immediacy of the contact and the communication bears an invasive and *overwhelming* aspect, making the integration of this part of their life narrative particularly challenging for the adoptees.

Re-negotiating the Adoptive Family Relationships

Our results show some negative effects of these contacts initiated by the birth family, such as feelings of anxiety and intrusion and consequent behavioral issues, confirming parental concerns expressed in other studies (Turkington and Taylor, 2009).

However, our results reveal also how the feelings of debt and even guilt triggered by these contacts initiated by the birth family, allow some adoptees to renegotiate relationships within their adoptive family. After experiencing initial overwhelming feelings of anxiety and intrusion, adoptees often take an active part in shaping the relation to their birth family members: they engage in a more or less frequent exchange with them through social media (Daria, Pierre, Marie, and Diana), plan to go visit them (Diana, Marie), make space for them in their daily life (Daria, Pierre).

At the same time, they reaffirm their feelings of belonging to their adoptive family. When confronted with their parents' feelings of insecurity, they try to reassure them about their filiation and bond to the adoptive family: Diana and Marie express their attachment to their "true" adoptive parents, even if they want to meet their biological family.

The parents themselves, even if challenged in their parental role, claim their child's belonging to their family and the primacy of their current family over the birth family. They insist on and make explicit their attachment to their child, which is even more important in the context of family distress and conflicts, they may often experience. They assert being the parents of these children. By doing so, they offer already an emotional and appeasing support to their children, as they anchor them in the here and now of their adoptive family. This result highlights, that the way in which adopted children and parents react to contact's require from the birth relatives, as well as whether they are able to integrate the past and the present in a coherent history, depend on the relationship they have built together since the beginning of adoption.

Therefore, the contact by the birth family can be in the long run an opportunity to reaffirm the mutual attachement (Pace et al., 2015, 2019) between children and parents in adoptive families and to redefine the family boundaries. A study exploring adolescents' feelings about openness in adoption revealed the difference between relationships to birthmothers and to adoptive parents: for many adolescents, the relationships to the birthmothers were more like friendships and did not replace their relation to adoptive parents (Berge et al., 2006).

The contact with birth families can represent an opening for parents and children to speak, sometimes for the first time, sometimes again, about their family construction, their relationships, and feelings of belonging. It supports an openness in communication about the adoption procedure, whose positive effects on the child's psychological outcomes are largely reported in the research (Grotevant et al., 2007, 2013; Hawkins et al., 2007; Le Mare and Audet, 2011; Siegel, 2012). These contacts with birth family members and the new informations and insights they potentially bear can sustain adoptees in the elaboration of their life narrative (Delaisi de Parseval, 2002; Golse and Moro, 2017).

Our results show that these new challenges faced by adoptive families confirm the dynamic aspect of adoptive relationships and the necessity of an ongoing process of active negotiation and involvement of those affected by adoption (Jones and Hackett, 2012).

The Issue of Boundaries

The matter of openness in adoption applies differently when the contact is initiated by the birth family itself. As stated earlier, the adoptees cannot think about the matter by themselves and with the support of their adoptive parents. They are confronted with the question of origins without having raised it themselves.

In this context, the issue of boundaries seems a central one. The notion of "boundaries" has always been important in adoption, where it refers to limitations of engagement of adoptive and birth family members (Grotevant et al., 2013). Even when the adoptive parents are in favor of openness in adoption, they face challenges in navigating between boundaries and contacts (Goldberg and Smith, 2011).

The feelings of anxiety, insecurity and even threat expressed by the parents in our clinical sample echo the findings of other studies exploring open adoption (Turkington and Taylor, 2009). Black et al. (2016) reported parental boundary concerns related to contact *via* technology, and more specifically concerns about potential intrusion by birth family members into their own private family lives.

The use of internet and social media creates new challenges in defining boundaries in adoptive family relationships (Hertlein and Blumer, 2014). The present results underline the need for specific support for the adoptive parents and adoptees, making them aware of the possibility of contacts by the birth family, preparing them for the renegotiation of boundaries, and address more generally the matter of openness in adoption.

The analyses presented here are however limited by the clinical aspect of our sample. This subject should be explored in a general population survey, using mixed—i.e., qualitative and quantitative—methods. Such a study design would allow to audio record and then transcribe the participant's narrative and not only to transcribe it *in vivo* during the clinical session. A second limitation, which is frequent in qualitative research, concerns the difference between families who volunteered in this study and those who declined. The participants in our study may have more psychological resources than other families in facing the challenges borne in contacts initiated by birth family members. Furthermore, future studies could include the third part of the adoption triad: the birth family. Their reactions to the new possibilities created by social media, as well as their related emotions, could be explored.

CONCLUSION

The results of this clinical study show the complexity of the contacts to birth family members, when they are not initiated by the adoptees themselves or their parents. Although they trigger feelings of anxiety, intrusion and guilt in both, adoptees and their parents as well as feelings of threat and insecurity specifically in adoptive parents, they bear the potential of renegotiating adoptive family relationships and positive effects on mutual feelings of filiation. The second major issue highlighted by our results, concerns the role of social media in the first contact between adoptees and birth family members. This mean of communication carries the risk of a non-prepared, invasive, and exclusively virtual aspect of the relation to the birth family.

Exploring this subject enables professionals involved in adoption to improve the conditions of these contacts, which present the risk of being experienced in a passive, if not, helpless position. Adoption professionals can prepare adoptees and their parents to the increasing possibility of these contacts through social media and to the related challenges in terms of child well-being, parent-child relation and family boundaries. They can also support adoptees and their parents in their search for appropriate online relationships with the birth family members.

This is even more important since it is not adoptees with poor relationships with adoptive parents that are most satisfied with birth family contact (Farr et al., 2014). At the same time, openness is not desired by all adoptees and some are happy with their lives without it (Berge et al., 2006). The diversity among the needs and desires of adoptive families' members support our conclusion that it isn't the contact with birth families that is at stake, but the way it takes place.

DATA AVAILABILITY STATEMENT

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by Comité d'Evaluation de l'Ethique des projets de Recherche Biomédicale (CEERB) du Groupe Hospitalo—Universitaire Nord, on the 29th of March 2011 (Institutional Review Board N° IRB00006477). Written informed consent to participate in this study was provided by the participants' legal guardian/next of kin.

AUTHOR CONTRIBUTIONS

Two trained researchers SS and AH, independently coded and interpreted the clinical transcripts. The emerging codes were repeatedly discussed with another research team member M-RM who had read the transcripts. All authors contributed to the article and approved the submitted version.

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The Impact of Breakdown in Filiation: The Instance of Children Exiled From Reunion Island to Mainland France Between 1962 and 1984

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The aim of this article was to show the consequences of breakdowns in filiation among people born between 1950 and 1970 on Reunion Island, who experienced particular traumas during their childhood. The research participants included 2,015 children exiled from Reunion Island to mainland France between 1962 and 1984 as part of a political project. Most of them we adopted, others were placed in foster families, foster homes, or farms. The forced exile was orchestrated by the French social services in charge of child protection (DDASS). Structured interviews were conducted for 13 people exiled when they were between 2 and 15 years old. The interviews were transcribed and then analysed. The results show that these children were exposed to abuse in their filiation through a series of traumas. For them, this abuse is still active today as the French government has not yet acknowledged the suffering of these children. The participants displayed numerous psychic disorders linked to their abandonment. They are still experiencing difficulties in assuming their identity, and these difficulties are transmitted to the next generation. Analysis of the impact of these filiation breakdowns leads the present researchers to suggest a specific clinical setting, based on a focus group, in other words a group therapy aiming to generate a group narrative process.

Keywords: children, Reunion Island, trauma, collective history, group

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INTRODUCTION

Between 1962 and 1984, 2015 children aged from 2 to 17 were transferred to mainland France as part of a political project (Feldman, 2018). At that time, Michel Debré was the MP for Reunion. He wanted to instate a powerful executive, as had been the case with Algeria, where he had been strongly in favour of maintaining a French colonial presence, before Algeria gained independence that same year.

In 1960s, Reunion, a French *département* since 1946, was faced with many difficulties: a demographic explosion, a serious economic situation with a lack of qualified manpower and great inequalities in income (Ascaride et al., 2004, p.49). At the same time, rural zones in mainland France were experiencing a desertification process and population migration towards urban areas. The *département* of Creuse in central France is a particular geographical case in point considered as being part of the French “empty zones”. As a result, during 1960s and 1970s, faced with the demographic explosion in Reunion and because the metropolitan rural countryside was being deserted, the government officially organised the emigration of some 75,000 Reunion islanders through the intermediary of the French bureau for the development of migrations in overseas territories.[1]

Two thousand and fifteen children were thus transferred to mainland France under the auspices of the French child protection institution and the French department of health and social affairs (DDASS). Social workers travelled up and down the island to meet families, whose situation had become vulnerable by social insecurity, inviting them to place their children first of all in care homes in Reunion. But these facilities were lacking on the island, and there was frequently pressure from the department of health and social affairs on the parents, who were often illiterate; this eventually led the parents to willingly allow their children to be sent to mainland France. These parents were given the impression that their children’s placement was only temporary and for their own good. However, the document they signed, without having been able to read it, was a seal of approval for their children’s definitive separation from them, which was made even more definitive when a decree dated October 15, 1960 (Debré) stipulated a ban on any claim: anyone claiming dysfunction was to be reprimanded, sent to prison, or excluded from French territory. From then on, these children became Wards of the French State (Ascaride et al., 2004). The communist party criticised this policy of forced migration, which also affected adults. They accused Michel Debré of “organising human trafficking” by sending Reunion workers towards mainland France (Eve, 2014, p.24).

This decision was kept silent for a long time (Cherki, 2006). However, on February 18, 2014, The French national assembly proposed a motion, calling for in-depth historical investigation of this affair, and its diffusion as they believed that the State had failed in its moral responsibility towards its wards. A commission of experts was created in February 2016 and a report with proposals for the provision of accompaniment for the former minors from Reunion was expected for 2018.[2] This commission, composed of a sociologist, a historian and a geographer, was not asked to assess the psychological repercussions of this “transplantation”. There was no psychologist. Furthermore, the information gathered in this report, most of it from archives, did not explore subjective aspects, i.e., the experience of this forced exile among those who had lived through it.

AIM OF THE RESEARCH AND METHODOLOGY

Within the framework of an ongoing study assessing the psychological repercussions of this very specific life experience, 13 interviews were conducted with people who had been transferred to mainland France between the ages of 2 and 15.[3] These interviews were made possible by the Federation for uprooted children, under the auspices of the DROM (overseas territories) and took place between 2016 and 2017. There were eight women and five men, presently aged between 47 and 67. The average age was 58 (**Table 1**). Seven interviews were conducted with people from Reunion living in Creuse, a French *département* they had never left since their arrival in the years 1965–70; three interviews were conducted in the Paris region and three others in the south of France, where these six people were residing. Among the 13 people, seven of them were aged 2–7 years when they arrived in mainland France, three were 9–11 years of age and three were 12–15. There was only one specific “family” situation; one woman, born in Reunion, arrived in mainland France when she was 2 with her mother who was then aged 17.[4] The average age of the interviewees at the time of their separation from their parents was 6 years. The average age at the time they left for France was 8 years. Thus, the period of instability for their placement – involving many separations – lasted an average of 2 years (**Tables 2, 3**). The 13 people interviewed experienced between two and seven separations, with an average of 3–4 separations.

The research methodology was based on one already used in our previous study concerning a particular population’s life experiences and outcomes, those of Jewish children hidden in France during World War II (Feldman, 2009), who had lived through collective events that necessarily had an impact on each individual’s subjectivity. The development of a clinical analysis model led us to use it in other situations so as to gain the understanding of these situations in the context of contemporary psychopathology, as experienced by these Reunion children who had been exiled or “transplanted” to mainland France.

In a first step, a qualitative analysis of the narratives enabled the detection of what became of the traces of trauma at different ages, which proved particularly visible at key moments in life (Feldman, 2019): adolescence, maternity, parenthood, retirement, old age, becoming grand-parents… These ages can be seen as milestones that are often periods of psychological upheaval, rendering the subject vulnerable, or conversely, they can be levers for potential change. In the case of the Reunion children, the same periods: adolescence, maternity and parenthood were particularly difficult milestones.

Our main hypothesis was as follows: children exiled from Reunion Island to mainland France experienced a series of traumatic events that altered the process of their development, and there are traces after 40 years. For the definition of trauma,

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[1] BUMIDOM (Bureau pour le Développement des Migrations dans les Départements d’Outre-Mer).

[2] I (first author) was auditioned on June 17, 2016 at the overseas Ministry during this commission to shed light on the potential psychological repercussions of such experiences. An expert report dated April 10 of that year evidenced the fact that this transplantation had taken place in compliance with practices and regulations operating in child protection at that time. Therefore, no evidence of child theft or abduction was found in the files.

[3] The interviews were carried out by the first author of the article.

[4] The subjects interviewed were signed the informed consent before taking part in the research.

we refer to a definition by Terr (1991) calling on Type-II trauma. This author distinguishes the effects of a single traumatic event, which she terms as Type I trauma, from the effects of a traumatic event that last over time and can be repeated (Type II). Our objective was to gather material that concerning the different problems specific to the unique situation of these children exiled to mainland France. What we have gathered are in fact life trajectories.

DATA COLLECTION METHOD

The decision was made to conduct a single interview. The mean duration of the interviews was 2.30 h. The shortest lasted 1.30 h and the longest 4.30 h. A single investigator (M. Feldman) conducted the interviews. The choice of conducting a single interview was motivated first because the study was an initial exploratory study that aiming to identify salient processes, and second in order to take account of the defense mechanisms coming into play. Indeed, at the time of this research, the expert report by the committee appointed in 2016 had not yet been issued to the Ministry for the overseas territories. It thus seemed to us more appropriate to wait for this first political step before envisaging interviews running over the long term. This ethical choice was intended to protect subjects from possible psychic decompensation in a period of ongoing uncertainty as to the political consequences of the issuing of this expert report to the French government.

Using semi-directive interviews, we asked each person to tell us about the events that they had been through. The questions were about family history and an attempt was made to go as far back as possible into the past.

We sought to identify the following: the experiences of children and parents on Reunion before their forced exile, the conditions of their separation, where they were placed, their experiences of nurseries and/or care homes and/or foster parents on the island before their departure, their journey from Reunion to mainland France, their arrival in mainland France, the conditions of their reception and placement, as well as their experiences of becoming an adult, taking account of key ages (adolescence, marriage, parenthood, becoming grand-parents and retirement), and any return to Reunion and possible reuniting with their biological families.

The interviews were conducted with the following chronology: life on Reunion, before exile: with the biological family and in foster/care homes; the journey to mainland France; life in mainland France: in care homes, with foster families and/or adoptive families; experiences at the different key age milestones; relationships with Reunion today; any reunion with their biological families; and difficulties encountered in the course of their lives.

After transcribing the interviews in full, two types of analysis were carried out: "biographical" and cross-sectional. The biographical analysis enabled and individualised narrative to be produced for each trajectory taking into consideration their fantasised reconstruction in time T of the encounter. In this analysis, we identified items that were common to all the narratives, reflecting the fact that everyone had been made vulnerable and had suffered consequences of the trauma.

The cross-sectional analysis compared each of the 13 observations item by item, according to a complementarist approach (Devereux, 1972). It also provided a psychoanalytical, historical and anthropological perspective. We conducted a fine analysis of the content of each interview, identifying themes and meta-themes that were common to the interviews overall, as provided for in the methodology of interpretative phenomenological analysis (Smith et al., 2009).

RESULTS

Across the 13 narratives, specific themes were identified in relation to traumas. These children were "exposed" to trauma many times before and after their exile to mainland France through their experiences as "transplanted" children. We were thus able to identify numerous vulnerability factors and the consequences of these traumas on their psychological development and their experiences of becoming adults.

Vulnerability Factors

They have been termed as "exposed" children (Moro, 1989).

In the mythological sense, to expose a child means to put him/her in a hostile environment, so that he/she is confronted with danger, or even death. This concept implies the idea that being exposed to an extraordinary risk can either lead the child to become extremely vulnerable, or on the contrary, to acquire exceptional potential.

The History of the Island Rendered These Children's Families Vulnerable

These children were vulnerable even before their "transplantation" because of the history of Reunion itself and that of their families.

Payet (2001, p.179) stated that the population of the island formed over 300-year period from a wide variety of ethnic groups. She explained that these people who were French citizens were from France, and also from Madagascar, Africa, India, China and the Comoros with their cultures, their beliefs and their languages, forming an "ethnic mosaic". The population on Reunion was thus forced to adapt and integrate, and by doing so, lived through a number of bereavements and renunciations, not forgetting the issues of colonisation and slavery up to 1848. Every Reunion family therefore has a complex historical past and has been affected by it. Each family has had to deal with their own particular heritage, their cultural representations and their system of kinship, and, in particular, the naming of people (how the name is written, attributed, transmitted and what its function is; *Ibid*, p.180). Ghasarian (2002) characterised the complexity of Réunion society by the presence of three driving forces: acculturation, creolisation and cultural re-invention.

Beyond this painful collective history, these children were vulnerable because of the family situation they were in. Most children came from families with considerable social insecurity.

Mothers were often single or had children from several relationships. In the interviews collected, there were often mentions of single-parent families, illness, violence and instability.

Filiation Breakdowns, Multiple Placements on Reunion Before Exile and Ill-Treatment

Filiation breakdowns correspond to the separation of children from their parents.

These children experienced a first separation, the separation from their parents, which is particularly painful. For children, separation is a source of anxiety, loss and abandonment, particularly, when the occurrence is sudden and abrupt. Furthermore, child–parent separations more broadly involve separation from familiar places and smells. Children's ability to keep a representation of a loved one alive is limited when they cannot see or talk to this person. Winnicott (1984, p.68) tells how everything seems to be all right for a few days or a few weeks, until suddenly children do not know whether their mother really exists anymore.

From this first separation, followed a series of placements and frequent ill-treatment that these children experienced in childcare institutions on Reunion.

Jean-Paul, born in 1970, was exiled at the age of 3. He reported having been abducted at 3 months old, being cared for by different nurses before a nursery fostered him until his journey to mainland France, where he was adopted. Born in 1967, Maryse was exiled when she was 4, after having been separated from her mother at the age of 2: "They came to tear us apart, yes, that's exactly it, they came to tear us apart". D. told me that she remembered the day when the social services came and remembered being traumatised because she was 10 years old "and everything happened in the midst of crying and howls, when the social services came to tear us away from the family, who never saw us again and were never given any sign of life from us. From this foster family, we were taken into a nursery in Saint-Denis. We stayed there for 2 years".

Madeleine was born in 1957. Her mother died when she was 9 months old, possibly following an accident and her father died after a "revenge attack". She and her sister, 4 years older than her, then went to live with their grandmother who died of TB. She was then placed in the Notre-Dame-des-Neiges orphanage and later placed in a religious institution. Before her departure for mainland France, she was placed with a foster mother who was "a child-abusing vixen,"… for 5 or 6 months. She was exiled at the age of 9.

Born in 1954, Gérard said that his mother had died after his younger sister was born and his father had died when he was 11. He had been raised by his grandmother then placed in foster care on Reunion before leaving for mainland France at the age of 12. Before leaving, he spent a year in a home; he remembered: "they used to set the dogs on us if we did not keep in line. There was physical abuse and everything".

Henri was born in 1953 of an unknown father. He remembered that his mother was often ill. When he was 5, Henri and his brother, who was 1 year older, were "abducted" to be placed in a nursery in Saint-Denis for 1 week. Henri was then sent to the *Plaine des Cafres* home and then to a foster mother. In 1965, his foster mother told him that is mother had just died, and the same year, the placement with his foster mother ended. He and his brother were taken into a home in Saint-Denis. He remembered that they had forced him to sleep with the pigs because he wet his bed. He said that he did not understand the staff's attitude towards him and expressed his memories of the suffering he had endured in foster care on Reunion Island.

Violette was born in 1952. She remembered playing with her brother in the street when a woman driving a Citroën 2CV stopped to give them sweets. She made them get into her car. Violette was 12 years old. Both children were taken to a foster care centre in Saint-Denis, where they were separated with no explanation. She said she was then sexually abused.

Born in 1950, Suzanne arrived in mainland France when she was 15 years old, after having been placed in different facilities on Reunion from the age of 4: nursery, children's home, religious institution and with a "child-abusing matron". Over the course of her placement history on the island and in metropolitan France, Suzanne was placed in seven different locations.

Following an often brutal first separation from their families, other separations occurred and children were often placed in foster care or in nurseries on Reunion before they left for mainland France, where they experienced further separations until, for the youngest children, they were finally adopted.

These separations are the very roots of the subjects' internal discontinuity, with a loss of the feeling of their permanent existence, vital for their development (Winnicott, 1987), because it forms the basis of structural stability that enabling children to build their internal world and acquire an identity (Houzel, 2016). Instability generates anxiety, which overwhelms the child. Therefore, any internal or external changes that children undergo lead them to perceive a distressing incoherence in their internal unity. Some children are subjected to chaotic, even disastrous experiences, and they have to grow up with them. These experiences can lead to the risk of depression, depersonalisation and attachment disorders in the long term. Furthermore, the age when separations occur is a particularly important aspect to be considered, since the impact of any breakdown depends on the developmental stage reached by the child. The younger is the child the greater is the child's dependence on the contributions of external reality. The absence of a healthy primary object-relation, the absence of language and of the ability for symbolisation can potentially undermine the constitution of a secure attachment.

A Policy of Deception

Vulnerability was compounded by deception, which played an active role in this policy of "transplantation": the promise made to the parents that their children would return and would be able to study in mainland France, a promise that was not kept. The children were also told lies: before leaving Reunion, they were shown beautiful pictures of France and they were promised "skiing holidays" and "Christmas celebrations". When they arrived in mainland France, the French institutional representatives often told them that they were orphans or that they had been abandoned.

Marie-Claire, born in 1958, who was transferred to mainland France when she was 9 and half years old, remembered: "So, I found myself on that plane, completely lost, with children crying around me".

Jean-Roger remembered being very scared in the plane and screaming. Marie-Claire continued: "You're an orphan, you do not have your parents any more, you do not have a family any more, no brothers, no sisters: I was told I was an orphan… She told me: "you are an orphan with no father, no mother," that is how I got to know it: "you are an orphan with no father, no mother, you do not have any parents, you do not have any brothers or sisters".

Jean-Paul told how his adoptive parents always told him that he was from Reunion. The only information they were given was that his mother had abandoned him because she was very young and very poor.

Breakdown in Affiliation Links

Upon arrival in mainland France, separation from their island and their cultural system was materialised by the geographical distance and also by the ban on their Creole language.

Marie-Françoise, who was born in 1960 and taken to mainland France when she was 3, reported that she had been beaten for speaking Creole: "But I did not know I was speaking Creole, I actually had to be told by a woman from Reunion that I spoke Creole".

When Jean-Roger arrived at the age of 7, his adoptive parents taught him how to forget Creole and speak French by "slapping [him] round the face".

Jean-Paul was exiled when he was 3 years old and said he had no memory of anything before 6 years of age, which is when he started to speak. Between the ages of 3 and 6, he had become mute. He remembered having received numerous speech therapy sessions and having faced difficulties at school.

In addition, the Church took an active part in these separations from their origins. Indeed, these Reunion children were either *yabs*, *malbars*, *cafres*, *zarabs* or Chinese.[5] When they arrived in France, they were christened, and thus converted to Catholicism.

Marie-Françoise, who was transferred to Creuse when she was 3 years old and adopted 3 years later, is now called as Claude: "there was [my name on] a plaque that was fixed to the wall above my bed, because in those days, there were plaques with saints on them, it was the way with saints. They were given for birthdays and we had to go to Sunday school".

Marie-Claire said: "Mass every Sunday, Sunday school with pervert priests". She added: "and there are people I have met up with again from St. Clar who have told me exactly the same things".

Humiliation, Ill-Treatment and Sexual Abuse

Humiliation, ill-treatment and sexual abuse before and after their journey were for most of the respondents among the traumatic effects of exile. Besides ill-treatment endured in children's homes and with foster mothers on Reunion, mainland institutions perpetuated the ill-treatment: for some boys, like Henri, they were used as farm boys and the eight women included in the study all endured abuse.

Upon arrival in the Guéret children's home in Creuse, some described their reception as depersonalised, almost as de-subjectivised: "we were put in a room naked, with just our pants on, I could see a big steam machine and they disinfected us with it". "There were so many children that they had to put mattresses in the corridors".

When Valérie was 3 years old, she was sent to mainland France with her siblings. She had no memory of her life on Reunion, she could only remember one thing: "I can see myself, I can see us on that plane, with a whole load of other children and I remember feeling completely lost". When she got to the children's home in Guéret, she remembered sleeping on a mattress on the floor in the corridor. Other fleeting memories came back to her and were linked to a hospital stay when she was treated for problems of undernourishment: "I can see myself hanging onto the nurses' skirts". When she came out of hospital, she was separated from her siblings and placed in a foster family for 4 years, during which time she was subjected to abuse: "The only place I felt safe was under the Table. I used to spend a lot of time under the table. The father of the family used to beat me". She was frightened. Occasionally "a white couple" used to come and visit her and would bring her dolls and presents. She remembered that the foster family's daughter used to systematically throw her dolls and her toys down a well.

Marie-Françoise also experienced abuse in her foster family: "I'd say 3×2=8, but I really did not deserve to be slapped for that," or again "when I grew older, I had friends, and when I saw how they were being treated, I thought: there's a problem here, because when my friend does something wrong, she does not get a slap from her mum, she gets reprimanded, whereas when I answer 8 instead of 12 or break a glass, I find myself with… I get punished on top of that, which is all the better on dark skin because you cannot see the bruises".

Henri arrived in Guéret in October 1966, after having transited through Paris, where "they were sorting all the kids". After 3 weeks at the Guéret children's home, "on November 22, I was placed with well-to-do farmers on a farm…" where he was treated, he claimed, as "a slave". He used to sleep on heaps of grain in the barn; he would wash with a basin and a bucket outside the house, "in summer as in winter". "I was

TABLE 1 | Participants' dates of birth.

1950	1	1958	1
1952	1	1960	2
1953	1	1963	2
1954	2	1967	1
1957	1	1970	1

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[5] *Yabs* are descendants from Bretons, *Malbars* are Hindus or Tamils of Indian origin, *Cafres* are black of African origin, descended from slaves and Zarabs are Muslims of Indian or Pakistani origin. The French from mainland France are called as Zoreilles.

TABLE 2 | Age at 1st separation.

3 months	1	7 years old	1
2 years old	2	9 years old	2
3 years old	1	10 years old	2
4 years old	3	13 years old	1

TABLE 3 | Age at the time of their exile to mainland France.

2 years old	1	9 years old	2
3 years old	2	11 years old	1
4 years old	1	12 years old	1
6 years old	1	13 years old	1
7 years old	2	15 years old	1

working 7 days a week, from six in the morning to ten at night, with no rest or anything. Those people were paid to exploit us (…) I was beaten every day". Despite his plea, he was not allowed to continue his schooling.

Marie-Claire, after having resisted adoption three times, stayed in the children's home where she had been placed after her arrival: "I was employed for 10 years. The first 2 years, they used me as a cleaner. Then, I stayed 13 years as a monitor. And, the following years I ended up replacing all the monitors who went on leave for specialised training. In fact I was pushed around as a stop-gap".

Maryse arrived in her foster family in Brittany when she 4 years old. The first memory she had was this: "I remember I used to wet my bed. To make me understand that I had to stop, she, my mother, put my knickers on my head and made me walk round the block of houses. Well, I did stop wetting my bed after that". (…) Reminiscing about her foster mother: "I remember a very violent woman, whether in actions or words, she used to say things like "be grateful we pulled you out of that shit" (…) In my mother's eyes, I was worthless, and whatever happened, I would end up on the street".

Madeleine recounted her "ordeal" when she arrived with her sister at a childless adoptive couple's home: "The ordeal started because this man, every night at 3 o'clock in the morning… it was a house where there was a wooden staircase, so we could hear the stairs creak. We used to sleep in the dining room because we did not have a bedroom. We only had a single bed so we used to sleep next to each other. So every night, he would come down and interfere with my sister and would end up slapping her. He would use words, of course… of a sexual nature. As for me, I was afraid, I could not breathe. From then on, I thought to myself: You have to play dead so that he cannot hear you. I started being unable to sleep, the same for my sister. It felt as if I was being raped myself as I was just next to her".

Questions about their origins were always present and re-activated by the mockery and discrimination endured, particularly because of these children's skin colour, different from the other children: "They used to call me chocolate, little *darkie*" one person reported. "A bus from the village used to pick us up in front of St. Clar, and we were considered as "social cases," mental cases (…). I could not stand being insulted like that (…) In 1969, when you came to a small village, there were no coloured people".

At school, near Guéret, as Valérie was the only child with dark skin, she endured discrimination. They used to say to her "Snow-White, you dirty *nigger*, did you wash this morning?" In secondary school, one pupil wrote a song about her: "the little *nigger*'s peed in the water…". Discriminations were such that she refused to eat at the canteen for 4 years.

Chaotic Adolescence

During adolescence, life becomes particularly difficult. It is a period of psychological upheaval; it is also a time during which ontological issues arise: Whom do I resemble? What do I belong to? Who do I want to become? (Mansouri, 2013). There are questions about the meaning of belonging. This period can be very painful. It is a time when the Oedipus complex is reactivated and when adolescent subjects are supposed to de-idealise parental images introjected during childhood, and at the same time, they are faced with the issues of the family heritage (*ibid*, 2013). For these children, for the younger ones in particular, this can correspond to a dislocation of introjected parental images. They thus grow up with these rifts, these discontinuities, these gaps that they have to fill almost impulsively to acquire a semblance of security, which is essential to survive and which necessarily comes with pathological defences.

Marie-Claire: "Whenever I had my period, I did not know what was wrong with me, why was I bleeding?" (…) "Every Christmas, we would be alone in bars. Where was everyone? Well, they were all at home with their families of course, celebrating. And we felt lost. At that moment, I realised that something was wrong… in my life, because I had an abortion, in fact I had more than that".

Marie-Françoise remembered that adolescent period: "I was in secondary school. Oddly enough, I was placed because I was one of the turbulent children"… "I used to do sports, athletics, competitions. They stopped me doing all this". That period also corresponded to the divorce of her adoptive parents. "I was 16 and I fell in love… he became my stepfather".

During that time, Jean-Roger experienced many years of drifting and instability both geographical and professional…

The Complexity of Reaching Parenthood

These difficulties in becoming a parent are linked to the separations, to a fluctuation or an absence of a parental model, to the instability of their relationship with the primary object, and these difficulties are reactivated by their new parental status. The eight women in the study all experienced domestic violence and separated from their partners.

Maryse raised her child with a violent man for 4 years. She then met another man who left when she was pregnant, and she then had two children with a third man whom she married twice, as she divorced from him once during that time.

"Violence is perpetuated," admitted Marie-Françoise. For Maryse and Marie-Claire, domestic violence followed on from their adoptive mother's violence or from their adoptive father's sexual abuse. For one, her partner was violent. For the other woman, violence was rife towards her children, who were later placed in childcare.

Violette was married to the first man she met when she was 22 years old. Her husband was an alcoholic and a violent man. She managed to get a divorce after she had had three children with him. These children have their own children today. The relationships with each one of them are very difficult, almost non-existent. She does not understand. Suzanne acknowledged the fact that her history made parenting difficult: "I did not know how to love my child… My daughter said: "mum, you never gave me any cuddles," I said: "it would have been easier if I had had cuddles myself". I said: "I never had a mum who gave me cuddles, it would have been easier had I received maternal love to be able to give it to my children". I did not know. This is why it's so hard. I was never brought up in that way, I was brought up in a violent environment".

Henri was sad to relate the difficulties he had with his sons: "With my elder boy, it's not great. We cannot talk that much because there's a problem of alcohol. He drinks a lot. With my second son, it's the same, he drinks, he takes drugs and he is violent, so I do not see him any more either. I keep saying: "I brought children into the world and this is where we are now".

Painful Homecoming With Reunion

Many years later, forging ties again with Reunion became necessary, but this homecoming reopened painful wounds on either side.

Marie-Claire discovered her own history when she was 30 years old: "I could see that I had a mother, that I was not an orphan with no father and mother. Because my mother had signed… this document so that I could come to France… to study. Which means that St. Clar knew I wasn't an orphan. I could become an orphan in a flash, because my mother signed the document. But my father did not want me to go. There was a thumbprint… I mean, he had written: I do not want my daughter to leave. So why was there a thumbprint? It was at the Saint-Denis prefecture. My cousin had arranged for me to get in touch with my mother. Feeling guilty, it took my mother a year and a half to respond. She was ashamed. So it was I who decided to meet her in 1987 (…). It was difficult for me to see my mother. In fact, I did not want to. I thought: "what am I going to say to her? It's going to be really, really hard (…). She told me what had happened when I went to see her in 1987. She said: "you know, I found you. The Social Services came to see me, they made me sign a paper so that you would go to *Plaine des Cafres*, so that it would give me time to get better and for you to get an education, and I would be able to come and get you a year later". She continued her narrative, stating that her mother had wanted to get her daughter back after 1 year but that she was no longer there.

When Valérie was about 30 years old, she learned of one of her brother's suicide; he was 32 years old. It was like a "trigger" for her, as it prompted her to go back to Reunion. Her adoptive mother was not very keen, but in 1992, she decided to go with her brother and one of her sisters. When she arrived on the island, she said she was in "total denial," she felt guilty and tormented by a conflict of loyalty towards her adoptive parents. Her first reaction was: "When I see the poverty in the family that claims to be my family, I say to myself "how lucky I've been to live in mainland France". She returned to mainland France and claimed to be a pure native from Creuse. Valérie then lived through a period of great instability. She said she moved house around 15 times. When she was 43 years old, Valérie returned to Reunion on paid leave, as usually granted to French overseas civil servants working in mainland France. When she returned, she asked her civil service department to be transferred to Reunion, which was granted. So she lived on the island for 9 years, particularly devoting her time to in-depth research on her family roots. But on Reunion, her history was seen as taboo. Her family refused to speak. A friend of her biological parents refused to talk to her. One of her cousins also kept silent, claiming: "the truth should be spoken once people are dead". One day, she met a *gramoune*[6], who started to cry upon seeing her: "you look so much like your mother!" But she refused to tell her anything. With a lot of determination, Valérie started to uncover fragments of histories, particularly about her mother who had apparently committed suicide at 28 because she had yet again become pregnant. Today, Valérie continues to search for information, but tongues remain tied. She has now returned to mainland France and has been retired for 2 years. She is involved in movements for the recognition of suffering among the ex-minors transferred from Reunion to mainland France, and in 2017 she was still hoping to go back to Reunion to continue her search. Her hypothesis was that she probably was a stolen baby. Her identity was erased: "on the civil act, I was born in Creuse, I have two names, two first names, two baptisms, two birth places". In her file, there was no document proving any abandonment.

Maryse went to Reunion for the first time in 1988, where she met her uncles, aunts, brothers and sisters. It was only in 2014 that she realised she had been adopted during the time Michel Debré was implementing his policy, and that she was not the only child involved. The family had never told her anything. She collapsed completely. Today, she continues to learn more and more about her childhood past.

Jean-Paul stayed on Reunion on a number of occasions; however, it was only in 2017 that he learned that he had been abducted from his mother when he was 3 months old, because he was shown a document, which had been drawn up by the social services in which maternal abandonment was mentioned, but without any trace of her signature.

The experience is therefore painful and the psychological repercussions are great at individual and inter-subjective levels. While most of the children did not set roots in mainland France, they did not grow roots in Reunion either, 40 years on. Quite the reverse, the early experiences of abandonment seemed to be reactivated.

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[6] Elderly person in Creole.

Consequences of Trauma

Specific Symptoms Among Children Exiled From Reunion

The people who were interviewed all shared a deep feeling of abandonment, throughout the many separations: from their parents, from the care home/nursery, from the foster home in mainland France, from their adoptive families, etc. A pathology of bonds is at the heart of their suffering. These "exposed" children became children who were "major relational burn victims" (Lamour and Barraco de Pinto, 2013, p.119).[7]

Their symptomatology covered a large spectrum: affective and/or professional instability, emotional lability, nightmares, fear of the dark, fear of being in a closed room, hyperactivity, addictive disorders and repeated suicide attempts, which, for most of them, started during adolescence and were often followed by psychiatric care with feelings of never knowing, where they were supposed to be: "I was never where I should be," "where should I be?" in the words of Marie-Françoise. There were feelings of anxiety, feelings of being nowhere, depressive episodes, somatic disorders such as ulcerative colitis and psoriasis. "I've always had the feeling of being alone," said Maryse.

Today, Valérie continues to have nightmares: she is being "chased," she has to "hide," she falls "into a hole," "no matter how much she tries to hide," she "continues to be chased". She is always afraid of closed rooms. She said that she had attempted suicide on two occasions. Valérie was followed by a psychiatrist and had treatment. She went through periods of depression. Because of the abuse she endured and because of serious health problems, she was considered as a disabled worker. Suzanne fights every day to live: "I take pills to sleep, I take pills to get up, I take pills to get through the day" (…). When talking about the children's experience of their exile from Reunion to mainland France she stated: "Even if we are alive, we have been killed in our souls".

For some years, after every return to mainland France from a stay on the island of Reunion, every time they return from a general assembly of the ex-minors from Reunion, many of them experienced a state of acute vulnerability: depression, suicide attempts, instability. Great vulnerability is experienced on the occasion of every process of separation, requiring psychological readjustment: adolescence, maternity, separation from a partner, their own child's adolescence, return to Reunion, return to mainland France…

Marie-Françoise remembered: "I stayed in Reunion for 5 months. I came back to France… I had a breakdown… I was hospitalised in a psychiatric ward (…) Every time I come back from Reunion, every time I feel lost. They give me treatment, and every time they are antidepressants, Xanax, Stillnox and so on".

Marie-Claire had ulcerative colitis when she was 20 years old, at the time she was leaving St. Clar. She had regular bouts of depression, especially after she had read through her file that had been sent from Saint-Denis, and after a film had been made of her story, in which she had taken part. In August 2015, she said she had been prescribed antidepressants, which she had taken for 4 days, after which time she had stopped them because she felt like "a zombie".

It is well-known that filiation takes shape *via* bonds and continuity and also by separations and discontinuities (Konicheckis, 2001). The quality of the fantastical and psychic development can make this discontinuity bearable and acceptable, or on the contrary, it can be traumatic and contribute to loosening the bonds. However, when a psychological breakdown occurs, as is the case with these children, and when their development and bonding process is hampered, discontinuity creates havoc. Every separation is thus experienced as an aftermath, which can sometimes lead to psychiatric decompensation.

Being removed from the cultural (Feldman, 2016), familial and geographical envelope, to which is often added physical and psychological violence, raises the issue of the legitimacy of existence, which is never resolved.

These observations are also reported among the formerly displaced children for reasons relating to public policies: Inuit children having undergone acculturation and forcibly placed in Christian children's homes (Mishara and Tousignant, 2004), half-cast children from Ruanda-Urundi removed to Belgium (Heynssens, 2012; Hennes, 2014), children stolen under Franco's regime (Vinyes et al., 2012) or again thousands of young Eurasian girls removed from Indochina to France between 1940 and 1970 for purposes of cultural assimilation *via* FOEFI (Fédération de l'Oeuvre de l'Enfance Française en Indochine). The mothers were obliged to sign a "*certificat de décharge*", which drastically reduced their rights towards the children, and siblings were systematically separated (Denéchère, 2020). These trauma and the post-colonial policies faced by these children had devastating effects on their subjective construction.

Intra- and Inter-Generational Family Disorders

When there are reunions with biological parents, they can be particularly difficult, even painful. After 40 years of silence, absence and lies, reunions are extremely difficult, sometimes impossible, with a persistence of the unsaid. From the point of view of these children who have become adults, how could they face finding their parents or other members of their families after believing they were orphans all these years? And, for some, the belief that they had been abandoned by their parents.

As for the parents, these reunions lead to a reactivation of past pain. If they are still alive, they have grown old and adapted their lives to this absence. The mourning for the loss of their motherhood (Racamier et al., 1961) and their parenthood is therefore destabilised, or even undermined. Wounds from the past are reopened. The return of their lost and often forgotten children is therefore painful to accept. These children have become strangers in the eyes of their biological parents and are often perceived as revenants. It is a real shockwave on either side of the family, which is made even greater because these reunions are unprepared. Even if some ex-Reunion children took the initiative to return to the island, often with considerable

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[7] A phrase taken from Lamour and Barraco de Pinto (2013).

apprehension, their parents on Reunion did not share the same time-line. For some, the surprise of this return is a bolt out of the blue.

Some children wish to settle down on Reunion. But their return triggers an aftermath effect on the history of the Reunion people. How can they integrate these returning migrants? How can these migrants adapt? This is all more true because they have been de-named, renamed and have been subjected to an acculturation.

Relationships with adoptive parents often remain difficult, especially when they played a part in the separation, chose to remain silent and ultimately did not do the right thing.

Difficulties with these children's own children are of prime importance. Their history is not elaborated. Past experience is manifested in the expression of non-metabolised, raw objects, and their children have become empty vessels of the parental history rather than inheritors (Feldman et al., 2016), and this is all the more true because the State has never acknowledged these events. Therefore, the encystment of the parental past is handed down to the descendants without any processing. Among the descendants, a certain form of drift or instability in affiliation can be identified for some, for whom the parents tried to be parents despite everything, while for others dysfunctional parenthood was such that they were taken into childcare. History repeats itself.

Regarding her daughter, Marie-Françoise said "I'm hoping for an event that will make us grow closer to each other". A crisis of transmission is experienced by both generations.

Only Jean-Paul, adopted by a kind and loving couple, appeared not to have experienced these difficulties with his children, he even involved them in the search for his filiation.

DISCUSSION

After Enduring an Accumulation of Traumas, These Children Became Adults Deprived of Their Inheritance and Whose Identity Had Ceased to Exist

The events endured since leaving Reunion and up to the present day have produced an accumulation of traumas, defined by Khan as the accumulation of repeated failures of the maternal object in its role as "a protective barrier of the auxiliary self" (Khan, 1976, p.74). They have an impact on the children's development and on their becoming adults (Feldman, 2013).

While the interviews collected are not representative of all the "Creuse children," the adults encountered seemed bound to reproduce the painful sequences of their childhood experiences and exposure to an accumulation of trauma. The Freudian concept of compulsion to repeat (1920) describes the way in which the traumatised subject, in an aftermath effect that is almost a compulsion, attempts to gain control over the disorganising effects of the trauma, and paradoxically to re-experience them as a result of an attraction towards the intensity of perceptions specific to the initial traumatic episodes (Freud, 1920/2001).

Beyond the notion of disaffiliation induced by childcare placement, it is the very notion of filiation that is being damaged, operating *via* a process of de-subjectivation leading to a suspension of identity. This damaged filiation is the result of the effects of de-filiation and disaffiliation and of a historical policy of de-subjectivation.

The Effects of De-filiation and Disaffiliation

These children endured de-filiation from their biological family and disaffiliation by separation from their island and their Creole cultural system. For children's secure psychic development, issues of filiation and affiliation are central. Indeed, a child's birth occurs within a particular genealogy, history and geography. As a child of a father and a mother, the child necessarily relates to their filiation: paternal, maternal parentage, family, and groups of people beyond to whom they belong; hence, the importance of filiation, which is a pre-existing base for any human being even before birth. The notion of filiation is used here in the way that Michael Housemman defined it, as quoted by Jean Guyotat (1995), in an anthropological perspective. According to him, filiation is governed by a genealogical principle whereby there is a notion of belonging to a certain community, comprising people who are said to have a common ancestor (p.8). Jean Guyotat (*ibid*) distinguished three aspects that were inherent in these filiation ties. The first aspect relates to established, official filiation, with the transmission of a name in the setting of relations with others, as defined by social forms. This mode of filiation takes discontinuity into account in the order of generations. Guyotat then describes a metaphorical and metonymical filiation. Between the body of the father, who gives his name, and the body of the child who receives it, a transfer of meaning occurs, a metaphor, whereas the body of the mother, which contains the body of the child, relates to close body-contact metonymic filiation, a blood bond or a bond of continuity. Finally, narcissistic filiation concerns the process of filiation. This bond is found within the notion of the filiation group, which supposes a reiteration of this bond from generation to generation, starting from prestigious ancestors (p.38). Given that each subject is assigned a place and a mission in the group they belong to (family and social group), filiation subjects them to the generational chain.

The term affiliation is borrowed from anthropology: it describes a belonging to a group (Levi-Strauss, 1973, p.132), whether it is cultural, social, ethnic, religious, etc. Filiation and affiliation together weave the individual into the continuity of generations.

Filiation is also defined by the name, which gives a legitimacy of existence since it has an origin, a function and a meaning. A name provides a sense of continuity in the existence of an individual who is inevitably caught up in the experiences of discontinuity and separation. It is a link inside the psyche, which defines the narcissistic function of paternity, whereby the continuity of the species and of individuals is preserved. Therefore, to change that name is to intentionally change the child's destiny.

Finally, affiliation links subjects to social issues in the terms of a narcissistic contract, in the sense that this contract has to be narcissistically invested by contracting parties, subject and group (Castoriadis-Aulagnier, 1975). In the absence of a narcissistic investment, the child is in limbo. The violence he is subjected to is to be found at the point, where he is forced to renounce everything that constituted his former identity.

Exposure to these many geographical filiation and affiliation breakdowns proved destructive for the children from Reunion, and jeopardised their genealogical foundations (Ayoun and Tabone, 1994, p.28).

These children were thus subjected to a metamorphosis of their identities, which was difficult or impossible to accept. Furthermore, this disaffiliation led to a primary narcissistic fault, which sooner or later freezes the subject in his psychic functioning or draws him towards a collapse of identity (Allouch, 2001, p.38) that analytic therapy may not be able to defuse.

This breakdown was also accentuated by the lies told to both parents and children. Lies are the most devastating for children because they grow up believing they are protected by adults. As a relational mode, lies lead children to lose trust in adults, and to a loss of "life theories" (Bailly, 2007) – these "theories" (p.241) that refer to a sub-group of the symbolic field. That is to say, during the first years of life, children work on the elaboration of their personal development and form hypotheses on their origins, on gender differences, on kinship, parental roles, etc. Traumas will then occur and relentlessly overturn the theories that children build throughout their development. Their historical perspective is thus called into question.

Damage to filiation can also be found here in the zeal of social workers and decision-makers in childcare social services in working to implement a politically-driven operation. According to Jablonka (2006, p.227), child protection systems were in this instance hijacked by the State to impose a new culture on these children.

Finally, Ascaride et al. (2004) reported on the attitude of the Guéret foster home director, who at the time, seeing the children's distress, wanted to take them back to Reunion during the holidays. He told how he had written a letter to Michel Debré, who had refused categorically. He himself was from Reunion and had introduced Creole culture in the care home: Creole meals, Sega music… This director was later dismissed.

The Effects of a Lasting Policy of De-subjectivation

This damage to filiation echoes that endured by their ancestors. The intention was to protect these children and to serve a political project, but they were subjected to damage to their filiation (Feldman, 2018), where it is easy to perceive the fallout from their colonised ascendants' history, people who were slaves over a 200-year period: these people had to obey their masters, had to bear the name of their owners (Payet, 2001) and had to be practicing Catholics, the only authorised religion (an article of the *Code Noir* or "black code"). The children from Reunion who were transferred to mainland France, disaffiliated, adopted, also had to bear the name of their "new parents," be baptised and go to catechism in a specific context. Many were exposed to violence. The inheritance of the alienating and denied violence in their collective history plays a role in their present-day individual histories. This could be linked to what Malika Mansouri (2013, p.165) recalled for Fanon, when in 1952 he took up a stance against the Algiers culturalist school saying that the alienation of the colonised people contributed to the deleterious individual psychological consequences of a situation of domination (Fanon, 1952). Traumatic markers of historical, familial and institutional violence were found among all the children, as was the impact on subjectivity.

Healing Aftermath Traumas *Via* Group Work

Issues of transmission, secrets, separations, conflicts, or mixed race brought on by colonisation and slavery are at the heart of the history of the Reunion people. The "transplantation" of these children and adolescents thus operates as an aftermath effect of this particularly chaotic history. Stories of multiple traumas experienced over many generations were heard from every subject interviewed. Because they are not transformed by the psyche, these raw traumas become potent as "subconscious residues" that accumulate and run through generations. They are non-elaborated raw elements that are brought to light by blanks, gaps or events that appear incomprehensible, or nonsensical, in the light of the subject's history. By way of a "narcissistic contract" (Aulagnier, 1975), this process prevents descendants from cutting ties with their ancestors and enables a transformation of the potential encystments of the past. This concerns both the parents, who lived in poverty and who were robbed of their parenthood, and the grand-parents, or even the great grand-parents, whose suffering caused by colonisation and slavery has never been recognised by France.

Our method consisted in elaborating a reflection from the histories of the people we met, to be as close as possible to them, without trying to interpret their words from a set perspective. We tried to show that the idea was not to label them the way clinicians may do from a traditional nosographic perspective. Nor was it to say that they had a neurotic or psychotic structure. They are not psychiatric cases, which would make them pathological cases, according to a generalizing nosography. Diagnoses tend to freeze people, lock them in, and they do not allow them to evolve. Through an analysis of their very particular life trajectories, we have tried to show the impact of historical events on their development processes and how they have suffered specific traumas. The people we met were affected by post-traumatic symptoms. We took an interest in their individual histories, because which are part of their collective history, by taking into account historical, political and sociological aspects.

To be able to care for of these former Reunion children, clinicians therefore need to consider each history as part of a trans-generational, historical and familial collective narrative (Feldman, 2009; Mansouri, 2013; Feldman & al. 2016; Feldman and Mansouri, 2018). The group setting, i.e., talking or focus group, seems important to implement. Indeed, it enables the collective part to emerge from each participant's intimacy. The idea would be to devise a multi-focal group led by two psychologists, to enable the diffraction of transfer and to enable clinicians to benefit from support when faced with the massive nature of the trauma experienced, and of the inherited trauma.

This group could integrate different disciplines (psychology, anthropology, history and sociology) and could use its group format for its containing functions, a focus of psychology for many years, especially in the setting of trauma. The group favours the restoration of subjectivity and elaboration, in particular because collective suffering compromises affiliations. Thus a plural presence can put things into historical perspective, leading on to a process of shared remembrance (Kaës, 2012, p.247). In addition, it can facilitate care that is better adapted to the cultural representations of the individual, envisaged in constant interaction with his or her birth affiliation.

Furthermore, with a transcultural approach (Berry, 1990) it will be possible to identify the processes involved in continuities and changes in play in the acculturation processes undergone.

In order for the collective to emerge in its relation with the intimate, everyone involved, including the psychologists, should introduce themselves with their affiliations, linked to their own collective past, so that a certain formerly repressed subjectivity can emerge within this articulation between the collective and the individual. The analysis of cultural counter-transference (Devereux, 1967; Rouchon et al., 2009) on the part of psychologists will help understand the elements emerging from the group.

Finally, a therapeutic approach could consist in the de-construction of numerous systems: the colonial system, the slave system, and also institutional systems, particularly child protection facilities, which operated for a long time on strong assumptions such as the supposed benefits of parent–child separations, the secrecy around origins, indenture at 13 years of age and the development of a dependence bond between individuals and institutions (Feldman and Hazan, 2017).

CONCLUSION

This initial study presents imitations, mainly for the lack of depth of the investigation, requiring further investigation in the future. Indeed, a single interview is not enough to identify the psychic processes at play. This exploratory research has nevertheless enabled the particular itineraries of a complex, collective history of assimilation to be identified. This entailed eradication from the cultural, linguistic and historical setting before arrival in mainland France, leading to devastating effects on subjectivity and the family dynamic.

These 2,015 Reunion children, and their own children, with their unique destiny call for clinical reflection to integrate all the elements of the current complexity mingling with the complexity of the past. Therefore, it is today clinically urgent to work towards the implementation of this group narration process, particularly as these narratives do not only concern those who lived through them but also their descendants. When raw elements are not transformed, the risk of their unprocessed transmission is significant, because the historical trauma persists, relentlessly trying to leave a trace. This trauma is organised in encrypted mode (Abraham and Torok, 1978), which alienates all freedom. The next generation therefore carries a "ghost" that haunts their memory and relentlessly undermines the familial psyche.

DATA AVAILABILITY STATEMENT

The original contributions presented in the study are included in the article/supplementary material, and further inquiries can be directed to the corresponding author.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by the Ethics Committee of the UFR SPSE (Psychological Science and Education Science Formation and Research Unit) of University Paris Nanterre. The participants provided written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

MF is a researcher. MM helped the methodology. All authors contributed to the article and approved the submitted version.

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Social Support of Organ Donor Families in China: A Quantitative and Qualitative Study

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Background: Donor families experienced a difficult time during and after the process of organ donation. There is a necessity to understand the support they received and what they need to help them get through a painful time. This study aimed to investigate the social support level and social support needs of the donor families in China.

Methods: A cross-sectional study was conducted among 102 donor families using a questionnaire to investigate their demographics and social support level. To further understand their social support needs, in-depth interviews were conducted among 9 donor families.

Results: Findings of the study showed that (1) Most of the family members (74, 72.6%) lacked social support, and only a small number of families (28, 27.5%) received sufficient social support (2). The coping style had an impact on the overall social support level ($P = 0.014$) (3). There was a lack of emotional support, information support and material support toward the donor's family members. Both emotional support and material support are significantly needed.

Conclusions: The overall social support level remained insufficient and the utilization degree of social support was low. Organ donor families are in desperate need of material and emotional support. The level of social support is largely influenced by the donor familie's coping style. Compared with a negative coping style, donor families who adopted a positive coping style acquire more social support.

Keywords: organ donation, donor families, social support, social support needs, coping styles

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INTRODUCTION

Organ donor shortage has become a crisis due to the significant mismatch between the increasing demand for transplantation and the limited availability of donors in the world. According to statistics, 17 patients in the USA died every day while waiting for donor organs (1). The demand for donor organs in China has been increasing by 12% each year (2). Since January 1, 2015, China has stopped the use of organs of death row prisoners for transplantation, voluntary organ donation after the death of the citizens has become the only channel for organ transplantation (3). China has become the second-largest country of organ transplantation with the number of organ transplantation hospitals amount to 170 all over the country (4). According to the Human Organ Donation Management Center of China, there were a total of 36,432 organ donation cases, and 10,8610 large organs of various types have been donated as of December 2021, ranking top in the number of organ donations worldwide (5). A voluntary organ donation is an altruistic act of love. Organ donors are expected to be respected in every country and be cared for. However, relatives of organ donors are the ones who are most likely to experience psychological disorders and stress during the process of organ donation (6, 7). Donor families experienced extreme emotions, psychological dynamics, and anticipatory grief (8, 9). A study showed that even after organ donation, donor families would still suffer bereavement, post-traumatic stress disorder, and depression (10).

Social support is regarded as a moderator of life stress (11). No guideline has clearly defined social support, but it is generally considered as services, care, or encouragement provided by the members of social networks (usually spouses, partners, family and friends) (12). Previous social support studies focused on specific diseases, such as diabetes, depression, AIDS, cancer and specific groups. Deshira D. Wallace highlighted the need to assess and leverage distinct types and sources of social support at different stages of the diabetes experience (13). Significant associations were found between diabetes type and social network, social support and health behavior (14). Besides, both diabetes-related medical symptoms and social support independently contributed to depression (15), depression also contributed to lower social support (16). Studies showed HIV risk behaviors increase with mental health needs and decrease with the level of social support (17). People who live with HIV/AIDS prefer to seek social support online (18). Social support is significantly needed among people who suffered from cancer (19–22). Besides, elderly people's quality of life was also influenced by social support (23, 24). Previous studies declared that increased social support should be given to pregnant women (25–27) and LGBT youth (28–30). However, little attention was paid to the social support of the organ donor's families. Relevant research revealed that the family members of organ donors lacked social and emotional support during the decision-making process (31). Moreover, adequate social support can avoid family conflict toward living kidney donor transplantation (32).

Currently, the lack of social support represents contraindication for organ transplantation and organ donation (33, 34). The number of organ donors has become short mainly due to the traditional cultural factors and limited relevant incentive policies in China. Confucian filial piety demands that the body should be kept intact and respected. Although cremation is carried out in many places of China, people prefer that the body remain intact (35). Therefore, the degree of social support received by donor families is relatively low in China. However, most of the organ donors and their families belong to socially vulnerable groups, among which there are some orphans and some families who lost their only child. Zhao Baige, the executive vice president of the Red Cross Society of China, said that more than 90% of the families were involved in the problem of applying for assistance in difficult times (36). Understanding the social support of donor families can enable coordinators to help families alleviate psychological distress (8). Identifying the specific support needs of family members is critical in helping them to cope with this situation (37).

Therefore, We attempted to explore the social support level and social support needs of the donor families. Taking Hunan Province as an example, this paper conducted a cross-sectional survey on the social support of organ donor families with quantitative and qualitative research methods. This study was helpful to provide a reference for the government departments in formulating relevant policies and targeting intervention measures.

METHODS

Research Participants

Based on the principle of voluntary consent and convenient sampling method, a questionnaire and qualitative survey were conducted on the immediate family members of organ donors, including but not limited to spouses, parents, grandparents and children. The study was carried out in the Hunan Province from April to August 2017. The inclusion criteria were as follows: ① direct family members of organ donors; ② good communication and reading ability; and ③ voluntary participation.

Research Tool

① According to the purpose of this study, a General Information Questionnaire including 9 items, such as gender, age, marital status, education level, health status, occupation, income, residence location and kinship with organ donors was compiled.

② Simplified Coping Style Questionnaire, which has good reliability and validity, was used to analyze psychological pressure, anxiety, social avoidance and distress of the family members of the donors. The Cronbach's α coefficient was 0.80, and the validity kmo was 0.714. It consisted of a positive coping style and a negative coping style. The research results showed a significant relationship between an individual's coping style and mental health.

③ Social support rating scale (SSR) consisted of 10 items, including three dimensions: subjective support, objective support and support utilization. The scale has good reliability and validity, with test-retest reliability of 0.92, Cronbach's α coefficient of 0.89–0.94, and validity coefficient of 0.724–0.835.

④ Semi-structured interviews were conducted to further analyze the social support needs of donor families. Interview Outline for the Social Support Level and Needs of the Organ Donors Families in Hunan Province were compiled by the researchers (see **Table 1**), which mainly focused on emotional support needs, information support needs, and material support needs. The research group followed the principle of informed consent and tried to improve the heterogeneity of interviewees, such as the relationship with donors, gender, age, family background and so on.

Data Collection and Processing

Questionnaire Distribution

Questionnaires were issued after the informed consent forms were signed by the participants. The questionnaires were distributed and collected on the spot and filled in anonymously. From April to August 2017, we conducted an

TABLE 1 | The interview outline for the social support level and needs of the organ donors families in hunan province.

1. How did you get information about organ donation?
2. As a family member of the donor, have you ever been leaked personal information? What measures do you want the government, the Red Cross, hospitals or other official institutions to do in terms of information protection?
3. Do you want to know about the recipient's physical condition and living condition after surgery?
4. Did you consider material support when making the donation decision? Such as financial aid? Have you and your family received material support?
5. Do you regret agreeing to donate your relative's organs? Why?
6. Do you need psychological comfort and support? Have you ever received psychological support? Such as the care of relatives and friends, or professional psychological counseling?

on-site questionnaire survey in the memorial activity held by the Red Cross Society of Hunan Province held for organ donors. At the same time, the organ donation coordinator was entrusted to send questionnaires to the donor's home. A total of 112 questionnaires were collected, of which 102 were valid and the effective rate was 91%. SPSS18.0 was used for statistical analysis. The analysis methods used included frequency, percentage and chi-square test, and the significance level was $\alpha = 0.05$.

Semi-structured Interview

From April to May 2017, nine immediate relatives of organ donors in Hunan Province were successfully contacted to participate in the interview, and the interview time was limited to 45 min to 1 h. During the interview, the behavior and reaction of the interviewees were observed and recorded. The interview materials were co-coded by two researchers. To protect the privacy of participants, the interviewees are numbered and presented in the form of "D1, D2, D3, D4, D5, D6, D7, D8, and D9."

Ethics

Approval for the study was obtained from the Institutional Ethics Committee of the Third Xiangya Hospital, Central South University.

RESULTS

Demographic Data of Respondents

The general demographic data of the respondents are shown in **Table 2**. There were 48 males and 54 females who participated in the survey, with an average age of 42.2 ± 12.7 years, ranging from 13 to 80 years old. Of the 102 participants, 73.5% were married, 54.9% were junior high school degrees or below. Forty-eight participants had a general health condition. The occupation of most of these was peasants. The average monthly income of 46 participants was <1,500 yuan and most were rural residents.

Results of Simple Coping Style Questionnaire

The coping style of organ donor's family members showed that the coping tendency value ranged from −2.06 to 2.80, with an average of 0.0008 ± 1.04 (see **Table 3**). Among these, 49 had a positive coping style when the coping tendency value was >0, and 53 had a negative coping style.

Analysis of the Social Support of the Family Members of Organ Donors

Overall Level of Social Support

The overall level of social support was reflected by the overall scores of subjective support, objective support and social support utilization. According to the scores of the social support rating scale, <20 points accounted for 0.98%, 73 (71.57%) had scores between 20 and 40, and 28 (27.45%) had scores higher than 40. This suggested that most of the family members received limited social support, and only a small number of families received sufficient social support.

Objective Support

Objective support of organ donors families is shown in **Table 4**. In the last year, 73.53% of the family members mainly lived with their families. The financial support and psychological comfort that they had received were mainly from spouses and relatives. Only a few of these have received official or unofficial support. These results showed that the objective support source of organ donor families was limited, and the financial support and practical help were mainly obtained from the family members.

Subjective Support

The results of subjective support of the donor families are shown in **Table 5**. Nearly half of the families received support from 1–2 friends, while 16.67% of the families didn't get help from friends. Some families received concern from their neighbors and colleagues. Nearly half of the organ donors got full support from husband, wife (lover), and parents.

Utilization of Social Support

The utilization of social support by the families of organ donors is shown in **Table 6**. Of the investigated family members, 21.57% chose never to tell anyone when they get into trouble. Nearly half of them complained to 1–2 people they were very close to, and most of these were their families. More than half of the donors did not accept or rarely asked for help when they had troubles. A quarter of the participants never participated in group activities, half of them had occasionally participated in group activities. These results suggested that the utilization of social support of organ donor's families remained low.

Influencing Factors of Social Support of Organ Donor Families

Taking the total score of social support level as the dependent variable and demographic characteristics and coping style scores of respondents as independent variables, chi-square test was conducted. The results are shown in **Table 7**. The coping style had an impact on the level of social support, and the difference was statistically significant ($P = 0.014$). The demographic characteristics of family members indicated that no significant differences in the score of social support level ($P > 0.05$).

To further clarify the role and trend of social support of organ donor's families, logistic regression analysis was conducted.

TABLE 2 | General demographic data of respondents ($N = 102$).

Variables	Frequency	Percentage (%)	Variables	Frequency	Percentage (%)
Gender			**Occupation**		
Male	48	47.1	Government staff, Business personnel, or technical staff	20	19.6
Female	54	52.9	Peasant	41	40.2
Age (year)			Freelance	17	16.7
<25	9	8.8	Other	24	23.5
25∼35	23	22.6	**Average monthly income (RMB)**		
>35	70	68.6	<1,500	46	45.1
Marriage status			1,500–5,000	41	40.2
Unmarried	12	11.8	>5,000	15	14.7
Married	75	73.5	**Registered residence**		
Divorced	4	3.9	City	23	22.6
Widowed	10	9.8	Countryside	79	77.5
Other	1	1	**Relationship with donor**		
Educational level			Spouse	7	6.9
Junior high school or below	56	54.9	Parents	47	46.1
Senior high school or junior college	39	38.2	Children	15	14.7
Bachelor degree or above	7	6.9	Brothers and sisters	22	21.6
Health condition			Grandfather	1	1
Bad	21	20.6	Grandmother	1	1
General	48	47.1	Grandchildren	1	1
Good	33	32.4	Other	8	7.8

TABLE 3 | Simple coping style questionnaire score.

	Variables (Score = S)	Frequency	Percentage (%)
Coping tendency value	$S > 0$	49	48
	$S < 0$	53	52
Highest score	$S = 2.80$		
Lowest score	$S = -2.06$		
Positive score	$S = 1.65 \pm 0.53$		
Negative score	$S = 1.36 \pm 0.55$		
Average score	$S = 0.0008 \pm 1.04$		

The odds ratio (OR) and its 95% confidence interval (CI) were used to estimate the protective as well as risk factors. These results showed that compared to negative coping style families, the families with positive coping style act as protective factors of social support (or = 0.323, 95% CI: 0.129–0.810), and this meant that the family members with positive coping style received more social support.

Interview Results

A total of 9 interviewees officially participated in this study. The general demographic data of the interviewees are shown in **Table 8**.

Analysis of Social Support Needs of the Family Members of Organ Donors

Emotional Support Needs

In-depth interviews were conducted with the nine donor families. The interviews showed that all families hoped that the government would establish a psychological counseling agency for the donor families to relieve psychological pressure. Losing-single-child family (D1 and D3) showed stronger emotional support needs. Six participants were affected by public pressure and hoped to gain understanding and respect from their families, friends, and surrounding people.

> D1: *I hope relatives, friends and coordinators come to see me. The government should establish psychological counseling institutions so that we can communicate with professional people more comfortably.*
> D3: *I hope my friends, relatives and Red Cross personnel would visit and comfort me. The government and professional institutions should help the families out of the psychological dilemma.*

Information Support Requirements

The study showed that all participants wanted to know the health status of the recipients after the operation. Three participants (D2, D3, and D4) mentioned that government departments and the public should pay attention to donor families, and the donation behavior needed to be recognized by society. Four participants (D2, D3, D6, and D8) proposed that the relevant departments and staff should protect the personal information of the donor's families.

> D3: *I want to know the process and medical knowledge of organ donation. We should vigorously publicize organ donation. The Red Cross Society and the hospital should protect the personal information of donor families. The act of donation can be*

TABLE 4 | Objective support.

Entry	Variable	Frequency	Percentage (%)
Q2. In the past year, you	Were away from your family and lived in a single room	12	11.76
	Lived with strangers most of the time	11	10.78
	Lived with classmates, colleagues or friends	4	3.92
	Lived with family	75	73.53
	No source	0	0
Q6. In the past, when you were in a difficult situation, the sources of financial support and help to solve practical problems were from	Spouse	43	42.16
	Other family members	37	36.27
	Relatives	52	50.98
	Colleagues	16	15.69
	Work unit	9	8.82
	Official or semi-official organizations such as party and trade unions	3	2.94
	Non-governmental organizations such as religions and social organizations	0	0
	Other	2	1.96
	No source	0	0
Q7. In the past, when you encountered an emergency, the sources of comfort and care you received were from	Spouse	55	53.92
	Other family members	43	42.16
	Relatives	67	65.69
	Colleagues	33	32.35
	Work unit	8	7.84
	Official or semi-official organizations such as party and trade unions	4	3.92
	Non-governmental organizations such as religions and social organizations	2	1.96
	Other	1	0.98

Q6 and Q7 are multiple-choice questions, so the sum of frequencies exceeds 100%.

> *publicized, but it is not specific to one person. My biggest wish is to know whether the recipients are in good health.*
> D4: *We hope to have sound regulations and policies on organ donation. The main reasons for the rumors and incomprehension are that the superior departments do not pay attention to organ donation and the public publicity is not in place.*

Material Support Needs

Several families of donors indicated they needed financial assistance. Participants D1, D3, and D6 showed that the families who lost their only child have a greater demand for pension and employment security. Especially for the families who have lost their main labor force. They need the help of government departments and community organizations in the economy and employment. Besides, the donor families stressed that they hoped the Red Cross would carry out memorial activities for organ donors on Tomb-Sweeping Day in memory of the donors.

> D1: *I hope to reduce the hospitalization expenses, funeral expenses and increase the endowment insurance.*
> D3: *We hope that government departments will formulate policies to provide old-age security and set up nursing homes for families who have lost their families.*

Social Support Analysis of Organ Donor's Family Members

Emotional Support

The main forms of emotional support for the donor families include visiting relatives and friends, going out for relaxation, telephone consolation, organizing collective activities and green channels provided by the hospital during the treatment. We noticed that two participants (D1 and D3) who lost their only child received more care and more forms of emotional support, such as chatting with relatives and friends, and the Red Cross's company during the donor's hospitalization.

> D2: *The coordinator, the Red Cross Society and township cadres, my relatives, friends and neighbors have visited my family. There will be telephone greetings every year when sweeping graves.*
> D3: *My friends and colleagues showed concern for me. I am very grateful to the Red Cross for their company in the hospital for more than 20 days.*

Information Support

According to the interviews, four participants obtained organ donation information through the hospital and Red Cross staff. Among them, participants D2 and D7 saw the media publicity

TABLE 5 | Subjective support.

Entry	Variables		Frequency	Percentage (%)
Q1. How many close friends do you have that can get support and help	None		17	16.67
	1–2		42	41.18
	3–5		29	28.43
	6 or more		14	13.73
Q3. You and your neighbors	Never care about each other, just nodding acquaintances		17	16.67
	A little concerned when encountering difficulties		21	20.59
	Some neighbors care about you		24	23.53
	Most of the neighbors care about you		40	39.22
Q4. You and your colleagues	Never care about each other, just nodding acquaintances		14	13.73
	A little concerned when encountering difficulties		21	20.59
	Some neighbors care about you		29	28.43
	Most of the neighbors care about you		38	37.25
Q5. Support and care from family members	**None**	**Little**	**General**	**Full support**
Couples (Lover)	14 (13.73)	9 (8.82)	20 (19.61)	59 (57.84)
Parents	18 (17.65)	7 (6.86)	27 (26.47)	50 (49.02)
Children	30 (29.41)	10 (9.8)	23 (22.55)	39 (38.24)
Siblings	10 (9.80)	13 (12.75)	42 (41.18)	37 (36.27)
Other members (such as sister-in-law)	26 (25.49)	25 (24.51)	29 (28.43)	22 (21.57)

TABLE 6 | Utilization of social support.

Entry	Variables	Frequency	Percentage (%)
Q8. Who will you talk to when you are in trouble	Never tell anyone	22	21.57
	Only tell 1–2 people who are very close	47	46.08
	If a friend asks, you will say	18	17.65
	Actively tell your own troubles to get support and understanding	15	14.71
Q9. Who will you ask for help when you are in trouble	Just rely on yourself, don't accept help from others	24	23.53
	Rarely ask others for help	40	39.22
	Sometimes ask someone for help	21	20.59
	When you are in trouble, often ask your family, relatives and friends for help	17	16.67
Q10. For groups (such as party organizations, religious organizations, trade unions, student unions, etc.,) to organize activities, you	Never participate	25	24.51
	Attend occasionally	51	50
	Participate frequently	15	14.71
	Take the initiative and participate in active activities	11	10.78

and actively contacted the media or Red Cross Society to express their willingness to donate. D5 and D6 said that organ donation coordinator's publicity on organ donation knowledge is essential. It is found that donors and their families themselves, as disseminators of information, bring good publicity effect to relatives, friends and even the public. Besides, lacking publicity on the donation, pressure from public negative opinions and the low recognition of donation behavior are the main reasons why the donor's family members are not willing to disclose their identities.

Material Support

Seven participants received financial assistance from the Red Cross Society, and two participants obtained the government's minimum living allowance. Six participants said that they did not consider financial compensation and emphasized voluntary organ donation. Among them, D3 said that the medical support provided by the Red Cross Society and the hospital was also an important factor in making the donation decision at that time.

DISCUSSION

Analysis of Social Support Needs of Organ Donor Families

In terms of emotional needs, family members hope to get emotional support from their relatives. Emotional support and help from relatives are essential (6). Timely intervention on psychological changes and bad emotions of donor families at

TABLE 7 | Analysis on influencing factors of social support level of organ donor's family members.

Variables	Social support		c2	p
	Lack	Adequate		
Gender				
Male	33 (68.7)	15 (31.3)	0.657	0.418
Female	41 (75.9)	13 (24.1)		
Age (year)				
<25	8 (88.9)	1 (11.1)	1.831	0.4
25–35	15 (65.2)	8 (34.8)		
>35	51 (72.9)	19 (27.1)		
Marriage status				
Unmarried	11 (91.7)	1 (8.3)	10.63	0.031*
Married	48 (64.0)	27 (36.0)		
Divorced	4 (100.0)	0 (0.0)		
Widowed	10 (100.0)	0 (0.0)		
Other	1 (100.0)	0 (0.0)		
Educational level				
Junior high school or below	41 (73.2)	15 (26.8)	3.486	0.175
Senior high school or junior college	30 (76.9)	9 (23.1)		
Bachelor degree or above	3 (42.9)	4 (57.1)		
Health condition				
Bad	18 (85.7)	3 (14.3)	3.147	0.207
General	35 (72.9)	13 (27.1)		
Good	21 (63.6)	12 (36.4)		
Occupation				
Other	45 (73.8)	16 (26.2)	0.114	0.736
Peasant	29 (70.7)	12 (29.3)		
Average monthly income (RMB)				
<1,500	34 (73.9)	12 (26.1)	3.447	0.179
1,500–5,000	32 (78.1)	9 (21.9)		
>5,000	8 (53.3)	7 (46.7)		
Registered residence				
City	19 (82.6)	4 (17.4)	1.509	0.219
Countryside	55 (69.6)	24 (30.4)		
Anxiety				
No	26 (70.3)	11 (29.7)	0.151	0.697
Yes	48 (73.9)	17 (26.2)		
Attitude				
Negative	44 (83.0)	9 (17.0)	6.073	0.014*
Positive	30 (61.2)	19 (38.8)		

**statistically significant.*

different stages can ease and improve their mood (38). This study showed that donor families received less emotional care from society, and the psychological pressure of some family members comes from the pressure of traditional beliefs and the public. Therefore, the families of organ donors strongly hope to be understood by the public.

In terms of information needs, donor' families hope to know more about organ donation and organ transplantation. They want to know the health status of recipients after the operation. Besides, the personal privacy protection of donors and their families should be strengthened. Most of the interviewees in this study came from rural areas of China. The education level of rural residents is relatively low. So it is difficult for them to obtain information. Limited knowledge about organ donation leads to greater public pressure after organ donation. Thus, The government and the Red Cross Society of China should strengthen the propaganda of organ donation in economically underdeveloped areas. Measures need to be taken to improve the correct understanding and recognition of organ donation by citizens.

In terms of material needs, Financial assistance can be provided according to the organ donor familie's economic conditions (39). A study showed that the donor families had a large demand for material support, including medical needs (medical expenses reduction and exemption, organ transplantation priority treatment), social assistance (increasing endowment insurance, education fund and minimum living allowance, etc.,), and employment opportunities.

Analysis of Social Support of Organ Donor Families

When it comes to organ donation, individuals should be encouraged to seek the help of family as well as friends, and they should be aware of the need for social support from family and friends during and after the decision (40). Anker AE pointed out that organ procurement coordinators (OPCs) identified six forms of emotional support and eight forms of instrumental support, with greater use of instrumental support strategies (41). The results showed that the family members of organ donors have received basic objective support, including direct material assistance, the transmission of organ donation-related information, medical services provided by medical institutions, and practical help. However, the sources of objective support for the donor families are limited. The main sources of financial support and practical help should come from spouses and relatives, while the support outside the family remained less. The subjective support of family members of organ donors is mainly emotional support and communication support. When seeking spiritual comfort and daily communication, family members tend to have personal relationships such as with relatives. Husband and wife and parents play an important supporting role. Stouder (42) has found that family support to be the most helpful in healing their grief, followed by friend's support, religious and cultural beliefs. Most of the family members talk to family members and get support from their immediate family members. This showed that the organ donor families have fewer approaches for psychological disclosure and their willingness to ask for help is not strong enough. It is found that the lower the utilization of social support, the lower the frequency of interaction with members will be. These results suggested that the utilization of social support from the family members of organ donors was low, and they did not take any initiative to seek support from the existing resources, leading to limited social support provided by others. Yang (39) has pointed out that it is their responsibility and obligation of the city and society to help the family after organ donation.

TABLE 8 | General demographic data of interviewees.

Number	Relationship	Interviewees			Donors			
		Age (year)	Location	Education level	Age (year)	Gender	Cause of death	Donate time
D1	Father	47	Countryside	Illiteracy	24	Male	Suicide	20/12/2016
D2	Elder sister	52	Countryside	Illiteracy	36	Male	Car accident	25/08/2012
D3	Father	67	City	Senior high school	33	Male	Illness	02/04/2014
D4	Father	54	Countryside	Junior high school	25	Male	Cerebroma	27/02/2016
D5	Father	49	City	Undergraduate	21	Male	Cerebroma	18/12/2012
D6	Father	47	Countryside	Junior high school	19	Male	Car accident	28/11/2013
D7	Elder sister	50	City	Junior high school	43	Male	Encephalorrhagia	01/09/2014
D8	Father	52	City	Junior college	15	Female	Glycogen storage syndrome	08/10/2010
D9	Mother	34	Countryside	Junior high school	7	Female	Cerebroma	23/12/2014

Analysis of Influencing Factors of Social Support

Social support is closely related to coping styles. The more social support the individuals get, the more they tend to adopt positive coping styles. But the less social support they receive, the more likely they adopt negative coping styles such as evasion. As an intermediary mechanism of mental health and stress response, coping style plays an important role in the physical and mental health of the individual (43). Positive coping style showed a correlation with mental health, while negative coping style showed no correlation (44). In this study, the family members with positive coping styles obtained more social support than those with negative coping styles. Accumulated evidence suggests that social support is influenced by genetic and environmental factors (45). Except for the support from relatives for males, genetic factors cause variations in all dimensions of social support. Shared environmental factors influence relative support and relative problems in both sexes (46). Tess Thompson has found that neighborhood-socioeconomic deprivation and neighborhood-level social support affected the individual-level perception of social support indirectly through individual-level predictors in breast cancer patients, and to a lesser extent, controls (22). L M Sagrestano suggested that marital status is the most important predictor of support from a baby's father, whereas support from friends and family is more complex, and is associated with ethnicity, socioeconomic status, age, parity, and marital (47). The influencing factors of social support for rural children in China include supports from parents, teachers, peers, schools and social organizations (48). Kim et al. (49) found that the level of social participation showed the largest effect on a social support network. The other policy areas also showed positive significant influences to a social support network in the order of cultural and welfare policy, walking and local living environment, and local safety. Study on the correlation among resilience, social support and coping style of caregivers of family members in stroke patients showed that positive coping style can help family members to use more social support, which can increase the utilization of social support (50). The families of donors with positive coping styles will actively seek for help, actively express their personal needs, and use existing resources, such as family members, friends, coordinators, government and Red Cross organizations to seek support.

Limitations

The current study had potential limitations. First, the sample size of this study is limited. The family members of organ donors are a special group of people. Being surveyed means that they would reminisce about the death of their families and experience the pain of losing their loved ones again, especially for respondents who participated in the semi-structured interview. Therefore, we use a combination of qualitative and quantitative methods to minimize the bias caused by the limited sample size.

CONCLUSION

The level of social support and the utilization degree of social support among organ donor families is generally low. Organ donor families strongly hope to be understood by the public. Special organ donor families, such as the lost-one-child families, showed stronger social support needs, including material support needs and emotional support needs. Donor families have a great demand for material support, including medical needs, social assistance and employment opportunities. The coping style of organ donor families has an impact on the overall level of social support. Compared with a negative coping style, the family members of organ donors who adopt a positive coping style acquire more social support. Many families were found not having access to sufficient support in their networks, the need for government or Red Cross assistance was highlighted.

DATA AVAILABILITY STATEMENT

The raw data would be made available by the corresponding author on a reasonable request.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by the Institutional Review Board of the Third Xiangya Hospital, Central South University (No.2016-S257). The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

AJL participated in research design and data analysis. HYH participated in data collecting, data analysis, and paper writing. ZHX and XTD collected data and did the literature search. WZX participated in research design, data analysis, and paper writing. All authors approved the final submission.

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