



# Multiple-family group treatment as an effective intervention for children with psychological disorders

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## Abstract

An estimated 20% of children<sup>1</sup> suffer from psychological disorders and only 10–20% receive adequate treatment. A lack of empirically supported treatments is one reason why relatively few children receive treatment for their psychological difficulties. Multiple-family group treatment (MFGT) is an empirically supported intervention for adults with chronic mental illnesses that may be an effective treatment for children with psychological disorders. This article reviewed the adult MFGT model and its empirical support. The quantity and quality of child MFGT research was then reviewed. Child MFGT models are compared with one another and to the adult MFGT model. All studies provided initial support of MFGT as an appropriate treatment for childhood disorders. However, the child literature as whole was relatively limited, unfocused, and lacked replication. Suggestions for future research are made, focusing on a structured and scientific approach to establishing MFGT as an empirically supported intervention for children.

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## 1. Introduction

An estimated 20% of children and adolescents suffer from a psychological disorder (Costello, Angold, Burns, Erkanli et al., 1996; Costello, Angold, Burns, Stangle et al., 1996; Narrow et al., 1998;

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<sup>1</sup> Unless otherwise specified, the term *children* refers to all persons younger than 18 years of age.

U.S. Public Health Service, 2002). Despite the frequency of these disorders and the existence of accurate and reliable assessment tools, only 10–20% of children suffering from psychological conditions receive specialized mental health services (Buckner & Bassuk, 1997; Leaf et al., 1996; U.S. Department of Health and Human Services, 1999). This pattern of treatment underutilization can be explained by a variety of factors including, but not limited to unsuccessful identification of children who need services, stigma associated with mental illness, a lack of awareness of or dissatisfaction with the mental healthcare system, a lack of funding to pay for mental healthcare, and a lack of empirically based treatments for children with psychological disorders (U.S. Department of Health and Human Services, 1999). While all of these factors likely contribute to the underutilization of services in children, a lack of empirically validated treatments for children may account for much of this discrepancy (Lonigan, Elbert, & Johnson, 1998).

In 1995 the American Psychological Association's Task Force on Promotion and Dissemination of Psychological Procedures (Task Force) published a report designed to encourage the development, investigation, and dissemination of empirically based psychotherapies. In this report, the Task Force formulated criteria for empirical validation, listed treatments that met these criteria, and advocated for the dissemination of these treatments. Two levels of empirical support, "well-established" and "probably efficacious", were developed based on replication of treatment effects, methodological rigor, use of a manualized treatment, and adequate descriptions of participants. Generally, "well-established" interventions represent treatments that have gained wide spread empirical support in well-designed studies. "Probably efficacious" treatments have received empirical support; however, either the quantity or quality of these investigations fails to meet criteria for well-established treatments. Using these criteria, the Task Force (1995) identified 18 well-established and 7 probably efficacious psychological treatments. The Task Force issued follow-up reports in 1996 and 1998 with an overall reduction in the number of well-established therapies from 18 to 16 and a large increase in the number of probably efficacious treatments from 7 to 56 (Chambless et al., 1996, 1998).

Among the list of 72 empirically supported treatments reviewed by the Task Force (Chambless et al., 1998), only three well-established and four possibly efficacious treatments for children were included, demonstrating the discrepancy between adult and child psychotherapy and intervention development research. In an effort to further assess child psychotherapy research, a special issue focused on empirically supported treatments for children appeared in the *Journal of Clinical Child Psychology* (1998). Articles in this special issue utilized the Task Force's (1995) criteria to assess psychotherapy literature across typical childhood clinical populations encountered by psychologists (Lonigan et al., 1998). These reviews included clinical disorders, such as depression (Kaslow & Thompson, 1998), anxiety and phobic disorders (Ollendick & King, 1998), autism (Rogers, 1998), conduct disorder (Brestan & Eyberg, 1998), and attention-deficit/hyperactivity disorder (ADHD; Pelham, Wheeler, & Chronis, 1998). Across these reviews, only 6 well-established and 20 probably efficacious treatments were identified. No treatments for autism, depression, or generalized anxiety attained well-established status and no treatments for autism attained even probably efficacious status. All interventions that attained well-established or probably effective status were based upon behavioral or cognitive behavioral approaches.

The Task Force's (1995) criteria have been criticized as arbitrary and biased toward cognitive and behavioral therapies. Despite these criticisms and the fact that there are other effective treatments for psychological disorders in children not identified by the Task Force or other reviews based on these criteria, the limited number of effective treatments identified as well-established or probably efficacious

suggests that additional research is needed to assure that children with psychological disorders and their families receive effective treatment.

With the goal of expanding the number of empirically supported treatments for children, adult interventions with empirical support have been adapted for this population (e.g., selective serotonin reuptake inhibitors and cognitive therapy for anxiety and depression; Barrett, Duffy, Dadds, & Rapee, 2001; Keller et al., 2001; Rynn, Siqueland, & Rickels, 2001). Family psychoeducation and support interventions for adults with serious and persistent mental illness (SPMI) are considered an evidence-based best practice (Dixon et al., 2001; Lehman & Steinwachs, 1998). Since family psychoeducation is being successfully adapted to other psychiatric conditions with adults (e.g., McFarlane, 2002) and medical conditions in adults and adolescents (e.g., Satin, La Greca, Zigo, & Skyler, 1989; Steinglass, 1998), this empirically validated treatment for adults with SPMI would appear to have good potential for adaptation to child psychological disorders.

A variety of family psychoeducation models have been developed and investigated (Anderson, Reiss, & Hogarty, 1986; Dyck, Hendryx, Short, Voss, & McFarlane, 2002; Dyck et al., 2000; Falloon et al., 1985) in adults with SPMI. While many of these interventions share a general focus on education, problem-solving, and support, they also have many differences in structure and content. Multiple-family group treatment (MFGT) has been found to be one of the most promising treatments for adults with SPMI (McFarlane, 2002). Characteristics of MFGT (e.g., alliance between clinicians and parents, education, support, problem-solving skills for parents) make it a particularly promising intervention for children suffering from psychological disorders.

This review describes the MFGT model and its empirical support for adults with SPMI. Childhood treatment approaches similar to the adult MFGT model are then reviewed and evaluated with a focus on the quantity and quality of empirical investigations. The status of the child MFGT literature is also placed into the context of the adult MFGT literature and another empirically validated family treatment for children with psychological disorders, parent training. Finally, a strategy for improving the development and empirical validation of MFGT models in child populations is suggested.

Literature searches utilizing PsychInfo were conducted to identify empirical MFGT literature. Search terms included, but were not limited to, *multiple-family group psychoeducation* and similar terms describing this approach (e.g., *family psychoeducation, family education*), *mental illness* and specific psychological disorders (e.g., *schizophrenia, bipolar disorder, depression, anxiety*), as well as *adults, children, and adolescents*. The reference sections of articles obtained from the PsychInfo search were then reviewed for relevant articles. Authors were also contacted directly to obtain in-press articles and information about their current research projects. Only articles that investigated family psychoeducation and support interventions in a group format were reviewed.

## 2. Adult multiple-family group treatment

The current generation of MFGT was developed by McFarlane (2002) and is a synthesis of an earlier psychodynamic MFGT model for in-patients with schizophrenia (Laqueur, 1976) and first generation single family psychoeducation (SFP) approaches of Anderson et al. (1986) and Falloon et al. (1985). SFP interventions have demonstrated reductions in psychiatric symptoms and treatment utilization (e.g., Falloon et al., 1985; Hogarty et al., 1991) and in combination with MFGT are considered a best practice for persons with schizophrenia (Dixon et al., 2001; Lehman & Steinwachs, 1998). In *Multiple-Family*

*Groups in the Treatment of Severe Psychiatric Disorders*, McFarlane (2002) and others summarize in detail, the current MFGT model (see chapters 5–9 for a detailed description of the model).

McFarlane's approach of MFGT is a 2-year intervention with four phases (joining, psychoeducational workshop, relapse prevention, skill building) involving five to eight mentally ill persons, their families, and two clinicians. The joining phase involves initial meetings with each patient and family independently to formulate a therapeutic alliance with families and assess patient symptoms, relapse warning signs, and family dynamics. Phase 2 involves a 1-day psychoeducational workshop that all family members, except patients, attend. In the workshop, MFGT clinicians present information about the psychiatric disorder, relapse warning signs, psychiatric medications, and the MFGT family guidelines (i.e., principles for symptom management based on biological and behavioral research). Family guidelines then become the focus of the relapse prevention (Phase 3) and skill building (Phase 4) phases. For the first year of MFGT, the group meets for 90 minutes twice a month and focuses on using the family guidelines to solve a problem that is identified by a particular family. This family then attempts to implement the group's solution and reports on the success of the strategy in the next meeting. During this phase of the intervention, problem-solving is focused on preventing patient relapse and hospitalization. During the second year of the intervention, the group meets monthly and focuses on using group problem-solving to improve vocational and social skills.

Throughout the intervention, the principles of education, problem-solving, support, and case management are implemented as possible mechanisms of change (McFarlane, 2002). Education begins in a structured manner with the psychoeducational workshop and continues informally throughout the two problem-solving phases. Each problem-solving session involves socializing, in which group members are prohibited from talking about the illness; the "go around," in which each family shares illness-related information and clinicians assess each family's current situation; problem identification, in which the group collaboratively identifies a problem to solve; and problem-solving, in which the group attempts to generate and evaluate solutions for the identified family's problem and formulate a plan that the family attempts to implement before the next meeting. Through repeated problem-solving sessions, families learn how to implement this specific technique in their everyday lives. As a result of the group format of MFGT and integration of socialization periods in all sessions, patients and families discover that they are not alone in their experience of mental illness and are able to expand social networks. The increased social support that MFGT members receive is hypothesized to be one of the major factors behind the possible superiority of MFGT over SFP (McFarlane, 2002; McFarlane, Lukens et al., 1995). The structure of MFGT also allows for comprehensive case management. Because MFGT patients share the same psychiatrist and MFGT clinicians, communication among the patient, family, and clinicians is improved resulting in higher medication compliance, fewer side effects, and lower rates of relapse. Relatively frequent MFGT sessions also provide opportunities for assessment and relapse prevention.

While MFGT has a specified process, four phases (structure) and four putative mechanisms of change, the specific manner in which it is implemented varies across clinical populations. McFarlane's (2002) model has been modified and implemented as a treatment for adults with schizophrenia, bipolar, major depressive, obsessive–compulsive, borderline personality, and chronic medical disorders.

Three empirical studies conducted by two research groups have investigated the efficacy of MFGT as a treatment for adults with schizophrenia (Dyck et al., 2000, 2002; McFarlane, Link, Sushay, Marchal, & Crilly, 1995; McFarlane, Lukens et al., 1995). McFarlane, Link et al. (1995), McFarlane, Lukens et al. (1995) investigated the efficacy of MFGT in two separate randomized studies (Table 1), one comparing MFGT with SFP and family-dynamic, multiple-family group treatment (FDMFG; Laqueur, 1976) in the

Table 1  
The methodological qualities of adult MFGT studies

Authors	Group assignment	Comparison groups	Sample size/group	Treatment manual	Sample characteristics described	Outcome measures
McFarlane, Link et al. (1995)	Random	MFGT	16	McFarlane et al. (1991)	Detailed demographic and clinical information	Psychiatric relapse, not accounting for dropout status
		SFP	18	Anderson et al. (1986)		
		FDMFG	7	General description provided		
McFarlane, Lukens et al. (1995)	Random	MFGT	83	Provided on request	Detailed demographic and clinical information	Psychiatric relapse, positive and negative symptoms, hospitalizations, medication, compliance
		SFP	89	Anderson et al. (1986)		
Dyck et al. (2000)	Random	MFGT	32	McFarlane et al. (1991)	Detailed demographic and clinical information	Negative symptom ratings
Dyck et al. (2002)	Random	SC	31	N/A	Detailed demographic and clinical information	In-patient, out-patient, and crisis service utilization hours
		MFGT	55	McFarlane et al. (1991)		
Hazel et al. (2004)	Random	SC	51	N/A	Detailed demographic and clinical information	Caregiver distress, caregiver resources
		MFGT		McFarlane et al. (1991)		
		SC				

treatment of 41 persons with schizophrenia (McFarlane, Link et al., 1995) and another comparing MFGT with SFP among 172 persons with schizophrenia (Table 1). SFP and MFGT were psychoeducational approaches and similar in every way, except for their single- versus multiple-family formats. In both studies, McFarlane et al. found that relative to SFP, MFGT had an equal or superior positive impact on measures of symptom severity and recovery. McFarlane, Link et al., 1995 found that compared to SFP patients over 4 years, MFGT patients experienced significantly fewer relapses, 78% and 50%, respectively ( $\phi^2=.21$ ); however, when patient dropout status was taken into account, the difference between MFGT and SFP relapse was not significant. McFarlane, Lukens et al. (1995) found that 28% of MFGT patients and 42% of SFP patients had at least one relapse during treatment. When accounting for medication compliance this difference approached significance ( $P=.06$ , two-tailed,  $\phi^2=.06$ ). An interaction between psychiatric symptom severity and treatment group was also observed. For patients without positive symptoms at the beginning of treatment, relapse rates for MFGT and SFP were nearly

identical. However, among patients with high levels of positive symptoms at the beginning of treatment, MFGT demonstrated significantly lower rates of relapse relative to SFP ( $\omega^2=.04$ ). Across the entire sample, treatment condition had no effect on rates of psychiatric hospitalizations, negative symptoms, or positive symptoms. However, patients in both groups demonstrated significant reductions in hospitalizations over time ( $\omega^2=.04$ ) and were more likely to be employed at the end of the study than they were before treatment began ( $\omega^2=.08$ ).

Dyck et al., (2002, 2000), recently completed a community-based randomized trial comparing MFGT to a standard psychiatric care (SC) condition in 106 out-patients with schizophrenia (Table 1). This study was unique in that patients were enrolled during out-patient treatment, in contrast to the majority of previous studies that have initiated treatment during in-patient hospitalization. Two initial summaries provide further evidence of the efficacy of MFGT on negative symptoms (Dyck et al., 2000) and psychiatric utilization (Dyck et al., 2002). Controlling for pre-randomization negative symptom scores, Dyck et al. (2000) found that MFGT group members had significantly lower negative symptoms, at 1 year, relative to SC participants ( $\omega^2=.11$ ). Dyck et al. (2002) analyzed the relationship between MFGT group membership and in-patient, crisis, and out-patient service utilization in the entire study sample ( $n=106$ ) over the first year of the intervention. When compared with SC and accounting for pre-randomization in-patient hospitalizations, significantly fewer MFGT participants received in-patient services ( $\phi^2=.03$ ). They observed no significant differences in crisis services or out-patient services across groups. Further analyses of service utilization over the entire 2-year study period and a 1-year follow-up period suggested that, relative to the SC group, MFGT participants demonstrated significant reductions in both in- and out-patient service utilization (McDonell, Short, Hazel, Berry, & Dyck, in review). This research group also observed that caregivers who participated in MFGT had significantly lower levels of psychological distress, relative to SC caregivers (Hazel et al., 2004).

Other clinical trials utilizing a variety of MFGT models have been conducted in adults with SPMI (Leff et al., 1989; Muesser et al., 2001; Posner, Wilson, Kral, Lander, & McIlwraith, 1992; Schooler et al., 1997; Shimodera et al., 2000; Solomon, Draine, Mannion, & Melsel, 1996; Uehara, Kawashima, Goto, Tasaki, & Someya, 2001). Some of these studies lacked the methodological strengths of Dyck et al. (2002); Dyck et al. (2000) and McFarlane, Link et al. (1995), McFarlane, Lukens et al. (1995) and thus complicate direct comparison. Based upon this review, MFGT appears to marginally meet criteria for a well-established treatment and clearly meets the criteria as probably efficacious treatment according to the Task Force's (1995) criteria (Chambless & Hollon, 1998). Two randomized clinical trial studies (Dyck et al., 2002; Dyck et al., 2000; Hazel et al., 2004; McFarlane, Lukens et al., 1995) conducted by two groups of relatively independent investigators utilized the same MFGT model in the treatment of adults with schizophrenia, and found small to medium positive therapeutic effects (Cohen & Cohen, 1983) of the intervention (Table 1). MFGT appears to only marginally meet the Task Force criteria for a well-established treatment because the two investigative groups did overlap and effect sizes tended to be modest (Dyck et al., 2002; McFarlane, Lukens et al., 1995). It is also important to note that no empirical investigations have demonstrated unequivocal support for the possible mechanisms of change listed above.

### 3. Child multiple-family group treatment approaches

Before child MFGT models can be evaluated, it is important to place MFGT in the larger context of family psychoeducation interventions in child clinical psychology. Approaches similar to MFGT have

a long history in child clinical populations. However, MFGT differs in important ways from other interventions. For example, behavioral parent training, a well-established treatment for children with oppositional defiant and conduct disorder (Brestan & Eyberg, 1998), appears similar to MFGT because it is a family psychoeducation intervention delivered in a group format. However, behavioral parent training involves only one (psychoeducation) of the three key content components of MFGT, and its structure is very different from the four phases of McFarlane's (2002) MFGT model. In addition, parent training relies on behavioral theory and behavior modification as methods for behavioral change. Other child and family interventions, such as functional family therapy and multisystemic therapy, also share similarities with MFGT, but are fundamentally different from MFGT in their structure and technique.

While empirical investigations of adult MFGT focus on persons with schizophrenia and their families, studies of MFGT in children focus on internalizing (e.g., depression, eating disorders), externalizing (e.g., ADHD, ODD (oppositional defiant disorder)), psychotic (e.g., schizophrenia), and cognitive (e.g., MR (mental retardation)) disorders. A total of 11 empirical investigations were found via literature review and direct author contacts. In addition, information regarding Schepp, O'Connor, Kennedy, and Tsai (2003) treatment program for children with first break psychotic disorders was obtained via direct contact. All of these studies investigated interventions that utilized a multiple group format and emphasized psychoeducation, problem-solving, and/or social support. Each model was compared with McFarlane's model of MFGT to examine the content, structure, and duration of these models. Each study was also examined according to Task Force's (1995) criteria to assess the empirical evidence for MFGT as a treatment for child psychological disorders (Chambless & Hollon, 1998).

#### **4. Multiple-family group treatment in children with internalizing disorders**

Two groups of researchers have investigated MFGT in the treatment of children with mood disorders (Fristad, Gavazzi, & Mackinaw-Koons, 2003a; Fristad, Gavazzi, & Soldano, 1998; Fristad, Goldberg-Arnold, & Gavazzi, 2002, in review; Goldberg-Arnold, Fristad, & Gavazzi, 1999) and anorexia nervosa (Geist, Heinmaa, Stephens, Davis, & Katzman, 2000).

In the first of four empirical investigations, Fristad et al. (1998) describe in detail a weekly, six-session, manualized multiple-family psychoeducation group (MFPG) intervention for out-patient children suffering from mood disorders. As described by Fristad et al. (1998) MFPG relies heavily on a psychoeducation approach. Each group meeting began and ended with both children and their parents present to discuss general issues. Parents, children, and adolescents each split into their own separate groups for the majority of sessions. Information was then presented in a developmentally appropriate manner to all three groups. The first three parent sessions focused on information about symptoms, treatments, and the interpersonal/family consequences of depression. The final three parent sessions focused on answering specific questions parents had about the content described in the first three sessions, as well as an overall summary in session six. Child sessions focused on three goals: normalizing the experience of depression, education about illness symptoms and treatments, and improving social skills. Adolescent sessions focused on normalization and adolescents were allowed to discuss topics related to their experience suffering from a mood disorder. Fristad et al. report that adolescents often chose to discuss topics such as drug/alcohol use, self-concepts, self-harm, and school performance.

Table 2  
Methodological qualities of child MFGT studies

Authors	Study design	Groups	Sample size/group	Treatment manual	Population age and diagnoses	Sample characteristics described
<i>Internalizing disorders</i>						
Fristad et al. (1998)	One group pre–post-intervention	MFGP	9 families	Described in detail	3 children, 6 adolescents suffering from mood disorders and their parents	No detailed description
Goldberg-Arnold et al. (1999)	One group posttest	MFGP	35	Detailed description and Fristad et al. (1998)	8- to 11-year-olds with specified mood disorders	Detailed child and family demographics, child diagnosis
Fristad et al. (2002)	One group pre–post-intervention	MFGP	35	Fristad et al. (1998, 1996)	8- to 11-year olds with bipolar ( $n = 16$ ) and depressive ( $n = 19$ ) disorders.	Detailed description of child and family demographics and child clinical status
Fristad et al. 2003b	Between group random assignment	MFGP	18	Fristad et al. (1998, 1996)	8- to 11-year old mood disorder children and families	Detailed description of child and family demographics and child clinical status
Geist et al. (2000)	Between-group random assignment	Wait list control	17	Described	12- to 17.4-year-old females with anorexia nervosa and their families	Detailed demographic and clinical descriptions of adolescents
		FGP	13	Described		
		FT	12	Described		
<i>Externalizing difficulties</i>						
Stone et al. (1996)	Pre–post-intervention	MFGT	22	McKay et al. (1995) and Tolan et al. (1993)	Mean age = 10 years, aggressive or inattentive behaviors	Detailed demographics on children and mothers

McKay et al. (1999)	Between groups, not random assignment	MFGT	34	McKay et al. (1995) and Tolan et al. (1993)	Mean age = 10 years, externalizing disorders	Detailed demographics on children
McKay et al. (2002)	Between groups, not random assignment	MFGT  Individual therapy Family therapy	138, not broken down by group	McKay et al. (1995) Tolan et al. (1993) N/A N/A	Mean age = 9.3 years, externalizing disorders	Detailed demographics on children
<i>Psychotic disorders</i>						
Schepp et al. (2003)	Between group, random assignment	Standard care MFGT  Standard care	Not broken down by group	Treatment manual available from the first author N/A	15- to 19-year olds with schizophrenia	No detailed demographic information published
<i>Mental retardation</i>						
Parker et al. (1987)	Pre-post-intervention	MFGT	3	None	16, 20, and 24 years of age with a diagnosis of MR	Only age of all participants
Russell et al. (1999)	Between group, random assignment	IGP  Didactic psychoeducation	29  28	Some description  Some description	Mean age of 6.4 years with a diagnosis of MR	Detailed demographic information on both children and parents

After describing MFPG, [Fristad et al. \(1998\)](#) presented initial data on nine families who participated in the intervention ([Table 2](#)). Parental expressed emotion was measured before the intervention, immediately after its completion, and at 4 months after it was completed. In addition, group members' satisfaction was assessed at the completion of the intervention. Parents reported acting significantly more positively and less negatively toward their children with a mood disorder immediately after completion of MFPG. They also rated their children's behavior as more positive and less negative after the intervention. Significant improvements were observed on all eight subscales of the standardized measure of expressed emotion. At the 4-month follow-up, significant improvements were observed on only four of the eight subscales. Child and parent satisfaction was positive. This study provides a description of MFPG and initial evidence supporting improved family functioning and participant satisfaction. However, this study's small sample size, lack of control or comparison group, and inadequate description of participants prevent a clear analysis of its applicability across patients.

In 1999 [Goldberg-Arnold et al.](#) reported a second investigation of MFPG and measured its effects on parents of 35 children with mood disorders ([Table 2](#)). The intervention used in this study was based on [Fristad et al. \(1998\)](#). However, parent sessions 4 and 5 were modified to address communication skills and problem-solving around symptom management, respectively. Study inclusions required that the child be 8–11 years old, diagnosed with a mood disorder, and have a parent willing to participate in the study. Families were then randomly assigned to MFPG or a 6-month wait list control condition. Participants in both conditions received care as usual. While this study incorporated a wait list control group, data gathered during the wait list period was not used to make between- or within-group comparisons. Open-ended questions were used to measure parent knowledge, coping skills, perceived social support, and attitudes at the end of the intervention and 3–4 months later. The authors hypothesized that parents would report that the MFPG increased their knowledge, coping skills, social support, and positive attitude.

Descriptive support was provided for these hypotheses. Increased knowledge was the most frequent improvement reported by parents. However, 3–4 months after the intervention was completed, parents most frequently reported positive attitude change toward their child with a mood disorder. Significantly more parents reported a positive attitude change at follow-up, when compared the initial post-intervention assessment. Therefore, parent attitudes may not change initially, but may demonstrate significant improvements after a longer period. While the results of this study suggest a positive effect of MFPG on family outcomes, no outcomes that could be compared between or within groups were examined. In addition, outcome measures were not standardized, the sample size was small, and no child outcomes were examined.

[Fristad et al. \(2002\)](#) summarize initial results from a recent clinical trial of MFPG in 35 children suffering from bipolar ( $n=16$ ) and depressive disorders ( $n=19$ ) and their family members ([Table 2](#)). This investigation examined the appropriateness of combining children aged 8–11 years with depressive and bipolar disorders into MFPG, as described by [Fristad et al. \(1998, 1996\)](#). Results indicated that before treatment began, bipolar children exhibited greater severity of mood disorder symptoms, as well as higher treatment utilization than children who suffered from depressive disorders. In addition, parents of bipolar children exhibited significantly higher rates of knowledge about their children's illness, relative to parents of children suffering from unipolar depression. Despite these differences prior to treatment, both groups appeared to benefit from MFPG. Although parents of children with depressive disorders had lower knowledge about mood disorders, relative to bipolar children's parents, prior to treatment; after completion of MFPG parents of both groups displayed equal knowledge of mood

disorders. Pre- and post-intervention comparisons within subjects were not conducted, but qualitative data gathered after the intervention suggested that the intervention has a positive impact on caregivers (e.g., increased knowledge, coping skills, and support).

Fristad et al. (2003b) summarize treatment efficacy data from their study in 2002. Children suffering from mood disorders and their families were assigned to treatment as usual (TAU) and MFPG or a wait list TAU condition. Inclusion criteria were a DSM-IV diagnosis of mood disorder and an IQ greater than 69. All children suffered from at least one comorbid psychiatric disorder. Fristad hypothesized that relative to the TAU group, MFPG participants would experience a reduction in parent expressed emotion, as well as increases in social support, parent knowledge about mood disorders, and increased access to mental health services, utilizing standardized measures, at 3 weeks and 3 months post-randomization. Results of this investigation supported the efficacy of MFPG. Relative to the TAU group, parents of mood-disordered children demonstrated increases in illness-related knowledge, social support, as well as increased numbers of MFPG parents being rated positively on a measure of expressed emotion. Excluding the nine families who were receiving adequate services at randomization, MFPG participants were significantly more likely to experience increased access to service utilization. Taken together, the work of Fristad et al. provides initial evidence that MFPG is an appropriate and efficacious intervention for children suffering from mood disorders. Fristad et al. provide the strongest empirical evidence for MFPG, but, the study lacks standardized measures of symptom severity and an adequate sample size to allow for accurate and reliable group comparisons. Currently, Fristad et al. are attempting to replicate their model in 165 children aged 8–11 with mood disorders. Results of this large randomized study will provide valuable information about the efficacy of MFPG as a treatment for children with mood disorders.

Geist et al. (2000) examined the efficacy of single family therapy (FT) and family group psycho-education (FGP) in the treatment of 25 in-patient adolescent girls with anorexia nervosa. Families assigned to the FT condition received eight sessions over 4 months. The main objectives of this intervention were to encourage participants to take an active role in their treatment, increase patient weight, and increase the openness of family communication. FGP was also administered in eight sessions across 4 months. FGP's goals were to increase patient and family understanding of eating disorders, as well as to provide a setting for the discussion how families can implement change. Each meeting lasted 90 minutes, with 45 minutes of education and 45 minutes of discussion. Parents and adolescents had separate discussion groups and all sessions were lead by relevant healthcare professionals (e.g., dieticians, psychiatric nurses). While brief descriptions of FT and FGP were provided, treatment manuals were not referenced. Participants were also allowed standard medical and psychosocial treatments. Inclusion criteria included female gender, age 12–17.4 years, and weight less than 90% of ideal body weight. Standardized assessments of height, body weight, ideal body weight, symptoms, and family functioning were administered before and after the interventions. Geist et al. provided descriptive analyses of each group. The authors hypothesized a positive therapeutic effect for both interventions over time.

Results included significant weight gain and acknowledgement of family dysfunction in adolescents participating in the study. No significant between-group or group by time effects were observed. The authors argue that given the similar positive effects of FT and FGP, the lower cost of FGP makes this intervention particularly promising. While the small sample size and lack of a control group may limit the generalizability of this study's findings, the use of a between-group design and standardized patient outcomes provide confidence in this study's results.

## 5. Multiple-family group treatment in children with externalizing disorders

Three studies assessing the efficacy of MFGT in children with externalizing disorders have been conducted (McKay, Gonzales, Quintana, Kim, & Abdul-Adil, 1999, MacKay, Harrison, Gonzalas, Kim, Quintana, 2002; Stone, McKay, & Stoops, 1996). These three studies were conducted on separate samples by the same investigative team and were based upon an MFGT model described by McKay, Gonzales, Stone, Ryland, and Kohner (1995) and Tolan, Florsheim, McKay, and Kohner (1993). In this model of MFGT, four to five families met for 90-minute weekly for 8 weeks. Each meeting had five components. Sessions began by providing updates about their experiences since the last meeting. Two group facilitators then presented 30 minutes of didactic information. Groups concluded after spending the remainder of the meeting discussing the presented topic, practicing family exercises, and assigning homework. Each session focused on at least one of the core concepts of rules, consequences and rewards, roles and responsibilities, respectful communication, and family relationships (McKay et al., 1995).

In the first of three investigations of this model, Stone et al. (1996) assessed the efficacy of MFGT in the treatment of 22 families of children with aggressive or inattentive behaviors. Standardized parent ratings of child behavior were collected prior to and at the completion of the intervention. Before the intervention, half of the identified children had clinically significant difficulties. Stone et al. hypothesized reductions in patient symptoms after exposure to the treatment.

Children demonstrated significant decreases on the hyperactive, impulsive, and difficulties learning domains of the Conners' Rating Scale after participating in MFGT. Similar to other child MFGT investigations, this study's small sample size, lack of a control or comparison group, and use of only one outcome measure limited its internal and external validity. In addition, when a Bonferroni correction was conducted to control for Type I error, none of the reductions reported by Stone et al. were significant. Stone et al. suggested that their study was exploratory and that they provided initial support for the ability of MFGT to improve children's symptoms as measured by a standardized measure.

In an effort to replicate the findings of Stone et al. (1996), McKay et al. (1999) investigated MFGT in a sample of 88 children with disruptive behavioral problems assigned to MFGT or individual therapy. It is important to note that the treatment model described above was doubled in frequency resulting in 16 weekly meetings. Participants were assigned to groups based on availability. Participants were demographically similar to Stone et al. and groups did not differ in demographics or diagnoses. Child symptoms were measured using standardized parent ratings and parent experiences were measured using open-ended questions and coded by two separate raters. Dropout rates, child symptoms, and parent experiences were compared across groups.

After 16 weeks, 59% of MFGT children were still receiving mental health services, compared with 39% of those in the individual therapy condition. Child symptoms were then compared across group members who attended at least 16 treatment sessions. MFGT was associated with reductions in child symptoms (e.g., conduct problems, impulsivity, learning problems, hyperactivity) over time when compared with children in individual therapy. Parents also found MFGT to be a beneficial experience. Seventy percent reported improvements in their child's behavior, while 54% of parents in the comparison condition reported improvements. The size of the sample studied and inclusion of a comparison group represent a significant improvement over Stone et al. (1996). However, this study did not randomly assign children to groups.

In a recent study, McKay et al. (2002) investigated the efficacy of MFGT in 138 children referred because of disruptive behavioral disorders. Participants were assigned to MFGT until groups were full.

Subsequent referrals were assigned to family or individual therapy. McKay et al. (2002) hypothesized that relative to the family and individual therapy comparison groups, MFGT participants would demonstrate significantly higher treatment attendance. Significant support was observed for this hypothesis, with MFGT participants attending an average of 7 (S.D. = 3.3) of the 16 treatment session compared with 4 (S.D. = 3.2) and 3.1 (S.D. = 2.7) for group and individual therapies, respectively. The authors suggest that among this sample of ethnically diverse, urban children suffering from behavioral disorders, MFGT may offer a treatment approach that is more acceptable to culturally diverse and economically disadvantaged families, relative to traditional treatment approaches. Despite the initial evidence for the efficacy of McKay and colleagues' model of MFGT (McKay et al., 1999, 2002; Stone et al., 1996), further research, utilizing the combination of adequate sample sizes and standardized measures of treatment outcomes, is needed to provide accurate and reliable estimates of this treatment model.

## **6. Multiple-family group treatment in children with psychotic disorders**

Although MFGT has received empirical support as a treatment for adults with psychotic disorder, only one group of investigators, Schepp et al. (2003), have investigated an MFGT approach in adolescents with psychotic disorders. Schepp et al. at the University of Washington, School of Nursing recently completed a randomized clinical trial of 144 adolescents (14–19 years old) suffering from schizophrenia. These children and their families were randomized to either a standard psychiatric care condition or a family-centered community-based self-management group, as well as standard psychiatric care. This model of MFGT includes 12 two-hour sessions over 8 months. The first six sessions of the intervention are administered weekly, followed by six monthly booster sessions. Sessions focus on a variety of topics designed to teach families to effectively manage the illness, including stress and its relationship to symptoms, relaxation training, emotional awareness, thought awareness, problems solving, and social skills. For the first hour of each session, children with schizophrenia, as well as their parents and younger siblings (10–18 years old), all meet together to learn and practice information relevant to that session. During the second hour of each session, these respective groups meet separately to further learn and practice these skills in a developmentally appropriate manner. Standardized patient, sibling, and parent outcome measures were collected at randomization, and again at 6 weeks, 6 months, and 12 months post-randomization. While this clinical trial was only recently completed, and results have yet to be published, the initial data suggest that this intervention is well tolerated by patients and family members and has demonstrated increased awareness of psychiatric symptoms among adolescents with schizophrenia and their parents (Schepp et al., 2003).

## **7. Multiple-family group treatment in children with mental retardation**

The literature review yielded two studies examining MFGT's effects on children with MR and their families (Parker, Hill, & Miller, 1987; Russell, John, & Lakshmanan, 1999). Parker et al. investigated the efficacy of MFGT in three adolescents aged 16, 20, and 24 years diagnosed with MR and their families. The authors sought to develop an MFGT model that would aid in emancipation of MR adolescents from their families. Groups lasted 90 minutes and were conducted every other week for 6 months. At least one parent and the identified MR adolescent was required to attend. However, each patient's entire family

was invited to participate. No specific information about the MFGT model was given except that it was developed to aid in emancipation and that it was based upon the work of Laqueur (1976). Participants rated their self-esteem and regard for all other family members before and after MFGT participation.

MR individuals and their brothers experienced increased self-esteem after the intervention. However, mothers, fathers, and sisters reported lower self-esteem after the intervention. After participating in MFGT, each family member rated their MR relatives, brothers, and parents more positively than before the interventions. However, ratings of sisters were more negative after the intervention. Parker et al. (1987) suggest that decreases in ratings of sisters of MR individuals were likely a result of sisters being held in very high regard by themselves and their family members before the intervention. The authors state that these results provide support for MFGT's ability to aid families of MR adolescents who are in the process of becoming young adults. The weaknesses of this study include extremely small sample size, no comparison group, no treatment manual or description, and the inclusion of only one outcome measure. Further, outcomes were described using group averages despite the fact that this study investigated only three families. In addition, the intervention used appeared to be psychodynamic and based upon the first generation MFGT model described by Laqueur (1976), making comparisons with other psychoeducation and support MFGT models difficult.

More recently, Russell et al. (1999) conducted a randomized clinical investigation of interactive group psychoeducation (IGP) and didactic group psychoeducation in the treatment of 57 children with MR and their families living in India. This study was designed to assess the relative influence of psychoeducation versus psychoeducation delivered in a discussion and problem-solving format (IGP) on family functioning. Both interventions were attended by only family members of children with MR. IGP sessions were conducted twice a week for 10 weeks. Topics related to causes, symptoms, caregiving, and socialization of MR children were covered through didactic, discussion, and problem-solving techniques. In the didactic group, psychoeducation condition participants received an equal number of sessions over 10 weeks; however, information was provided in a didactic fashion only. A standardized measure of participants' attitude toward their child with MR was administered before and after treatment was delivered.

Relative to the didactic psychoeducation condition, the IGP group experienced significantly greater improvements on all but one subscale of the outcome measure (attitude toward intellectual disability subscale). When group differences were examined separately in parents of children with mild and moderate MR, significant differences were only observed in the mild group. The authors suggested that this was a result of the small number of moderately MR children in this study ( $n = 12$ ). Further, Russell et al. (1999) postulate that the significant improvements observed in IGP, relative to didactic psychoeducation only, were likely a result of the its discussion and problem-solving components of the intervention. This study's strengths included a relatively large sample, random assignment to groups, adequate description of the sample, and a standardized outcome measure. The weaknesses of this study were the lack of treatment manuals and the lack of patient outcome measures. The fact that this study was conducted in India limits its generalizability to western populations.

## 8. Summary and evaluation of child multiple-family group treatment research

Overall, 11 studies utilized a variety of research designs to investigate six similar MFGT models in children with psychological disorders. This relatively limited amount of empirical investigation was

surprising given the abundance of family treatments for children with psychological disorders and the evidence for MFGT in adult populations. However, the recent growth in the adult and child literatures suggests that MFGT is a current area of development and investigation (e.g., the current work of Dyck et al., Fristad et al., and Schepp et al.).

The variety of MFGT models investigated also makes evaluation of the literature as a whole difficult. In addition, five of the studies reviewed did not provide a treatment manual and three did not provide an adequate description of the MFGT model used. Studies that provided descriptions or references to treatment manuals varied widely in their content and structure. Two models focused primarily on psychoeducation (Fristad et al., 1998; Goldberg-Arnold et al., 1999; Schepp et al., 2003), one focused primarily on discussion (Parker et al., 1987) and three models focused on both psychoeducation and discussion (Geist et al., 2000; McKay et al., 1999; Russell et al., 1999; Stone et al., 1996). Therefore, similar to McFarlane's MFGT model, the majority of MFGT models designed for children integrated psychoeducation. However, contrary to McFarlane's MFGT model and SFP approaches for adults, only three child MFGT models explicitly utilized problem-solving techniques (Fristad et al., 1998, 2002, 2003a, 2003b; Russell et al., 1999; Schepp et al., 2003). Further, none of the interventions reviewed integrated specific techniques, such as socialization, to increase social support among children and/or caregivers. Nor did these models explicitly integrate case management as a mechanism of change.

Other differences across MFGT models were apparent. One model included only parent groups (Russell et al., 1999), three included separate groups for parents and children (Fristad et al., 1998, 2002, 2003b, 2003a; Geist et al., 2000; Goldberg-Arnold et al., 1999) and two models had groups that included both parents and children (McKay et al., 1999; Parker et al., 1987; Stone et al., 1996). Contrary to other treatment approaches, Schepp et al. placed equal emphasis on breakout and joint groups. The MFGT models reviewed also varied in duration from 6 weeks (Fristad et al., 1998) to 8 months (Schepp et al., 2003) and were brief relative to McFarlane's model. Despite their relative brevity, both of these models focused on treating chronic mental illnesses, such as bipolar disorder (Fristad et al., 1998) and schizophrenia (Schepp et al., 2003). While these interventions likely provide important psychoeducational and problem-solving skills to participants, their relatively brief duration may limit facilitation of significant social bonds between group members and/or clinicians, as well as long-term case management.

Empirically, the child MFGT models reviewed also lacked replication. Only two groups attempted to replicate their respective MFGT model in two separate, but similar, clinical samples (Fristad et al., 1998; Goldberg-Arnold et al., 1999; McKay et al., 1999; Stone et al., 1996). However, modifications to each model were made between investigations (e.g., doubling the number of sessions, McKay et al., 1995, 1999, 2002; Stone et al., 1996). Therefore, these second investigations by the same research groups may not represent replications of the same treatment. The lack of replication among the child MFGT literature suggests that these researchers' efforts are in the early stages of development, relative to the adult literature and other empirically supported treatments for children with psychological disorders.

The child MFGT literature lacks methodological rigor (Table 2). Only three published investigations compared their MFGT model to a comparison treatment (Geist et al., 2000; McKay et al., 1999; Russell et al., 1999) and only two utilized TAU comparison groups (Fristad et al., 2003b; McKay et al., 2002). All of these between-group studies, except for McKay et al. (1999) and McKay et al. (2002), used random assignment to group and only McKay et al. (1999) and Russell et al. (1999) had group sizes that would be considered as adequate by the Task Force's (1995) criteria.

Of the outcome studies that utilized a single group design, three of the four investigations used a pre–post-intervention design (Goldberg-Arnold et al., 1999, utilized only a posttest design). Two of these studies had less than 10 participants (Fristad et al., 1998; Parker et al., 1987), decreasing the probability of detecting changes over time. Therefore, among pre–post-intervention investigations reviewed, only Stone et al. (1996) utilized a methodological design and an adequate sample size to assure that within group changes could be observed.

Across the 10 within- and between-group investigations reviewed, two lacked standardized measures of any kind (Goldberg-Arnold et al., 1999; Parker et al., 1987), two lacked measures of child outcomes (Goldberg-Arnold et al., 1999; Russell et al., 1999), and two lacked adequate descriptions of participants (Fristad et al., 1998; Parker et al., 1987). Therefore, 4 of these 10 published studies included standardized measures of child symptoms and provided adequate descriptions of their participants (Fristad et al., 2003b; Geist et al., 2000; McKay et al., 1999; Stone et al., 1996).

If the overall methodological quality of each of the completed studies reviewed is examined, no study meets the Task Force's (1995) criteria of a "good" study. Fristad et al. (2003b), Geist et al. (2000), McKay et al. (1999), Russell et al. (1999) and Stone et al. (1996), come closest to meeting these criteria. However, McKay et al. did not use random assignment, Stone et al. did not investigate a control or comparison group, Russell et al. did not assess child outcomes, and the group membership of Fristad et al. (2003b) and Giest et al. was not large enough to detect group differences (Table 2). In addition, neither Russell et al. (1999) nor Giest et al. utilized a treatment manual.

Despite the variety of treatment models investigated and the methodological weaknesses of the child MFGT literature, all outcome investigations reviewed provided initial evidence that MFGT may positively impact children suffering from internalizing disorders, externalizing disorders, and MR and their families (Fristad et al., 1998, 2002; Fristad et al., 2003b; Geist et al., 2000; Goldberg-Arnold et al., 1999; McKay et al., 1999, 2002; Parker et al., 1987; Russell et al., 1999; Stone et al., 1996). Three between group studies comparing MFGT to other interventions (i.e., individual and family psychotherapy, didactic psychoeducation) found that MFGT had superior influence on dropout rates, patient symptoms, parent satisfaction with psychiatric services (McKay et al., 1999, 2002), and attitudes of parents toward their mentally ill children (Russell et al., 1999). In addition, Geist et al. found that MFGT had a positive affect on weight gain and family functioning in adolescent girls with anorexia nervosa, relative to a family therapy condition.

## 9. Comparing child and adult literatures

The empirical support for adult and child literatures do not differ in quantity with 11 and 10 published investigations, respectively, although both literatures are small when compared with other main stream therapies (e.g., behavioral parent training; Brestan & Eyberg, 1998). While equal in quantity, the adult and child literature differ significantly in quality. Relative to the child literature, the adult literature has demonstrated a focus on empirical validation through randomized clinical trials of a specific model of MFGT in one clinical population (i.e., adults with schizophrenia), as exemplified by Dyck et al. (2002), Dyck et al. (2000), Hazel et al. (2004), McFarlane, Link et al. (1995) and McFarlane, Lukens et al. (1995). These two investigative groups represent a coordinated effort to establish clear empirical support for the efficacy of MFGT as a treatment for adults with schizophrenia. They allow for comparison across studies and marginally satisfy the Task Force's (1995) criteria for

well-established treatments. In contrast, the child literature is characterized by various treatment models, few treatment manuals, heterogeneous populations, and limited replication of the same model using between-group studies. The child MFGT models reviewed appeared to be developed in relative isolation, suggesting a lack of formal systematic collaborative efforts with each other and adult MFGT researchers.

## 10. Recommendations

Qualities of the adult MFGT and other empirically supported interventions for children with psychological disorders (e.g., behavioral parent training) provide insight into how child MFGT studies may be improved. The parent training literature (Brestan & Eyberg, 1998) and studies by Dyck et al. (2002), Dyck et al. (2000) and McFarlane, Link et al. (1995), McFarlane, Lukens et al. (1995) demonstrate an approach by which interventions are designed and tested in a structured and comprehensive fashion. Indeed, this approach has led to the development of a large body of literature supporting behavioral parent training as an effective treatment for children with oppositional and conduct disorders, as well as empirical support of MFGT in adults with schizophrenia.

Generally speaking, a systematic focus may be the key to empirical validation. Rather than studying a variety of MFGT models across an assortment of developmental and clinical populations, investigators need to focus on repeated quality investigations on a limited number of MFGT models in a specific developmental and/or clinical population. If these investigations support the efficacy of MFGT in this specific population, then this model may be modified and investigated in other populations. This is not to say that researchers currently studying MFGT in children should stop adapting their interventions to different disorders; rather, they may want to consider collaboration and communication with one another and current adult MFGT researchers in an attempt to develop a more systematic body of child MFGT evidence.

Specifically, efforts to validate MFGT as an effective treatment for children may best be focused on chronic and severe psychological disorders, such as schizophrenia, bipolar disorder, autism, MR, and obsessive–compulsive disorder. Relative to other clinical populations, these groups lack empirically validated treatments and are similar to the population for which MFGT was originally designed. Children suffering from depressive and generalized anxiety disorders may also benefit from MFGT model development and efficacy investigations because of the lack of empirically supported treatments for these populations. Children with externalizing disorders and specific forms of anxiety may also benefit from MFGT; however, the presence of other empirically supported treatments in these populations (Brestan & Eyberg, 1998; Ollendick & King, 1998; Pelham et al., 1998) lowers the need to develop and test MFGT as an effective intervention for these children.

## 11. Conclusions

MFGT, as described by McFarlane (2002) has received empirical support in the treatment of adults with schizophrenia. Further, the intervention has been found to be adaptable to other psychiatric and medical conditions with adults (McFarlane, 2002), and there is some evidence of effective adaptation to adolescents with medical disorders, such as diabetes (Satin et al., 1989). With developmental and clinical

modifications to this manualized and empirically supported treatment, adaptations of this MFGT model to children could prove to be highly efficacious, effective, and cost effective.

MFGT is particularly applicable to the treatment of children with psychological disorders because it incorporates the entire family system. The transactional and multisystemic nature of childhood mental illness suggests that family system interventions may be more efficacious than treatments of the mentally ill child alone. MFGT provides education, support, problem-solving skills, and case management to the entire family allowing for greater generalization outside the treatment session. MFGT also engages the parents as collaborators and partners in the treatment process. This is particularly important in treating children whose psychological difficulties may impact their cognitive and adaptive functioning (e.g., MR, childhood onset schizophrenia) limiting the efficacy of individual psychotherapy. Further, family treatments, such as parent training, have received well-established empirical support in children with psychological disorders (Brestan & Eyberg, 1998). Finally, although the focus of MFGT is the management of psychopathology in the identified patient (child or adult), there is evidence that MFGT also positively impacts the psychological health of caregivers (Fristad et al., 2003b; Hazel et al., 2004).

The group format of MFGT offers certain advantages over traditional individual family approaches. The group structure of MFGT and the explicit integration of social support in McFarlane's and other MFGT models allows parents to expand their social networks. These characteristics result in an intervention that may be more engaging to children and their families than traditional psychotherapies. McKay et al. (1999, 2002) suggest that as a result of its collaborative group format, MFGT may have a particularly well suited for clinically challenging and ethnically diverse populations who may have had negative experiences with, or a lack of trust for, traditional family therapy, and the mental health system in general.

Economically, the group format of MFGT is cost effective, allowing treatment of five to eight families at once. In the world of managed care, the cost effectiveness of MFGT, relative to other treatments, is a very important strength. MFGT may be most cost-effective and have the greatest impact when delivered as ancillary treatment (e.g., bipolar disorder) or a treatment for childhood disorder for which individual treatment may be unwarranted or extremely expensive (e.g., long-term treatment of children with MR). In the latter situation, MFGT allows for the delivery of psychoeducation and behavior management constructs, while providing the social support, problem-solving, and case management in a group format, saving the cost of providing such services on an individual basis. Among chronic conditions, an effective, multicomponent family treatment, such as MFGT, may provide long-term economic savings over the course of the affected individual's lifetime.

Finally, the flexibility of MFGT allows for modification and application to a variety of child populations. Therefore, while MFGT's flexibility is not unconstrained (it has a defined structure and content), it can be modified and used as a treatment for a variety of clinical populations. Certainly, the application of McFarlane's (2002) MFGT model to child and adolescent populations would require modification to account for developmental issues. The MFGT model described by Fristad et al. (1998) provides an example of how developmental modifications could be made. This model includes breakout groups for children so that psychoeducation can be presented in a developmentally appropriate manner. Other developmental modifications might include briefer sessions for younger or cognitively impaired children, greater peer interaction for adolescents, role playing the problem-solving approach and other skills in MFGT sessions, and the inclusion of siblings in multiple-family groups. Other modifications can be made to increase the efficacy of the intervention with specific populations. For instance, an MFGT model designed for high functioning adolescents suffering from depression and their families may be

short in duration (less than a year) and focus on psychoeducation, problem-solving, and social support, rather than intensive case management; whereas an MFGT intervention for children with chronic mental health conditions, such as MR or autism, may involve only parents, and resemble the MFGT model used in the treatment of adults with SPMI (e.g., long duration of the intervention, focus on psychoeducation, problem-solving, social support, and intensive case management).

The flexibility of MFGT also allows for the integration with other empirically validated therapeutic techniques. For instance, an MFGT intervention for depressed children could include both cognitive behavioral and/or interpersonal theories and techniques in the psychoeducation and problem-solving phases of the intervention. Therefore, both the identified children and their parents could learn cognitive behavioral and interpersonal techniques in a group format allowing for greater generalization of therapeutic effect and delivery of these therapies in an inexpensive manner. There is precedence for this type of integration with adults. McFarlane's MFGT model was integrated with assertive community treatment to create a model called family-Aided assertive community treatment (McFarlane et al., 2000). This combined intervention, produced superior employment outcomes among high-risk persons with severe mental disorders, relative to assertive community treatment alone (McFarlane et al., 2000).

These qualities suggest that MFGT may be an efficacious treatment for children with psychological disorders and their families. However, MFGT has failed to attain substantial empirical support as a result of the limited quantity and quality of treatment investigations. The adult MFGT and behavioral parent training literatures suggest a focused scientific approach for attaining empirical support for MFGT in children. While current investigations may provide initial empirical support for MFGT, additional empirical studies conducted in a collaborative and systematic fashion are required in order to determine the efficacy of this promising family, psycho-education and support intervention.

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