Evidence In-Sight:
The evidence base for multiple family group therapy
The following Evidence In-Sight report involved a non-systematic search and summary of the research and grey literature. These findings are intended to inform the requesting organization, in a timely fashion, rather than providing an exhaustive search or systematic review. This report reflects the literature and evidence available at the time of writing. As new evidence emerges, knowledge on evidence-informed practices can evolve. It may be useful to re-examine and update the evidence over time and/or as new findings emerge.

Evidence In-Sight primarily presents research findings, along with consultations with experts where feasible and constructive. Since scientific research represents only one type of evidence, we encourage you to combine these findings with the expertise of practitioners and the experiences of children, youth and families to develop the best evidence-informed practices for your setting.

While this report may describe best practices or models of evidence-informed programs, Evidence In-Sight does not include direct recommendations or endorsement of a particular practice or program.

This report was researched and written to address the question:

- According to the literature, what is the evidence base for multiple family group therapy?
- Is it an evidence-informed practice that is appropriate for mixed groups of families and youth with a variety of social, emotional, and behavioral concerns?

We prepared the report given the contextual information provided in our first communications (see Overview of inquiry). We are available at any time to discuss potential next steps.

We appreciate your responding to a brief satisfaction survey that the Centre will e-mail to you within two weeks. We would also like to schedule a brief phone call to assess your satisfaction with the information provided in the report. Please let us know when you would be available to schedule a 15-minute phone conversation.

Thank you for contacting Evidence In-Sight. Please do not hesitate to follow up or contact us at evidenceinsight@cheo.on.ca or by phone at 613-737-2297.
1. Overview of inquiry

This request was submitted by an urban, community mental health agency that is looking at strategies to reduce wait lists and to provide services for families with a variety of needs and concerns. They have an experienced, well trained group of senior clinicians who are interested in adopting a group intervention that is suitable for clients with diverse problems. The clinicians who would take on a new treatment program are MSW-level child and family workers. Groups would be for children and youth, and their families, with a range of presenting problems including internalizing and externalizing concerns. The organization has evaluation capacity in place to measure outcomes. They intend to implement a new group-based program within the next 4-6 months.

The clinicians who will take on this new program are familiar with multiple family group therapy, a treatment approach that was formally created in 1964. One supervisor has used the program in past, but they are not familiar with the recent research on this program, and they are looking for an answer to the question:

*Is multiple family group therapy an evidence-based program that is appropriate for mixed groups of families and youth with a variety of social, emotional, and behavioral concerns?*

2. Summary of findings

- Multiple family group therapy is a loose term used to describe therapy in which more than one family is seen in a group setting; it does not refer exclusively to a manualized, formal intervention.
- Multiple family group therapy has been used to treat a variety of mental health concerns, including substance abuse in adults and adolescents, eating disorders in adolescents, and to address family dysfunction.
- Multiple family group therapy is almost always used in conjunction with other methods of treatment.
- Multiple family group therapy is associated with higher retention rates in treatment programs, including for families struggling with broken-down communication.
- Multiple family group therapy is as effective for adolescents as it is for adults.
- None of the studies we found provide explicit guidance on referral or clear inclusion/exclusion criteria for families and clients.

3. Answer search strategy

- An initial search was conducted on Google Scholar using the search term ‘multiple family group therapy’.
- www.multiplefamilygrouptherapy.com lists multiple articles and resources pertaining to multiple family group therapy. Articles listed on the website were downloaded from PsycInfo.
- Additional searches were conducted using the search terms ‘multiple family therapy group’, ‘multiple family therapy’, ‘group family therapy’ in both the PsychInfo and PubMed databases.
- Relevant references cited in articles from the above searches were also retrieved.

4. Findings

The first mention of conducting therapy groups with multiple families was reported in 1964 by H. Peter Lacquer, earning him the distinction of ‘the father of Multiple Family Group Therapy’ (Foster, n.d.). Dr. Lacquer developed what he called “Sunday meetings” where 4-5 inpatients and their families would meet to develop a better understanding of their family member in treatment (Orvin, 1974). In 1969 George H. Orvin used this approach for youth as an adjunct to an existing inpatient treatment program, which already consisted of individual psychotherapy for the adolescent, couples therapy...
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for parents, and individual family therapy. The groups consisted of eight families, a therapist, and two resident psychiatrists for a total of around twenty-eight people per session. Orvin’s program took place at a teaching hospital in South Carolina and treated adolescents with any disorder provided it was the adolescent that requested to enter treatment.

Multiple family group therapy as a treatment method has branched out to address numerous mental health concerns. As a result, ‘multiple family group therapy’ has become a loose term to refer to any treatment program that involves conducting groups with members of multiple families. Despite the absence of a rigorous, formalized methodology across all applications, multiple family group therapy (MFGT) does have an evidence base as an effective treatment approach for a variety of mental health problems.

Since MFGT is not a discrete, well-defined program that follows clear delivery guidelines, it is challenging to determine precise referral or inclusion/exclusion criteria for families and clients. Some of the literature summarized in this report provides general guidance related to being sensitive to providing groups for children of approximately the same age and providing separate groups for couples and single-parents. Laquer (in Wolberg & Aronson, 1980) identified six factors that can be useful in determining if families are appropriate for MFGT and readiness for leaving therapy groups:

1. Attention: be able to focus on events most important for the family and not procrastinate on what needs to be done.
2. Tenderness: must be sensitive and value each member and express themselves openly.
3. Choice: must be able to make realistic selections between impressions and information that is correct or incorrect.
4. Organization: must have enough of a family structure to react sufficiently and adapt.
5. Operation: family needs to be able to process events and information in a productive manner.
6. Wisdom: must be able to sense and recognize situations, consider available options, assess consequences of each option and come up with proper solutions and how to follow through with them.

The majority of articles focus on one of three aspects of MFGT as a treatment method:

1. The theoretical background/development of the program
2. End of treatment program results
3. Follow-up outcomes after leaving therapy.

This Evidence In-Sight report focuses on outcome results across four different mental health concerns. Links to supplementary information on the theoretical underpinnings and implementation considerations are provided. Since MFGT is not a copyrighted treatment program, this report does not capitalize it.

4.1 Addictions

Multiple family group therapy has been used to treat alcohol and substance abuse in both adults and adolescents, and the evidence indicates that it can be appropriate treatment approach for youth and families who do not specifically require individual interventions.
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A meta-analysis by Stanton and Shadish (1997) included 15 studies with 1,571 participants attending substance abuse programs. Of the 15 studies, nine focused on 985 adolescents. Five of the studies had results demonstrating family involvement methods produced more favorable results than individual or psychoeducation methods. The four remaining studies found that family therapy was effective in reducing substance abuse, but the result was not significantly different from results obtained via the comparison method (e.g. individual treatment with a separate parent group). These four studies were still deemed valuable as they demonstrated suitability as a cost-effective method involving fewer staff. Results of the entire analysis found that MFGT is considered favorable over individual therapy, peer group therapy, or single family psychoeducation sessions. MFGT was associated with relatively higher rates of engagement within treatment and retention in treatment. One of the inclusion criteria was that studies used random assignment to conditions, so by extension the meta-analysis did not determine any specific criteria about client or family characteristics that could guide referral or suitability for MFGT.

In a small study, Cadogan and colleagues (1973) had 20 adult alcoholics and their partners participate in weekly group sessions for three to six months following discharge from an alcohol treatment program. A comparison group of 20 patients were placed on a waiting list for group therapy. The goal of the intervention group was to improve problem solving and communication between couples via conversations in a group setting, with other couples who were experiencing a similar situation. At the end of the six month study period 45% of the therapy group members remained abstinent, compared to only 10% of the control group.

Another study involving adult alcoholics (McCrady et al., 1979) compared two different types of therapy groups at an inpatient psychiatric hospital with a control group at the same hospital. The control group participants received individual therapy for their alcohol addiction. The first experimental group participated in ‘couples involvement’ therapy in which patients and their spouse or partner attended group sessions with other couples, in addition to their own individual therapy sessions. The second experimental group participated in ‘joint administration’ therapy, during which spouses and partners lived in the ward with the patients and participated in all activities. Rates of abstaining from alcohol at six months following treatment were 83% for the couples involvement group, 61% for the joint administration group, and 43% for the individual treatment group. The authors noted that the couples treatment group produced clinically significant rates of abstaining from using alcohol.

More recently, Schaefer (2008a; 2008b) described a residential program for alcohol addiction. Residents were invited to ask a family member (immediate or extended) or support person to attend a weekly session lasting 90 minutes. The program was less structured in that family members attended on a voluntary basis. During a 12 month period of time 34% of all family members had attended only one session, 39% of all family members had attended between two and five sessions, and 27% of all family members attended between 6 and 12 sessions. Although the author does not include exit or outcome data, five themes emerged throughout the process:

- Improvements in broken family relationships
- Decrease in fear when attending the group sessions
- Shared understanding developing between family members
- Increased self-awareness and improved communication within families
- Recovery is a process that takes place on an ongoing basis
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Although the findings from Schaefer do not directly address the efficacy of MFGT as an alcohol addiction treatment per se, they do speak to the effectiveness of MFGT in helping to engage family members in the treatment process and in mending and rebuilding broken or estranged family relationships. Although no explicit inclusion or exclusion criteria for involvement were stated, findings indicate that groups could be effective in engaging family members from families with broken or poor communication.

4.2 Eating disorders
Dare and Eisler (2000) conducted a program for adolescents with eating disorders that began with intensive, full day sessions before gradually reducing to shorter and less frequent sessions. There were three main aspects to the treatment:

- Help the clients and their parents to come up with a strategy to better manage the symptoms of the young person’s illness.
- Focus on the need for the families, both on their own and as a group, to consider the changes that take place during adolescence and the importance of support from the family so that the individual may grow in the manner they desire, yet retain family traditions
- Help families to look ahead and think in terms of the changes they would like to see

Although the sample size was too small and unique to draw firm conclusions, the authors found in feedback received from clients in the program that compared to a traditional family treatment program, families were very enthusiastic about the MFGT. Specifically, the adolescents in the program appreciated the opportunity to compare their lived experiences with other families. The therapists noted that, as a group, the learning process could be more engaging and reliable than individual psychoeducation and dissemination of information in the form of a lecture.

Geist and colleagues (2000) directly compared the effects of single family therapy with multiple family group psychoeducation. Their sample consisted of 25 adolescent inpatient females between the ages of 12 and 17 who were randomly assigned to one of the two groups. Each group met once every two weeks for four months. During the course of these sessions participants had access to standard medical care and other psychosocial treatments. Weight gain was achieved in both groups following the four month period, but no significant change was noted in psychological functioning by either adolescents or their parents. The authors concluded that the treatments were equally as effective, with multiple family psychoeducational group therapy being a more cost-effective alternative.

Scholz and colleagues (2005) took a three phase approach over 12 months to use MFGT with anorexic adolescents and their families. The first phase was an intensive week focused on the parents’ ability to manage specifics of their child’s eating disorder with the idea that parents, not the therapist, take responsibility for managing their child’s disorder by determining boundaries and not engaging in debates or negotiating sufficient food intake over a specific time period. The second phase followed three weeks later with three additional single-day intensive sessions. The goal of this phase was to shift the focus to relationship issues within the family to aid parents in being able to manage conflicts and learn to forgive others. In the third phase of the treatment families came together for two full days in a month and tapered to one day per month for four months. The focus of the final phase was relapse prevention and future planning. Specific topics focused on early warning signs and the benefits and consequences of more independence.
At the end of the program, 40% and 60% of the parents rated MFGT as satisfactory or very satisfactory. 40% and 39% of patients found MFGT as satisfactory or very satisfactory. Conversely, all of the parents and 89% of patients rated inpatient care as either not satisfactory or not at all satisfactory.

4.3 Family dysfunction
Behr (1996) describes using multiple family group therapy with chronically dysfunctional and socially isolated families. Sessions included up to six families with a combination of full group participation and sessions with the children and parents in their own groups. Therapists found that the children’s group was taxing and difficult given the different ages, maturity levels, and attention spans. The author suggested matching similar families and children for enhanced group cohesiveness, and having separate groups for single parent families and coupled families. One benefit was that the group process was an effective way of involving fathers or stepfathers in the therapy process.

In a randomized control trial, Meezan and O'Keefe (1998) assigned families to either a MFGT group or a control group receiving standard family therapy. All families were those where child maltreatment was a commonality (with the exception of sexual abuse, which was excluded from the trial). The treatment program involved 6 to 8 families meeting for two and a half hours per week for 34 weeks. After six treatment cycles, a total of 42 families had passed through the MFGT group and 39 through the control group. Authors found that the families involved in MFGT were more engaged in the process of treatment and were more likely to complete more treatment sessions. A measure of family functioning at the end of treatment revealed statistically significant differences between groups for parent-child interactions (including major differences in child assertiveness). Additionally, the number of domains in which positive change occurred was significantly higher in the MFGT group than for the control group.

4.4 Mood disorders
Fistad and colleagues (1998) conducted a six session multiple family psychoeducation group intended for children with mood disorders. The group consisted of nine families and during sessions attendees were split into groups of parents, children, and adolescents to present information at a developmentally appropriate level. The three goals of the program were to normalize the experience of depression, provide educational information about symptoms and treatments, and improve social skills. Immediately following the six sessions, parents reported more positive actions and less negativity toward their children, as reported on all eight subscales of the Expressed Emotion Adjective Checklist, a standardized measure of expressed emotion. Four months following the program, only four of the eight subscale scores yielded positive improvement. The study did not assess depressive symptoms in children, or as perceived by the parents, but instead focused only on family climate.

Goldberg-Arnold and colleagues (1999) used a multiple family psychoeducation group therapy with 35 children and their parents, intended to help alleviate difficulties of care burden in families with children with a mood disorder. At the conclusion of treatment, increased knowledge was a common comment from all parents. Upon follow-up 3-4 months later, significantly more parents reported positive attitude change compared to their initial attitudes immediately following the treatment. Authors stipulate that attitudes may not change initially, but may develop in the time that follows the intervention. Child outcomes were not assessed, nor was a between group analysis performed even though there was a waitlist comparison group.
Fristad and colleagues (2003) conducted a study with 35 families split into multiple family psychotherapy groups in addition to treatment as usual either immediately (n=18), or to a waiting list for multiple family psychotherapy but still receiving treatment as usual (n=17). Multiple family psychoeducation groups met weekly for six weeks. At six months follow-up, families involved in the MFTG experienced:

1. Greater levels of knowledge about mood disorders in childhood
2. Parents reported an increase in positive family interactions
3. Children reported a perceived increase of support from their parents
4. Families had increased their use of appropriate services.

An important point to be made is that, in each of these cases, multiple family group therapy was not the exclusive method of treatment, but was used in conjunction with other treatment methods as a means of providing both continuous care, increasing parents’ support networks, and as a way of providing continuing care.

5. Next steps and other resources
A review conducted by McDonell and Dyck (2004) included 11 studies using various research designs to investigate children with psychological disorders covering internalizing disorders, externalizing disorders, psychotic disorders, and intellectual delay. The authors found that, compared to the adult literature on MFGT, studies involving children are characterized by various models of treatment, few standardized manuals, and limited replication of the same model. The authors suggest that although MFGT may be efficacious in the treatment of mental health problems in children, more effort is needed on the part of researchers to develop standardized treatment models with replicable results.

With McDonell and Dyck’s suggestion in mind, the following articles discuss program structure, staff training, and implementation of multiple family group therapy programs.


Knowing what works and receiving training on an evidence-informed practice or program is not sufficient to actually achieve the outcomes that previous evaluations indicate are possible. A program that has been shown to improve mental health outcomes for children and youth but that is poorly implemented will not achieve successful outcomes (Fixsen et al, 2005). In order for a program to be evidence-informed, it needs to be applied with fidelity to the design and it needs to be implemented using supportive “drivers” related to staff competency, organizational leadership and organizational capacity. These drivers include assessing and monitoring the outcomes of your practice using evaluation or performance measurement frameworks, which are particularly important when there is insufficient evidence in the literature to guide clinical decisions. Choosing a practice is an initial step toward implementation, but the implementation drivers are essential to ensure that the program reaches appropriate clients, that outcomes are successful and that clinical staff members are successful in their work.

The Ontario Centre of Excellence for Child and Youth Mental Health has a number of resources and services available to support agencies with implementation, evaluation, knowledge mobilization, youth engagement and family engagement. For more information, visit:
http://www.excellenceforchildandyouth.ca/what-we-do or check out the Centre’s resource hub at http://www.excellenceforchildandyouth.ca/resource-hub.
For general mental health information, including links to resources for families:
http://www.ementalhealth.ca
References


