Support groups for parents with an adult child suffering from bipolar disorder

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Confronted with the disconcerting behaviour exhibited by their children, parents of bipolar patients are in severe distress. Research focuses on the study of the 'burden' that the pathology puts on caregivers, owing to their experience of depression, sometimes combined with the presence of hostile attitudes and negative affects. In France, parents of adult patients encounter an initial specific difficulty: they are not systematically included in the care management system. Thanks to the initiative of an association of psychiatrists and psychoanalysts, the authors set up a psychoanalytic support group for the parents of 'bipolar' adults. The diagnosis of a bipolar disorder is established by a psychiatrist within a medical structure. Support groups for parents do exist in France, but their experiences have not led to scientific publications on this specific topic. Existing publications focus on other types of pathology and other therapeutic approaches. In this article, we will highlight how this type of psychoanalytic support group, with operating rules based on the theoretical work of Anzieu, can help parents of patients with bipolar disorders. Group participants accepted the principle of a research study that maintained their anonymity. We collected and analysed qualitative data from the first year of the group, so we highlight the specific difficulties of these parents, faced with chronic disease. The relevance of our qualitative study also resides in the data collected over a period of time, enabling us to see the progress made, and encouraging us to reflect on the place of psychoanalytic groups for parents, as well as on the care management of this pathology.

Keywords: bipolar disorders; chronic disease; caregivers; support group for parents; psychoanalytic support group; aggressiveness

1. Introduction

Confronted with the disconcerting, dangerous or surprising behaviour patterns exhibited by their children, parents of bipolar patients are in severe distress (Bauer et al., 2011). In France, parents of adult patients encounter an initial

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specific difficulty: they are not systematically included in the care management system (because their child is an adult) even though as parents they feel anxious and disoriented. Thanks to the initiative of an association of psychiatrists and psychoanalysts, the authors set up a psychoanalytic support group for people faced with bipolar disorders. In this paper, we present results from a study in one of the support projects, aimed at putting together a small support group for the parents of adult children with bipolar disorder. In fact, support groups of parents do exist in the care management system of France, but their experiences have not led to scientific publications on this specific topic. Existing publications focus on other types of pathology (Bouet, Valet, & Marcelli, 2000; Bouet & Valet, 2008; Jeammet, 1984; Poinso, Lalande, Battista, & Rufo, 1998), and other therapeutic approaches (Cook-Darzens, 2007a, 2007b). We will highlight how this type of psychodynamic support group can help parents of patients with bipolar disorders.

2. Bipolar disorder and the family context

2.1. Bipolar disorder: history and conceptual evolution

Whereas bipolar disorder represents the sixth leading cause of disability in young adults according to the World Health Organization, the prevalence of the global spectrum of bipolar disorders is reported at 2.4% in the general population (Merikangas, Jin, & Jian-Ping, 2011). Today, bipolar disorder is defined according to the DSM V (American Psychiatric Association [APA], 2013)¹ as a chronic pathology with different types. Type I is defined by the presence of at least one manic episode and Type II, by at least one hypomanic episode associated with at least one major depressive episode; furthermore, several subsyndromic forms exist. This nosological entity, reported since the DSM III (APA, 1980),² has replaced (without being an exact synonym) the term 'manic-depressive psychosis', defined by Emil Kraepelin (1921) in 1913; melancholy and manic episodes as affects and behaviours have been described since ancient times. Freud (1915/1917) viewed melancholy as a mental mechanism in which the superego struggles fiercely with the object, incorporated by identification within the ego. Abraham (1911/1986) introduced the manic-depressive position as a 'cannibalistic moment leading to the introjection of the object, but in a catastrophic mode since the ego-ideal battles the introjected object' (Toboul, 2013, pp. 81–82); 'The patients have a tendency to ascribe their feelings to the torturing consciousness of their own physical or psychical defects' (Abraham, 1911/1986, p. 38). Klein (1968) supported the idea that melancholia results from having introjected a whole and real object, which the ego then fails to achieve a full identification with. According to Klein, the progression to a manic state is in fact a flight from melancholia. However, the introduction of the death drive suggests another conception of the object, by linking it with the libido. Lacan (1991) revisited the idea of a damaging

‘jouissance’, where there is no substitution for the lost object: ‘... since the self identifies with this object, the relationship with the ego is simply reduced to this destroyed object’ (Toboul, 2013, p. 88). However, Lacan believed melancholia and mania could be treated clinically by psychoanalysis.

2.2. Bipolar disorder and family suffering

The World Health Organisation defines Quality of Life (QOL) as ‘individuals’ perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns’; QOL is based on the subjective and objective perception of an individual’s life (Bacqué, 2012). Studies focusing on the QOL of bipolar patients report the negative effects of the pathology with globally a lesser quality of life compared to the general population (Figueira, 2008; Gutierrez-Rojas et al., 2008; Ishak et al., 2012), and, in particular, altered social functioning and emotional relationships. Most patients report that social support is determining of their QOL (Michalak, Yatham, Kolesar, & Lan, 2006). Patients with greater social support showed a higher QOL (Nauert, 2008). These studies also highlight the burden of their mental pathology for these patients, associated with a life experience of social stigmatisation and exclusion leading to isolation, and sometimes with a real loss of relationships with loved ones.

Other studies (Bauer et al., 2011; Perlick et al., 2007) focus on the study of the burden that the pathology puts on caregivers, through their experience of depression, which is sometimes combined with the presence of hostile attitudes and negative affects. Steele, Maruyama, and Galynker (2010) found that most caregivers suffered from psychological disorders involving an increased use of mental health services.

2.3. The place of the family in care management

The involvement of the family in the care management of bipolar disorder is not simple. For Cuche, Raffaitin, and Gerard (2003) families are an important source of information, and contribute a high value-added complement in the treatment process. Due to the fact that patients are no longer confined to medical institutions and stay at the hospital for shorter periods of times, families are more involved in the care of their family member, while feeling powerless as a result of a lack of information on the pathology. Different types of family care support exist, from psychoeducational groups to different types of family-centred therapies (M’Bailara & Gay, 2014):

- Psychoeducational groups are dedicated to understanding the nature of the pathology, prodromal symptoms and treatment education (M’Bailara & Henry, 2007);

- Cognitive therapies are centred on communication and improvement of the family's mode of functioning (Pavuluri et al., 2004; West et al., 2009);
- 'Family-Focused Treatment' (FFT) is centred on psychoeducation and communication with patients (Miklowitz, George, Richards, Simoneau, & Suddath, 2003);
- Groups gathering several families, with a systemic orientation, have the objective of sharing their difficulties and resources and are implemented to solve problems and identify pathogenic behaviour patterns (Cook-Darzens, 2007b).

Very few groups are offered that are based on other theoretical standards, such as psychoanalytic support groups.

3. The support group

For the past 4 years, under the auspices of 'UNAFAM'³ (the National Union of Friends and Families of Persons with Mental Disorders), a psychiatrist working in Strasbourg University Hospital⁴ and a psychologist⁵ have organised regular meetings. These large support groups (about 30 persons) are open to patients, caregivers, partners, spouses, parents and children affected by bipolar disorder and wishing to share their experience. Themes discussed during these sessions were documented in notes taken by a psychologist⁶ present during each support group session. Their analysis has highlighted the painful experiences of families (feelings of being powerless, guilt, a desire to hear of similar experiences) and the suffering of patients (loss of autonomy, isolation, social and professional inclusion difficulties), as well as a need to understand certain elements better by holding regular meetings to share experiences in smaller groups.

It was from this context that the idea stemmed of implementing a more specific project of small 'emotional support groups'. According to Caron and Guay (2005), emotional support 'implies the possibility of expressing emotions and obtaining feedback', and it promotes 'the maintenance of an emotional balance in human beings' (p. 17). In September 2013, the authors started two groups, one for parents and the other for patients; each psychodynamic support group had two co-leaders, a psychiatrist from a medical structure and a psychologist.⁷

The smaller group started over a ten-month period during the school year, characterised by the very regular presence of mothers and fathers of bipolar patients. In this context, we define a group as the 'gathering of a group of persons in the same place, at the same time, in order to perform a common task to achieve the same goal' (Réveillaud & Guyod, 2009, p. 103). Based on the theoretical work of Anzieu (1971, 1982, 1984/2016), operating rules were defined from the start:

- Regularity: from the second session, participants made a commitment to participate in the group until the last session of the school year.
- Free speech: participants were invited to speak freely about any subject they chose, in a respectful and attentive listening environment.
- Confidentiality: 'what was said in the group stayed within the group' and was not discussed with others outside the group.
- Solidarity and absence of judgement: This rule is essential to the implementation of a 'psychological group structure' as defined by Kaës (2010), according to these three characteristics: group space, relationship space and individual space.
- Abstention: co-leaders maintained a compassionate benevolent neutrality.

Group work consisted in facilitating exchanges in a dynamic of sharing experiences. The transference of patients onto the group, the mobilisation of defences, unexpected contact with buried past experiences, sharing with other persons the difficulty and the reality of the disease that was avoided or denied up to now, all required the professionals leading the group to have insight into their own psychic movements. They also needed to identify the different dimensions of the psychic functioning of each participant in the support group (Anzieu & Kaës, 2000).

We have chosen to present in this paper the data from the first year of the support group experience (it has run for three years to date), where we have greater insight. We are not presenting this experience as necessarily generalisable, but our study has the merit of having collected qualitative data on the experience of families, which one usually does not have. The relevance of our study will also reside in the longevity of the group, enabling us eventually to see progression (or not) and encouraging us to reflect on the place of psychoanalytic groups for parents in providing care management for this pathology.

Regarding our population study, parents of bipolar adult children participated in a small group following information given (date and location) during the larger UNAFAM support group. The group included eight persons who committed to participating for the entire year, with non-attendance permitted only in exceptional circumstances. These participants were parents of bipolar adults aged 19 to 40, from the French middle class, living in rural or urban areas. Diagnosis of bipolar disorders had been established by a psychiatrist within a medical structure. Group participants accepted the principle of a research study that maintained their anonymity.

The sessions took place in a specific room⁸ once a month with 90-min sessions. Ten sessions took place during the first year of the support group's implementation.

Data were collected via notes taken after sessions. Personal data were kept anonymous. We studied the data with a content analysis method (Krippendorff, 2004) in order to define the themes, and a speech analysis method in order to hear the wording specific to each parent, reflecting his or her experiences and psychic movements. In extracts quoted, material has been anonymised.

4. Themes emergent within the group

4.1. The upheaval related to the first psychiatric crises

This period can sometimes be quite explosive due to the specificity of the manic phase. One of the characteristics of the support group was the presence of parents confronted with the progression to different stages of their child's disease. Thus with parents exposed to their children's first psychiatric episodes, the first hospitalisations, the contact with services was marked by the burden of the intense emotional experience related to these events: a state of shock; a stunned state, often fostered by a period of doubt and diagnostic hesitation. The parents shared their incomprehension, their uneasiness when faced with the first behavioural changes they perceived in their child: suicidal behaviour, aggressive behaviour, incoherent speech with delirious aspects, and difficulty in keeping up with reality, instability and unstable lifestyles. These symptoms appeared even more worrisome, since they were in total contrast with the personality they knew and loved. Later on, any episode, even a small one, that varied from the patient's usual behaviour, when the clinical state seemed stable, reactivated in them the painful and traumatic experience of the first crises, associated with the fear of a new episode, and its potential dramatic consequences, posing a real danger to themselves or others. 'Is he taking his medication?' 'Will this come back again?' were all elements reflecting the permanent state of alertness and anxious hyper-vigilance of these parents: 'We are never at peace ... always vigilant and on edge'.

4.2. The specific relief related to diagnosis and renouncement

Faced with this crisis state, the diagnosis was firstly seen as a relief, with the possibility of making sense of pathological behaviour that had hitherto not been comprehensible for the family. Thus the words 'manic', 'depressive' and 'delirium' were now part of a better defined entity, the term 'bipolar' referring to a condition that could now be treated and cared for; this elusive disease was now seen to be accessible to treatment and care. Sometimes, relief was accompanied by a more or less illusory expectancy of a miracle treatment that would resolve everything. Often with the diagnosis came the feeling of 'having lost time': 'psychiatrists did not see anything', or 'they were not properly trained'. We interpreted this as evidence of the polymorphism of the clinical symptoms of bipolar disorder during adolescence and the beginning of adulthood. Indeed,

the diagnostic difficulties linked to this time period do make parents and family feel anxious and angry.

However, this step is also associated with the burden of disease chronicity, the understanding of the disorder and its associated long-term treatment and the reconsideration of all projects: university courses, professional life, emotional relationships and financial autonomy. This challenges autonomy-seeking and separation processes, crucial issues at this period. 'How will he fare if we are not there?', 'A child is for life – we cannot give up on her'. All these aspects required a process of renunciation for the parents and their child.

4.3. The role of parents in specific care management

The fact that the participants were parents of an adult child was paradoxical because they were often left aside by the health care system, even though they were on the frontline as caregivers. One of the points underlined by parents was the contradictory position they were placed in regarding the care management of their child. They brought up the feeling of being largely ignored by medical professionals, undermined in their fear and anxiety even though they were the first ones identifying on a daily basis the first signs of a manic or depressive episode, or noticing poor treatment compliance. They shared their feelings of being put aside, and often reported feeling that the diagnosis would have been made earlier if they had been seen by psychiatrists who had witnessed the events and behaviours they had. There was sometimes an accompanying fantasy that earlier diagnosis could have prevented more catastrophic events; in addition, there were feelings of anger and resentment for having their parental abilities judged, with initial clinical episodes perhaps being trivialised or interpreted as educational shortcomings. Paradoxically, these same parents noted they are the first to be contacted to organise the return home upon the patient's discharge from the hospital, or when an enforced hospitalisation is decided upon, and the help of a third party is required because that third party is often a close family member. The parents insisted on the difficulties related to taking such a decision, when they were aware of the need to provide immediate care to their children while anticipating multiple guilt-filling recriminations. The parents were reporting their concern in maintaining a quality relationship with their child, a relationship too often weakened by the pathology, with a more or less justified fear of a total relationship breakdown: 'When I made this decision, he was angry at me', 'They do not realize', 'I was scared, he was mad, but if I had to do it again I would; with the follow-up, the treatments, he is much better and agrees that it was the right choice'.

Faced with this period of diagnostic uncertainty, which might have lasted quite a while, filled with doubt and insecurity, the skills and training of psychiatrists are sometimes challenged by parents, especially at the beginning of the disease. With time, the clinical improvements observed alongside and suitable treatment, accepted by the patient, allow parents to adopt more nuanced

positions. Globally, these parents report their isolation, and the absence of a clear status in relation to the medical decision-makers, which they would like to improve in order to achieve a 'partnership' with health care professionals and hospitals, with a specific space for parents to speak out.

4.4. The place of parents when faced with compromised autonomy for their children

Faced with the shock of this pathology, it appeared difficult for the parents to position themselves in relation to young adults who were often in a situation of denial or mistrust regarding the care management proposed by health care professionals. How could one be vigilant, present without being intrusive or too controlling? How could one keep the right distance? What was the frontier between 'normal' and 'pathological'? 'They need to become autonomous, but at first it is quite difficult for them, they are lost ... So we need to be there for them, to support them, without doing things for them', 'They need to rediscover their self-confidence', 'It is complicated, it generates conflicts'. Some parents were less trusting, for example: 'He makes excuses, blames it on the disease', whereas other parents nuance and interpret their children's behaviour as an anxiety-triggered refuge for their children, confronted with the burden of certain tasks.

Some parents also shared their uneasiness faced with the remarks, not always kind ones, of family and friends: 'They say we don't know how to deal with him, we should shake him up, because he is too spoiled', 'They do not always understand that he does not do this on purpose'.

It seems important for these parents to restore an active parenting role, while making sure they do not position themselves as therapists. The experience of certain parents was helpful for others to hear, because it showed that future projects were possible, even if some adjustments had to be made. Thus, one of the young adult boys was able to get back to work and start a loving relationship, even if the work did not match his initial training, all this after a manic phase which was extremely destructive for him and his parents.

4.5. A possible positive evolution

Parents most often shared the positive impact of learning about the diagnosis. It enabled them to understand the inconsistency of certain behaviour patterns or words, which sometimes took irrational, worrisome or even scary aspects. With the possibility of distancing themselves from those symptoms, recognising their pathological dimension, another life seemed possible, by rekindling the mentalisation abilities that were frozen in the stunning shock triggered by the first crises – 'The most important thing is the treatment ... he must accept it and take it'. Thus first steps within the group related to initial acceptance of the 'bipolar disorder' classification, understanding the importance of treatment,

accepting the burden of chronicity, the acceptance of related consequences and the giving up of certain projects (professions, university studies). Over time it seemed nevertheless possible for the parents to regain some kind of balance. Some other projects could be realised through the possibility of social re-inclusion, a certain affective stability, allowing the progressive repair of intra-family relationships and restoring the positions of everyone, while reigniting a positive dynamic after a period (varying in length) of inertia and uncertainty. These new projects needed to take into account the reality of the pathology, and treatment-related constraints (fatigue, weight gain, as well as concentration and memory difficulties) and were accompanied by a lingering form of vigilance, which parents tried to ensure did not prevent and minimise the possibility of adaptations in the young adults.

Anger, denial, ambivalence and massive anxiety can lead, in the best of cases, to a form of acceptance, or unfortunately sometimes to a type of resignation: 'It is sometimes a weight, a burden that we carry'; this was voiced within the group with the aim of getting support.

4.6. The issue of transmission, a filial link

The child's pathology can revive certain wounds and reactivate in some parents the life experience of other crises with a loved one, spouse or parent, suffering from the same pathology. The evidence of certain risk factors related to family genetics, recognised in bipolar disorder, calls into question transgenerational relationships and adds to potential trauma: 'We believe it is our fault', or on the contrary, 'Why us? Nobody is sick in our family'. These same parents bring up their more or less justified fear that one of their younger children might present with the same type of pathology.

When the question of having a child comes up for these patients, it is sometimes difficult to adopt the right position; 'When we know what we have gone through as parents, we want to tell them not to take any risks'.

4.7. The place of patients in society

The question of society accepting the pathology was also a recurrent theme in the group. Parents were faced with ongoing difficulties in resolving administrative issues, due to slow and cumbersome administrative processes and an absence of continuity and support in their implementation. This applied to filing to obtain the disabled adult allowance given by the government, obtaining recognition of the status of a worker with disabilities, taking legal action to put the adult child under legal protection, and obtaining support and follow-up from social workers. Parents were divided over whether society was making advances in accepting pathology. Concerning the disappearance of some taboos and acceptance of the reality of the disease, they made comments such as: 'It is more talked about in the media, it has become less scary for others';

'Bipolar disorder is easier to hear than manic-depressive psychosis', 'But progress still needs to be made'. In this case, the group took a militant stand, asking for more acceptance and comprehension; this stand contributed to the sense of mutual emotional support, since it united the group under one cause.

5. Challenging parental narcissism

Bipolar disorders, regardless of their type or clinical expression, their period of evolution and their more or less severe consequences, mark the psychological life of each family member, especially parents. This ordeal, this relationship crisis, tends to trigger a certain number of psychological reactions, which cannot be considered as simple 'epiphenomena', and seem to be an integral part of the pathological process. In fact, some themes discussed in the group and certain reactions observed seemed to converge.

5.1. Anxiety

Entering the world of bipolar disorder provoked in parents massive anxiety reactions that resulted in real psychological states of shock with, in some cases, the build-up over time of symptoms similar to post-traumatic stress. These reflected the festering aspect of this life experience: anxious hyper-vigilance, permanent alertness, tracking the smallest tell-tale sign of a manic or depressive episode. The first psychiatric episodes can awaken in certain parents painful emotions, former painful episodes, related to negative previous experiences during psychiatric crises of other family members: spouses, parents, sometimes other children. Thus, the status of parents can be shaken by the sudden revelation of other pre-existing episodes masked by an apparent family balance.

This anxiety can also lead some parents to adopt overprotective attitudes with certain activity limitations that are less justified. This behaviour can also be linked to ambivalence in the relationship with the patient.

5.2. Depression

The disease can also trigger real depressive tendencies, sometimes reactional ones related to the crumbling of parental defence mechanisms when the announcement of the disease is sudden, or when a potential vital risk is perceived: suicidal behaviour or extremely dangerous behaviour secondary to a state of manic exhilaration, for example. This depressive experience seems sometimes to correspond to a more complex process, the disease unveiling in the parent an underlining pre-disposition.

Faced with this life experience, the risk for some parents lies in dealing with it by being 'over-present', sometimes even in a self-sacrificial way, by taking up the role of the health care team when simply being a parent becomes too difficult. For others, the fear of being judged as 'bad parents' or 'rejecting

parents' tends to lead them to escape the relationship, by adopting a certain superficiality and by avoiding dealing with the health care management of their child.

5.3. Aggressiveness

Reactions of aggressiveness can be rooted in the parents' feelings of guilt; they are stuck in ambivalence that they find difficult to own. The reality of the disease can represent such a real narcissistic wound: the image of their child fades away from the image of the imaginary child that they have built up, the latter being replaced by the less gratifying reality. Thus, this situation exposes them to the gaze of others, putting them outside the norm. These parents, washed out with the feeling of not being up to the task, of not having been able to protect their child, are afraid of failing in the parental process, and of confronting the risk of caring for a child again.

Parents are more or less conscious of this aggressiveness, which leads to a feeling of guilt. This aggressiveness can be denied or turned around by over-protecting the patient, giving the parent the illusion of having a measure of control, with the risk for their child of then settling into a position of dependence, a diminishing regressive situation. The risk for the patient lies in fighting this dependence by defiance and thus developing oppositional behaviour patterns. The aggressiveness can then be projected onto the medical team, questioning their competence and benevolence.

5.4. Guilt

Guilt can be more obvious when the disease has a family characteristic. This guilt can also have an effect on the difficult position of parents towards other siblings, with parental attention on both psychological and material levels focused on the sick young adult, to the detriment of others, perhaps by asking them 'Not to make an already difficult situation worse'. The narcissistic wound perceived by the siblings can add to parental guilt, thus promoting unavoidable conflicts and exacerbating rivalry. Finally, guilt can be experienced because one has required siblings to share in the burden of the disease of a brother or a sister who is not always autonomous – 'Who will take care of him later on in life?'

The group was allowed to speak about negative affects ('One cannot divorce one's child') without being judged, enabling the participants to own and mentalise their experiences.

6. Discussion: therapeutic aspects of the group

The implementation of a support group for parents, often isolated in their suffering when faced with young adults in a situation of crisis, can help

participants share and elaborate on their difficulties and parental conflicts. Thus, faced by the upheaval triggered by the disease, members of the group, rich in different life paths, enabled the sharing of more or less painful experiences, which for some were still quite present. Others had already found a positive resolution, leaving the field open to less dramatic possibilities in the future. Through an attentive but detached listening approach, advice was offered regarding the best attitudes to adopt, examples of a possible emotional life were underlined, the possibility of reintegration over time was held out, once the treatment had stabilised. The group could offer experience of landmarks, and hope, enabling people to get over states of initial shock and uncertainty. With its structuring effect, the group could, within a framework with a certain permanence and periodicity, offer mutual scaffolding to a narcissism that had sometimes been quite severely affected. Thanks to its structuring elements and rules, it welcomed and contained the expressions of anxiety and depressive affects, the life experience of being in a dead end, and rekindled the possibility of thinking. Sharing experiences could also help reduce the feeling of isolation, of being put aside.

This system also let participants express negative feelings that had never been verbalised before: guilt, the fantasy of abandoning the child, reconsideration of certain life choices ('having children'), ambivalence when faced with a son or daughter who was not very rewarding, fear of the aggressiveness present in their child, feelings which were denied or repressed. Putting these feelings into words with the support of the group dynamic permitted a release, since the guilt which was nevertheless present became more tolerable, and the psychic elaboration allowed people to overcome negative affects, which could otherwise remain stuck and interfere with relationships.

It also seemed possible, via learning about the pathways walked by other parents, to tolerate a little better the moments of doubts and uncertainty. This sharing of experience led to the idea of setting up a group, an association in order to defend participants and to increase recognition of the consequences of mental disorders affecting children.

7. Conclusion

This group-based 'parents' care system seems relevant and innovative regarding bipolar disorder. The chronic nature of this pathology is difficult to bear for parents and their children. The fact of being parents of adult children tends to leave the parents outside the health care system, even though they remain involved and concerned. For all these reasons, the small support group seems to answer a crucial need. Faced with parental exhaustion, as we have previously described, the group provides an emotional support to remobilise mental resources and prevent parents from being overwhelmed by anxiety and weariness. Our hypothesis is that the group allows these parents to continue their role as caregivers for the patients themselves.

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Notes

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders.
2. See Note 1.
3. Union Nationale des Familles et Amis de personnes Malades et /ou Handicapées Psychiques.
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