

THE ESSENTIAL ELEMENTS OF MULTI-FAMILY
GROUP THERAPY: A DELPHI STUDY

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ABSTRACT

The purpose of this Delphi study was to explore and identify a panel of experts' opinions of essential elements for successful multi-family group therapy (MFGT) and to propose the identified elements as guidelines for future MFGT theoretical and program development. Multi-family group therapy continues to be implemented while there is little empirical research to support how it is effective and with what populations and presenting problems it is best employed. A panel of MFGT experts identified 35 essential elements for successful MFGT. Many of the identified elements coincided with elements identified in the relevant literature. However, elements specific to MFGT were distinguished. The essential elements are presented as guidelines for MFGT theoretical and program development. The implications of this study for theory, research, and practice are discussed.

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TABLE OF CONTENTS

	Page
LIST OF TABLES	iv
I. INTRODUCTION AND STATEMENT OF PROBLEM	1
Purpose of Study	3
II. REVIEW OF THE LITERATURE	4
III. METHODOLOGY	20
Selection of Panel Experts	21
Procedure	21
Development of Questionnaire I	22
Development of Questionnaire II	23
Analysis of Questionnaire II	25
IV. RESULTS	27
Expert Panel	27
Variables Identified by the Expert Panel	32
V. DISCUSSION	38
Correspondence of Results with the Relevant Literature	38
Implications for Theory	42
Therapeutic setting	43
Therapist characteristics	43
MFGT interactions	44
Implications for Research	45
Implications for Practice	46
Therapeutic setting	46
Client characteristics	47
Therapist characteristics	47
Client/therapist relationship	48
MFGT interactions	48
Limitations of this Study	49
Summary	51
REFERENCES	52
APPENDICES	59
VITA	82

LIST OF TABLES

Table	Page
1. Primary and Other Theoretical Orientations of Expert Panel	29
2. Group Therapy and Family Therapy Theories Used by Expert Panel	30
3. Expert Panel's Years of Conducting Therapy	31
4. Problems Addressed by the Expert Panel in Multi-Family Therapy Groups.....	33
5. Identified Elements by Levels of Importance and Consensus	34
6. Expert Panel Identification of the Essential Elements for Successful MFGT	35

I. INTRODUCTION AND STATEMENT OF PROBLEM

The purpose of this study was to explore and identify a panel of experts' opinions of essential elements for successful multi-family group therapy (MFGT) and to propose the identified elements as guidelines for future MFGT theoretical and program development. Family therapists, counselors, social workers, psychologists, addiction specialists, and other professionals have been conducting MFGT: a combination of family therapy and group therapy whereby groups are comprised of families (i.e., couples, single-parents and children, etc.) rather than individuals. The cost-efficient modality of MFGT (Boylin, Doucette, & Jean, 1997; Quinn, Bell, & Ward, 1997; Strelnick, 1977) continues to be implemented while there is limited empirical literature and research to support how it is effective. Furthermore, as program directors and therapists develop, structure, and implement MFGT, there is an absence of guidelines and empirical research of its essential components.

There are numerous theories in the field of marriage and family therapy that guide therapists as they interact with families. Most of these theories have their roots in systems theory (Becvar & Becvar, 1988; Bertalanffy, 1968). Recent overviews of the empirical literature support the efficacy and effectiveness of systemic marriage and family therapy (Pinsof & Wynne, 1995; Shadish et al., 1993). Researchers in the field not only continue to identify the essential elements of family therapy for effective therapeutic outcomes (White, Edwards, & Russell, 1997), but also develop and combine modalities for

applications with families. Both MFGT and positive therapeutic outcomes are suggested areas for future research (Sprenkle & Bischoff, 1994).

It is important that researchers in the field of marriage and family therapy empirically investigate the effectiveness of MFGT as well as explore and delineate the elements essential for successful therapeutic outcomes. At this point, there remains limited research on how MFGT contributes to positive treatment (Boylin et al., 1997). Furthermore, as theories for family therapy and group therapy exist, a comprehensive theory of MFGT does not exist. It is therefore important to investigate and identify elements essential for successful MFGT to be examined as potential guidelines for theoretical development.

There are two major methods to identify the essential elements of successful MFGT therapeutic outcomes: (a) conduct MFGT process and outcome studies to identify the important variables associated with positive MFGT outcomes and (b) integrate the experiences and knowledge of experts to identify the necessary elements. The Delphi method (Linstone & Turoff, 1975) has been utilized and modified in marriage and family therapy studies (Figley & Nelson, 1989; Stone Fish, 1989; Stone Fish & Piercy, 1987; White et al., 1997; White & Russell, 1995; Winkle, Piercy, & Hovestadt, 1981) to obtain consensus from a group of experts on a particular topic.

Stone Fish and Busby (1996) identified the Delphi method as useful when the researcher wants to: (a) explore emerging areas of inquiry and theories, (b) poll experts on a particular subject utilizing a dialogue format, (c) structure communication about a topic so that consensus can be reached, (d) negotiate a reality to be useful in moving a

particular field forward, (e) plan for the future through development of policy issues, and (f) bridge the gap between research and practice (Stone Fish & Busby, 1996). The Delphi method is applicable for this study as it is often used to obtain empirical data in areas where none previously existed and to survey experts on a particular topic. In addition, the Delphi method allows the researcher to identify expert opinion about key variables for future program development, thus having the potential to bridge a gap between research and practice. Therefore, the Delphi method is relevant to identify essential characteristics for effective MFGT and to propose guidelines for future MFGT program and theoretical development.

Purpose of this Study

The purpose of this study was to explore and identify a panel of experts' opinions of essential elements for successful multi-family group therapy (MFGT) and to propose the identified elements as guidelines for future MFGT theoretical and program development. A panel of experts were selected and invited to participate in this Delphi study. Panelists were asked to identify the critical factors of MFGT that contribute to positive therapeutic outcomes. The essential elements of MFGT determined by the panel of experts will be proposed as guidelines for future MFGT theoretical and program development.

II. REVIEW OF THE LITERATURE

Descriptions of multi-family group therapy (MFGT) first appeared in the literature as multiple family therapy (Bowen, 1976; Laqueur, LaBurt, & Morong, 1964). In addition to MFGT being referred to as multiple family therapy, it has also been described as multiple family group therapy (Behr, 1996; Strelnick, 1977; Szymanski & Kiernan, 1983), multifamily therapy (Boylin et al., 1997; Greenfield & Senecal, 1995), and multi-family group therapy (Kymissis, Bevacqua, & Morales, 1995). Laqueur, one of the first to publish on MFGT (Laqueur et al., 1964), used MFGT in a hospital setting with schizophrenic patients. He reported that MFGT was time efficient, cost efficient, and produced change faster than therapy with individual families (Laqueur, 1976).

Laqueur (1976) asserted that MFGT was distinct from other forms of therapy as it allowed the community to enter into therapy via other families; Whitaker believed that MFGT was effective because it allowed a person to experience his or her own family dynamics in other families without being overwhelmed by his or her own family context (Boylin et al., 1997). Furthermore, Bowen (1976) stated families benefit from MFGT, as they are able to listen to other families while not having to prepare their next comments. Bowen applied his theoretical concept of triangles to families and groups of families as he focused on emotional interdependence between family members while other group members silently observed.

As many family and group theories have common roots in systems theory (Becvar

& Becvar, 1988; Bertalanffy, 1968), therapists have not only outlined the similarities and differences between family therapy and group therapy modalities (Hines, 1988), but have demonstrated how families can be viewed as a group (Becvar, 1982) and how family theory can be utilized as a group resource. Moreover, several therapists have outlined group developmental processes and applied and compared these to MFGT (Colangelo & Doherty, 1988; Kimbro, Taschman, Wylie, & MacLennan, 1967; Strelnick, 1977). In an MFGT context, individual families not only benefit from family therapy, but also from the group therapy experiences. Theoretically, MFGT presents additional opportunities for families to address aspects of their functioning through the group process.

A family-based group can provide a natural connection for group members to facilitate cohesiveness and create a context where similarities and differences can be acknowledged (Trotzer, 1988). Combining family therapy with group therapy has the following group therapy advantages: diminished isolation, equal power status which the group confers on each family, abundant scope for indirect learning, and the provision of role models through subgroupings (Behr, 1996).

Cassano (1989) examined the interactional patterns between therapist, families, and the group in an MFGT context. The 3 families who participated in the 10 multi-family group sessions were referred to the Department of Social Work due to difficulties in parent-child relationships. Data were collected through structured observations and coding of verbal interactions. Results indicated six types of interactional sequences within the MFGT sessions: professional (therapist with an individual), peer intra-family (parent with parent or child with child within same family), peer inter-family (parent with parent

or child with child of different families), non-peer intra-family (parent with child within same family), non-peer inter-family (parent with child of different families), and group (group with an individual).

Results indicated the multi-family group progressed from primarily professional interactions to intra-family and inter-family interactions as the group developed and focused on the substantive group work. In addition, subgroups of non-peers occurred more often within families and subgroups of peers occurred predominantly across families. The parents in the group were found to assume roles in processing the family problems whereas the children were found to assume the role of expressing group needs. Five main levels of interactions and social processes were addressed in the multi-family groups: dyadic, subgroups within families, family units, subgroups across families, and the group as a whole. It was recommended that an effective group facilitator attend to each of the levels and types of MFGT interactions.

Although there have been various comparisons and applications of family and group theories to MFGT as well as a description of MFGT interactions, an integrative and comprehensive MFGT theory does not exist. Utilizing various group and family theories, clinicians have conducted and implemented effective MFGT in various settings with numerous presenting problems. The majority of relevant literature of MFGT has consisted of program descriptions and results based upon clinical impressions. Multi-family group therapy programs have addressed families dealing with social isolation, elderly in long term care, marital conflict, bi-polar disorders, schizophrenia, obsessive-compulsive disorders, children with attention deficit disorder with hyperactivity,

adolescents diagnosed with anorexia nervosa, and substance dependence for adults and adolescents.

Behr (1996) recently implemented multi-family group therapy as a treatment modality for socially isolated families with long-standing dysfunctions. He described an MFGT program where families and children attended a single day workshop. Four therapists facilitated an MFGT session, separate sessions for children and parents, and a final MFGT session. During the separate groups, the facilitators paired children with non-siblings to foster additional experiences. Themes addressed in the MFGT sessions included anger in the family, loss, illness, intimacy versus privacy, relationship between family and school, socialization problems, and limit setting. Results of the program were obtained from clinical impressions and included diminished isolation for families, equal power status with the group members, an abundant scope of indirect learning, and provision of numerous role models. Behr reported the MFGT process was effective in engaging fathers as well as enabling a shift from problem-based to issue-based therapy. He recommended developing multi-family groups of families with shared identified problems.

Schwartzben (1992) incorporated MFGT with families who had elderly members living in a long-term care facility. He presented a program description where up to 27 family members from an entire floor participated in monthly, MFGT sessions. In addition to dealing with issues and concerns related to individual resident care plans, groups engaged in activities focused on supporting one another and addressing issues related to family dynamics. Results of the MFGT sessions included an increase in empowerment of

family members to work on family and residential issues. In addition, the MFGT sessions enhanced the quality of life for the residents and improved their relationship quality with family members.

Rabin (1995) utilized MFGT for couples dealing with marital conflict. She presented a psychoeducational program with a multi-family group therapy component for Israeli couples dealing with conflict as a result of low-income or a diagnosis of post-traumatic stress disorder. The multi-family groups consisted of up to 10 couples and met for 10 consecutive weeks. Goals consisted of decreasing the stigma of marital therapy and enhancing relationship skills and knowledge. Results of the program demonstrated an increase in marital satisfaction, an increase in the level of intimacy, and satisfaction with the group process. In addition to clinical impressions, results were obtained using a pre-post self-report measure of marital satisfaction.

Couples where one member is diagnosed with bi-polar disorder have also been treated within an MFGT context. Brennan (1995) presented the MFGT content of 2 hour sessions during a 14 week series he developed. Groups included between 6 and 9 individuals diagnosed with a bi-polar disorder and their families, most often the spouse. The groups were facilitated by at least two therapists. The structure of the group was closed in that after the second session, no new members could join. It was reported that a closed group would facilitate trust among the group members as well as build supportive relationships and peer networks. Results reflected a positive response to the group process, an increase in communication among family members regarding the bi-polar illness, and a development of a support system. Results were obtained through clinical

impressions and evaluations conducted during the final session of each group.

Hyde and Goldman (1993) suggested MFGT as a modality to help couples dealing with schizophrenia. Although they did not delineate an MFGT process, they did present an MFGT contract that focuses on family attendance, education, medication adjustments, and “do’s and don’ts” for schizophrenia. They recommended MFGT as a modality to address family problems and to overcome treatment barriers common in couples dealing with schizophrenia.

Black and Blum (1992) found MFGT to be effective in the treatment of obsessive-compulsive disorders. They presented a program description and outlined two groups that met twice a month. One group was designated for the individual diagnosed with obsessive-compulsive disorder (OCD) and the other group for their family members. The number of participants for each group ranged from 6 to 25. A psychiatrist and a social worker facilitated the open, ongoing groups. Goals of the patient group were identified as providing education, building support and encouragement from peers, increasing self-confidence, and creating a non-threatening atmosphere for resocialization. Goals of the family group included providing education, building support and encouragement from peers, providing hope and understanding, understanding the impact of OCD on family life, learning to cope with OCD manifestations, and learning how not to perpetuate and encourage OCD behaviors. They reported positive outcomes based on clinical impressions. The following recommendations were presented for successful multi-family groups: client homogeneity, implementation during periods of transitions, clear roles of facilitators, assurance of confidentiality, and group voice in determining the group

structure and function.

Greenfield and Senecal (1995) conducted recreation therapy for children with attention deficit disorder with hyperactivity in a multi-family group setting. They presented a program description followed by clinical impressions. Recreational family groups were developed at a full time psychiatric day treatment program with over half the families having a history of aggression. Goals included engaging parents in the child's treatment. The groups consisted of 5 families with children and met for 90 minutes, 2 times a month. Results included an increase in parenting skills, improved interpersonal family communication, diminished isolation, increased sensitivity to children's strengths, and increased self-confidence of the child.

Marner and Westerberg (1987) developed a multi-family group for families with an adolescent diagnosed with anorexia nervosa. They outlined an MFGT program consisting of 13 sessions each lasting 90 minutes. The group was comprised of two co-therapists and 8 families meeting every other week. Sessions included patient groups, parent groups, and family groups. Clinical impressions indicated an expressed relief in the ability to share similar feelings and an experience of encouragement and support. Disadvantages of the MFGT process were reported to include support of 'the anorexic' identity and various group pressures to avoid conflict.

Cwiakala and Mordock (1997) implemented MFGT with play therapy for substance addiction recovery. Family groups occurred in an adult, inpatient facility. Each patient and their families attended two groups, each 3 hours in duration. The groups were divided into segments of adult discussion, child play, and parent/child summary groups.

Goals of the groups were to facilitate parent-child communication about addiction, to use play as a non-threatening metaphor for communication, and to learn concrete methods to improve family relationships. Results were obtained from clinical impressions and a brief questionnaire. Results from the brief questionnaire indicated 80% of the participants rated the experience as excellent and improving communication with children. Clinical impressions supported play as a major contribution to establishing a non-threatening medium, an increase in peer support, and a decrease in addiction denial due to peer confrontations.

Adolescents struggling with chemical dependence have also been treated within the MFGT modality. Polcin (1992) presented a program description where MFGT was one of several treatment components in an adolescent residential treatment facility. During the MFGT groups, at least one parent attended each week with their adolescent. The multi-family groups had several phases where education of chemical dependent family patterns occurred, community supports were explored, families addressed core issues, and families developed new methods of resolving issues through communication. Clinical impressions indicated the advantages of the MFGT component included the opportunity for families to mirror, support, and confront each other. In addition, adolescents were reported to learn how to develop supportive relationships with adults other than their parents.

Kymissis and his colleagues (1995) detailed an MFGT program for adolescents with substance dependence and either an Axis I or Axis II disorder as specified in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (APA, 1994). Families

participated in family therapy sessions prior to and during the MFGT process. The group consisted of 4 adolescents and their families that met for 8 consecutive weeks for 1-hour sessions. Two therapists, a substance abuse counselor, and a psychiatrist facilitated the groups. Video recording of sessions provided supervision and play back for clients in session. Clinical impressions and conversations with participants were used to identify the results. Results indicated adolescents were more likely to accept confrontation and advice from the parent of another family than their own parent. Communication improved within families; the MFGT process allowed individuals to see beyond their subjective experiences and to understand the roles and perspectives of others. In addition, the MFGT topic was found to frequently become the family therapy topic. They recommended having at least two therapists for the MFGT approach with clear communication and role delineation between themselves. They stated “further studies are necessary in order to determine the elements which make multi-family group therapy useful and effective” (p. 113, Kymissis et al., 1995).

The relevant literature discussed above contains numerous MFGT descriptions and successful outcome results based primarily on clinical impressions. There are only several studies that empirically examined MFGT outcomes. Multi-family group therapy programs have been empirically investigated with families dealing with poor relationships, schizophrenia, substance abuse, medically ill children, adolescent mood disorders, and first time juvenile crime offenders.

Duff (1996) examined the outcome of multi-family group play therapy in improving family relationships. Fifty-two families comprised of 134 family members

completed the study. After the families attended the initial session where the study was explained, a demonstration of a typical family play activity was presented and pre-treatment measures were conducted. The researcher randomly assigned families to either the treatment condition or the control group. The treatment condition consisted of two groups that totaled 33 and 34 members and the two control groups totaled 33 and 34 members. The treatment group participated in MFGT focusing on family play during weekly, 90-minute sessions, for 6 weeks. The control groups attended the last half of the final sessions where post-treatment measures were obtained.

The Beaver's Self-Report Family Inventory was used to measure family health and communication style from the perception of each individual family member. The research design used in this study was the Solomon Four Design with random assignment. The data were primarily analyzed using an analysis of variance (ANOVA) and t-tests. Results indicated group family play was effective in improving family relationships, specifically a significant increase in family communication and problem solving skills.

Bentelspacher, DeSilva, Goh, and LaRowe (1996) empirically explored the effectiveness of an MFGT program with 30 ethnic Chinese and Malay families coping with schizophrenia. They presented a description of their 5-week program in which sessions lasted 2 hours. Seven separate groups were conducted with 4 to 8 members in each group. They reported the ethnic culture presented additional obstacles for therapy as prohibitions to self-disclose existed. The research design employed was a multiple case descriptive design where they analyzed the views of the participants, group leaders, and

observing researchers.

Data collection involved semi-structured interviews with group members and leaders as well as in-session observations. The semi-structured interview assessed the understanding of the program's educational material and the degree of comfort and willingness to participate in the MFGT process. Results indicated the MFGT program was beneficial to the ethnic Asian families struggling with a family member diagnosed with schizophrenia. The families participating in MFGT increased their degree of comfort in group activities, self-disclosure, problem solving, and behavioral rehearsals. In addition, the MFGT process provided several group curative factors for the participating families: instillation of hope, altruism, and guidance.

McFarlane, Dushay, Stastny, Deakins, and Link (1996) investigated the differences in outcomes for patients diagnosed with schizophrenia combined with a complicating factor who participated in either MFGT or in episodic crisis family interventions. Of the 68 schizophrenia patients and their families randomly assigned, 37 participated in the MFGT groups and 31 participated in crisis family interventions. The operating principles of both treatment conditions were based on assertive community treatment and family psychoeducation. The multi-family groups were conducted at three mental health centers and met every other week for 2 years. Each multi-family therapy group contained approximately 6 patients and their families who explored alternate problem solving strategies.

Outcome measures focused on re-hospitalization in association with symptomatic relapse, employment, family burden, and family well-being. Repeated measures of

symptom status were obtained at 8-month intervals using the Positive and Negative Syndrome Scale. The functional status, quality of life, family burden, and social network were evaluated pre- and post-treatment using the Social Adjustment Scale-III, Family Version. Results indicated a significant decrease in re-hospitalization rates, a decrease in symptom levels, and an increase in therapy participation for both treatment conditions. In addition, the MFGT and crisis family interventions resulted in a significant improvement of the patient's functioning, improvement in objective and subjective burden on family members, and a decrease in dissatisfaction and over-involvement with patients. Specific to the MFGT condition, the results indicated a higher employment rate than the non-MFGT condition.

Boylin and his colleagues (1997) researched the effects of MFGT with women in a treatment facility for substance abuse. Multi-family groups were conducted for 90 minutes on a weekly basis in a 90 day, fixed-length-of-stay treatment program which emphasized substance abuse as a family disease. Two therapists conducted the MFGT sessions with up to 50 attendees. The policies and procedures of the MFGT sessions were developed between the clinicians and the facility staff in efforts to increase the stay of treatment for female clients.

A total of 75 male and female clients and their families attended the MFGT sessions and were statistically compared to 144 clients who were not involved with MFGT. Results were obtained using an ANOVA based on clients' length of stay, gender, and MFGT participation. Results indicated the MFGT sessions were a significant positive intervention for female clients in lengthening their stay and in completing the program.

The data did not demonstrate any effect of MFGT for male clients. In addition, the MFGT sessions were found to increase communication between clients and their families as well as increase the awareness of family members regarding their contributions to the client's substance abuse.

Wamboldt and Levin (1995) empirically studied the effectiveness of MFGT with families with medically ill children and adolescents. Children and adolescents with asthma participated in a 2 day, 5 hour, MFGT program. A total of 54 separate multi-family groups were conducted, 17 of which empirical data were obtained. A total of 72 families and 164 individuals attended these 17 MFGT groups. Group sizes ranged from 2 to 9 families and from 4 to 30 individuals. The first day of the MFGT program consisted of a 3 hour, asthma education class including asthma information and self-management techniques. In addition, management of psychological concerns was stressed as essential to illness management. The second day of the program involved a 2-hour, process-oriented group led by two psychotherapists. Subgroups were formed based on illness roles: patient, primary caretaker, and other family members. Each subgroup processed feelings while the other subgroups listened. A time for discussion and a family art task completed the program.

A brief attitude survey was administered immediately prior to and after the 2 hour, process-oriented family group. The brief attitude survey responses were scored on a visual analogue scale. Several ANOVAs and t-tests were conducted for statistical analyses. The results indicated the MFGT program significantly increased the feeling that others understand and are helpful to their child and family regarding the illness. In

addition, the MFGT program was found to be significantly effective in increasing the importance of the value of sharing feelings regarding the illness with other family members.

Fristad, Gavazzi, and Soldano (1998) analyzed the use of MFGT with children and adolescents diagnosed with a mood disorder. They described an MFGT program consisting of 6 sessions with 9 families participating. The children and adolescents diagnosed with a mood disorder had been prescribed psychotropic medication. In addition, the families participated concurrently in individual and/or family therapy. The program used subgroupings of parents, children, and adolescents at various times to focus on specific therapeutic issues. The primary measure used for evaluation was the Expressed Emotion Adjective Checklist and was administered prior to MFGT, after the final session, and at a 4-month follow-up. In addition, a final evaluation form with Likert-type and open-ended questions was obtained after the final session. Results were preliminary in nature as the study lacked sufficient statistical power with only 9 participating families. Results appeared to suggest improvement in all families from baseline to post-treatment with regards to emotional expression within the family.

Quinn and his colleagues (1997) described an MFGT program with first time juvenile crime offenders and provided empirical evidence of effectiveness. The Family Solutions Program was described as a 9 week program focusing on themes pertaining to families of first time juvenile crime offenders: decision making, cooperation, family communication and rules, importance of education, conflict resolution, anger management, impact of crimes, and potential consequences. A total of 183 families

completed the program in 24 groups with an average of 8 families per group.

The outcome measure used in the results was the rate of recidivism. Program participants were compared with non-participants. Results indicated program graduates had significantly lower rates of recidivism. Furthermore, the number of offenses for those who re-offended were significantly lower. The MFGT processes identified as being important to the successful outcome were an establishment of trust and hope within the group.

The researchers in the relevant literature provided MFGT program descriptions with positive outcomes for families. In addition to clinical impressions, several studies empirically examined effectiveness of MFGT. Results from the studies indicated MFGT was effective for improving family relationships, communication, problem solving skills, marital satisfaction, awareness of family roles, sensitivity to family strengths, emotional expression, and family empowerment and participation. Furthermore, MFGT created a sense of hope and diminished isolation for families as support systems were developed. The MFGT process was reported to have provided opportunities for families to model, support, and confront each other, as family members were able to see beyond their subjective family experiences. The programs described varied greatly in structure, frequency of sessions, number of sessions, session duration, number of participants, presenting problems, group goals, facilitator roles, theoretical backgrounds, therapeutic settings, and the use of subgroups.

In addition to positive outcomes of MFGT, the researchers recommended at least two therapists facilitate multi-family groups and clearly communicate their roles. It was

also recommended groups include client homogeneity, an assurance of confidentiality, and group voice in determining group structure and function. Moreover, it was recommended the therapist be able to attend to the various levels and types of MFGT interactions within and between families.

Although the researchers in the relevant literature provided successful MFGT program descriptions and theoretically outlined group and/or family therapy processes that occur in MFGT, there is a lack of an integrative theory specific to MFGT. Elements distinct to MFGT were not empirically identified in the literature. Moreover, little is known as to how MFGT contributes to positive outcomes or what elements are essential for its effectiveness. To date, there is an absence of an empirical study that examines the essential elements of the MFGT modality or offers guidelines for MFGT program development.

III. METHODOLOGY

The purpose of this study was to explore and identify a panel of experts' opinions of essential elements for successful multi-family group therapy (MFGT) and to propose the identified elements as guidelines for future MFGT theoretical and program development. This researcher employed the Delphi method (Linstone & Turoff, 1975) to obtain an expert consensus of the essential elements for positive MFGT outcomes. This research method is often used to obtain empirical data in areas where none previously existed and to guide the development of policy issues and models (Linstone & Turoff, 1975; Stone Fish & Busby, 1996).

The Delphi method involves several distinct phases (Stone Fish & Busby, 1996). First, a panel of experts on the topic under study is asked to generate as much input as they would like about the topic. In the second phase, the researcher consolidates the individuals' responses and understands how the group views the topic. Third, the disagreement of opinions is addressed. The final phase involves the initial information being fed back to the group for their individual analysis and additional opinion. The researcher decides how these phases occur (Stone Fish & Busby, 1996) so panelists can express their opinions and reach consensus.

Traditionally, the Delphi method contains a series of two or three questionnaires (Stone Fish & Busby, 1996). As with other modified Delphi studies in the field (Figley & Nelson, 1989; Stone Fish, 1989; White et al., 1997; White & Russell, 1995), a series of

only two questionnaires was used. As there was a potential for a large list of generated variables, a series of two questionnaires attempted to retain panelist involvement and reduce redundancy a third questionnaire may have produced.

Selection of Panel Experts

The selection of Delphi panelists for this study was non-random and of utmost importance in obtaining a comprehensive evaluation of the topic. Simple criterion-based selection and network criterion-based selection methods were used to identify a potential panel for this study.

In simple criterion-based selection, a researcher creates a list of pertinent attributes and then selects a sample that matches the criteria (Goetz & LeCompte, 1984). This selection procedure allows the researcher to choose the panel for their knowledge and expertise, which is imperative for quality outcome using the Delphi method (Stone Fish & Busby, 1996). Potential panelists in this study met two of the following criteria: (a) had conducted relational therapy (group, couple, or family) for the past 5 years, (b) had conducted MFGT for at least 3 years, and/or (c) had published in the area of MFGT. In addition to simple criterion-based selection, network criterion-based selection was used in this study. Network criterion-based selection is a method in which potential participants are named through participant referrals (Goetz & LeCompte, 1984).

Procedure

The researcher identified initial potential panelists through a review of the MFGT literature and practitioner referrals. The researcher attempted to contact each potential panelist by phone in June 2000 to explain the study, solicit potential panelist referrals, and

extend an invitation for their participation; voice messages were left if the potential panelist was unavailable.

A packet was sent to each of the potential panelists in June 2000. The packet contained an Initial Cover Letter (see Appendix A), two copies of an Informed Consent Form (see Appendix B), a Demographics Form (see Appendix C), Questionnaire I (QI; see Appendix D), and a stamped envelope to return completed materials to the researcher. The cover letter explained the study and asked the participant to complete both copies of the Informed Consent Form where their signature indicated their willingness to participate; they were asked to retain one copy for their records. The Demographics Form was used for verification of the inclusion criteria and for descriptive purposes of the sample. The panelists were asked to complete and return one copy of the Informed Consent Form, the Demographics Form, and QI in the enclosed, stamped envelope.

Development of Questionnaire I. Questionnaire I was an open-ended questionnaire that solicited panelists' opinions of the essential elements for positive therapeutic outcomes of MFGT. Structure was provided by category headings to stimulate and guide panelist responses (Stone Fish & Busby, 1996). Panelists were asked to generate no more than 5 variables under each of the following categories: (a) client characteristics, (b) therapist characteristics, (c) client/therapist relationship, (d) client/group interactions, (e) therapist/group interactions, (f) therapeutic setting, and (g) other characteristics. The category headings corresponded to similar categories identified as important to positive clinical outcomes of marriage and family therapy (Figley & Nelson, 1989; White et al., 1997).

Four weeks after sending packets to the panelists, the researcher contacted those panelists by phone whose completed packets containing QI had not been returned. The researcher reminded them of the study, offered to answer any questions, invited them to return the materials if they had not already done so, and offered to send another packet if necessary.

Development of Questionnaire II. After receiving the completed materials from the participating panelists in August 2000 and analyzing the data, the researcher developed Questionnaire II (QII; see Appendix E). The responses generated from QI were combined to create the variables for QII. This researcher compiled, word for word, a list of all participant responses from QI under each category.

Several responses were edited in order to specify unique variables contained within a response. For example, under the client/group interactions category, the response of ‘Sufficient respect of adult family member to care for and want to appropriately support, protect, and care for children. Be able to learn through the modeling and sharing of other group members’ was formed into 2 distinct variables: ‘Sufficient respect of adult family member to care for and want to appropriately support, protect, and care for children’ and ‘Be able to learn through the modeling and sharing of other group members’. This researcher edited several variables by replacing the phrase ‘multi-family group therapy’ with ‘MFGT’. In addition, several variables were also edited to reduce redundancy. For example, under the therapist/group interactions category, the response of ‘Separate age and focus appropriate groups to prepare for the large MFGT process (separate groups include: a young children group, ages 3 to 7; older children, ages 8-12; adolescents, ages

13 to 17; and young adults, ages 18-20)' was edited for redundancy to form the following variable: 'Separate age and focus appropriate groups to prepare for the large MFGT process (i.e., ages 3-7, 8-12, 13 -17, and 18-20)'.

To assist the panelists in reading the generated responses, the researcher added a beginning phrase to each response when necessary in order to make a sentence relating to the category heading. For example, in the therapist characteristics category, the response of 'honest' was combined with the phrase, 'The therapist is', to form the following variable: 'The therapist is honest'. After forming the variables from the responses in each category, identical variables were only listed once. This created a panelist-generated list of distinct variables under the respective categories.

To complete the development of QII, the researcher presented the generated list of variables in their respective categories along with a 5-point Likert-type scale. In addition, the researcher developed a QII Cover Letter (see Appendix F). Prior to sending QII and the QII Cover Letter to the panelists, both were reviewed by Anne Prouty, Ph.D., faculty advisor for this research study, and Howard Protinsky, Ph.D., methodologist for this study.

In September 2000, the participating panelists who returned QI were sent QII, the QII Cover Letter, and a stamped envelope addressed to the researcher. On QII, the panelists were asked to rate the importance of the generated items as essential to positive outcome of MFGT on a 5-point Likert-type scale: (1) very unimportant, (2) unimportant, (3) neutral, (4) important, and (5) very important. Using the Likert-type scale for each item, panelists had

the opportunity to voice their agreement and disagreement with the anonymous group data. The panelists were asked to complete and return QII in the enclosed, stamped envelope.

Three weeks after sending the second questionnaire to the panelists, the researcher telephoned those panelists whose completed QII had not been returned. The researcher reminded them of the study, offered to answer any questions, and invited them to return the materials if they had not already done so. After receiving QII from all panelists continuing to participate in the study, the data were recorded and analyzed by the researcher.

Analysis of Questionnaire II. Data analysis consisted of calculating the median and interquartile range for each QII variable in order to identify consensus of the most important variables (Stone Fish & Busby, 1996; Stone Fish & Piercy, 1987). The median identified the central tendency of the responses for each item on the important-unimportant Likert-type scale. In other words, the median indicated the level of importance at which half of the responses fell above and half fell below.

The interquartile range provided information about the variability of responses and is a statistic about the level of consensus. The interquartile range is the range of the middle half of responses; a small interquartile range indicates high consensus and a large interquartile range indicates low consensus. A statistical program, SPSS version 8.0 for Windows 95, was used to calculate descriptive statistics that included the median and interquartile range of each variable. Descriptive statistics were calculated in the same manner for variables that contained missing data by using their respective number of responses.

Those variables with a high level of importance and a high level of consensus were

retained. Those items having a median importance of at least 4.5 on the 5-point scale and an interquartile range of equal or less than 1.0 were retained. In other words, a variable was retained if a minimum of 50% of the panelists rated it as very important and at least 75% of the panelists rated it as important or very important.

IV. RESULTS

Expert Panel

Practitioners provide multi-family group therapy (MFGT) in many treatment contexts and with numerous presenting problems. In addition to MFGT, practitioners conduct multi-family educational groups and facilitate family meetings in treatment programs. The researcher identified an initial 18 potential panelists through a review of the MFGT literature and practitioner referrals. The potential panelist contacts resulted in 3 additional panelist referrals, one of whom had already been identified, which resulted in a total of 20 potential panelists. A packet was sent to each of the 20 potential panelists in June 2000. Of these 20 potential panelists, 3 did not respond, 2 indicated they were not interested, 3 deferred to a colleague, and 2 indicated they did not have time. Therefore, a total of 10 panelists agreed to be in this study.

Of the 10 panelists agreeing to be in the study, 9 completed the first Delphi questionnaire (QI) by August 2000 and were mailed the second questionnaire (QII) in September 2000. The 10th panelist returned QI after QII was created and mailed. Even though several of this panelist's responses were identified on QII, not all were included in its development; the final panel was reduced to 9 participating panelists. All of the 9 panelists who received QII, completed and returned it by November 2000. The sample size of this study is small due to the limited number of 'experts' meeting the inclusion criteria as well as attrition through the self-selection process. Inclusion criteria for future

studies may include programs where practitioners conduct MFGT, multi-family educational groups, and/or families together in a group setting.

The panel was comprised of 7 females and 2 males that formed a group of experts varied in professional identities, theoretical orientations, and clinical experiences. The international panel included 2 participants who resided in Canada while the remaining panelists resided in the United States of America. They ranged in age from 27 to 58 with a mean age of 45.9 years. Eight of the panelists identified their ethnicity as Caucasian with the other identifying as Canadian/Italian.

In describing their professional identity, 4 panelists identified themselves as a 'marriage and family therapist', 2 as a 'social worker', 1 as a 'marriage and family therapist and divorce mediator', 1 as an 'assistant professor', and 1 as a 'child psychiatrist'. The panelists' primary and other theoretical orientations are presented in Table 1. The expert panel's group and family therapy theories used in MFGT are presented in Table 2. Seven of the 9 panelists have an MFGT publication.

The expert panel indicated experience with conducting relational therapy, currently providing MFGT, and previously providing MFGT. Table 3 presents the range and average number of years of the panel's therapy experiences. In terms of MFGT, 7 panelists identified themselves as currently providing MFGT in the following clinical settings: a private practice, an university, a church, a government agency, and a residential adolescent facility; one panelist indicated currently providing MFGT in three of these settings. The other 2 panelists had previously provided MFGT. Five of the

Table 1

Primary and Other Theoretical Orientations of Expert Panel

<u>Orientation</u>	<u>Primary</u>	<u>Other</u>
Systems (Family and Ecosystems)	3	0
Solution focused	2	2
Strategic family therapy	1	2
Structural family therapy	1	2
Experiential	1	1
Psychodynamic, Analytic	1	1
Child/parent play therapy	1	0
Competency based	1	0
Process oriented	1	0
Strength based	1	0
Bowenian, intergenerational	0	2
Cognitive Behavioral	0	1
Educational support group	0	1
Feminist	0	1
Gestalt	0	1
Reality therapy	0	1

Table 2

Group Therapy and Family Therapy Theories Used by Expert Panel

<u>Theory</u>	<u>Panelists</u>
<u>Group Therapy</u>	
Yalom	2
Corey	1
Educational support	1
Remedial social group work (Vinter et al.)	1
<u>Family Therapy</u>	
Structural	6
Solution focused	5
Bowenian, intergenerational	4
Strategic, MRI-strategic	4
Experiential (Satir)	3
Family Systems	2
Ecosystems (Imber-Black)	1
<u>Other</u>	
Eclectic, multiple	4
Coaching	1
Process oriented	1

Table 3

Expert Panel’s Years of Conducting Therapy

<u>Therapy</u>	<u>Years Conducting</u>	
	<u>Range</u>	<u>Mean</u>
Relational Therapy	6 - 35	16.2
MFGT in Current Setting	0.5 - 7	3.5
MFGT in Previous Setting	1 - 25	9.0

panelists indicated MFGT experiences in previous settings including a residential adolescent substance abuse facility, a children’s mental health center, a pediatric hospital, a day treatment program, and an addiction center.

The multi-family groups facilitated by the panelists varied in members attending, group structure, and presenting problems. One panelist indicated an average group size of 90 members comprised of 30 families. The other 8 panelists indicated an average number of families attending each group as 5.81 families ranging from 3 to 10 families. These groups included a total of individuals ranging from 5 to 16 with an average of 12 participants. The number of sessions per multi-family group ranged from 6 to 20 with an average of 11.77 sessions. Of the 9 panelists, 5 indicated each MFGT session averaged 2 hours in duration while the others reported durations from 1 to 2.5 hours. All panelists indicated the MFGT sessions were held on a weekly basis while 1 panelist indicated some also occurred bi-weekly.

The panelists held various roles in their MFGT experiences: 6 were facilitators, 6 were supervisors, and 8 were program developers. The structures of the groups were somewhat similar as 8 panelists reported their multi-family groups were of a limited number of sessions. Two panelists reported their groups were open and on-going while 2 others indicated they facilitated closed groups where no new members could join.

The panelists indicated rich variations in presenting problems of the MFGT clients. Of the types of family units attending the multi-family therapy groups, 7 panelists met with couples, 6 with children and parents, 4 with adolescents and parents, and 1 with all relatives welcome. The majority of panelists indicated the client's presenting problems were homogeneous whereas 2 panelists indicated they were heterogeneous. The presenting problems and issues addressed in MFGT are presented in Table 4.

Variables Identified by the Expert Panel

In response to the first Delphi questionnaire, the 9 member expert panel identified a total of 248 items as essential for positive outcome of MFGT. Of these items, 219 were unique and used as variables in this study. They are presented in QII (Appendix E) under their respective category headings: client characteristics (43), therapist characteristics (42), client/therapist relationship (24), client/group interactions (35), therapist/group interactions (43), therapeutic setting (28), and other characteristics (4).

All 9 panelists returned QII where they rated the 219 variables on the level of importance for positive outcomes of MFGT using the following 5-point Likert-type scale: (1) very unimportant, (2) unimportant, (3) neutral, (4) important, and (5) very important. To identify consensus of the most important variables, data analysis consisted of calculating the

Table 4

Problems Addressed by the Expert Panel in Multi-Family Therapy Groups

<u>Presenting Problem</u>	<u>Panelists</u>
Conduct disorder, delinquency	3
Domestic violence	3
Substance addiction	3
Divorce	2
Marital disharmony	2
Parent counseling	2
Borderline personality disorder	1
Child abuse	1
Compulsive behavior	1
Death	1
Dysfunctional parent/child relationships	1
Family communication	1
Lack of resources	1
Mood disorder	1
Seizure disorder (child and adolescent)	1
Separation anxiety	1
Social isolation	1
Stress	1
Thought disorder	1

median and interquartile range for each QII variable (Stone Fish & Busby, 1996; Stone Fish & Piercy, 1987).

Variables rated by the panel as very important had a median of greater than or equal to 4.5, as important had a median greater than or equal to 3.5 and less than 4.5, and as neutral or lower had a median lower than 3.5. The agreement of the importance for each variable was either of high consensus (interquartile range less than or equal to 1.0) or low consensus (interquartile range greater than 1.0). The number of variables in each category of importance and consensus are presented in Table 5.

Table 5

Identified Elements by Levels of Importance and Consensus

<u>Consensus</u>	<u>Importance</u>		
	<u>Neutral</u>	<u>Important</u>	<u>Very Important</u>
High Consensus	7	70	35 *
Low Consensus	21	76	10

* met inclusion criteria for essential elements for MFGT

Overall, 191 of the 219 variables were rated as important or very important by at least 50% of the panel; the panel was in agreement of the level of importance of the vast majority of the variables. The expert panel was in consensus of the importance for 112 of the 219 variables. In order to identify those variables essential for positive MFGT outcome, only those variables rated as very important by at least 50% of the panelists and rated as important or very important by at least 75% of the panelists were retained. Of the 219 variables, 35 met the inclusion criteria. In other words, 35 variables had a median

importance of at least 4.5 on the 5-point scale and an interquartile range of equal to or less than 1.0. The 35 variables identified by the expert panel as essential elements are presented in Table 6 under the following categories: therapeutic setting, client characteristics, therapist characteristics, client/therapist relationship, and MFGT interactions.

Table 6

Expert Panel Identification of the Essential Elements for Successful MFGT

Therapeutic Setting (5)

The therapeutic setting rules should be established and consistently held

¹ The therapeutic setting is confidentiality maintained

¹ The therapeutic setting is safe

¹ The therapeutic setting is respectful

A co-therapist is most helpful (usually) in this modality especially with MFGT with families

Client Characteristics (6)

The client is not psychotic

The client is willing to consider need for change

¹ The client is able to speak and understand the language being used

¹ The client is in regular attendance

The client is in sufficient health to participate and function

The child client is given protection from further abuse and neglect if abuse and/or neglect has occurred in the family

Table 6
(continued)

Therapist Characteristics (12)

Qualities

- ^{1,2} The therapist is non-judgmental
- ^{1,2} The therapist has empathy
- ¹ The therapist is understanding
- ^{1,2} The therapist is a listener
- ^{1,2} The therapist has flexibility

Abilities

- ¹ The therapist is able to be directive when necessary
- ^{1,2} The therapist is able to encourage and respect group members' perspectives
- The therapist is able to attend to group process
- The therapist is able to establish a safe environment
- ^{1,2} The therapist has the ability to effectively collaborate as a team member with co-therapists to support both the MFGT as a whole and various components (individuals, families, women, men, adolescents, and children)

Knowledge

- ^{1,2} The therapist has experience and knowledge of family therapy
 - ^{1,2} The therapist is well versed in family systems theory
-

Table 6
(continued)

Client/Therapist Relationship (4)

The client/therapist relationship is safe

² The client/therapist relationship has acceptance

^{1,2} The client/therapist relationship has trust

The client recognizes that the therapist values the client

MFGT interactions (8)

¹ The group has no violence and minimally hostile

The therapist is supportive of group

¹ The therapist affirms

The therapist displays leadership

^{1,2} The therapist maintains boundaries

^{1,2} The therapist has humor

² No one person controls the group

The therapist develops sound judgment as to when to intervene directly with clients
and when to trust the group process

¹ identified in White et al. (1997)

² identified in Figley and Nelson (1989)

V. DISCUSSION

The purpose of this study was to explore and identify a panel of experts' opinions of essential elements for successful multi-family group therapy (MFGT) and to propose the identified elements as guidelines for future MFGT theoretical and program development. The 35 variables identified by the expert panel for successful MFGT are presented in Table 6 under the following categories: therapeutic setting, client characteristics, therapist characteristics, client/therapist relationship, and MFGT interactions. The therapist characteristics are subdivided into qualities, abilities, and knowledge.

In order to provide clarity and develop a context for discussing the results of this study, I will provide an initial appraisal of the results within the relevant literature. This correspondence with the literature is followed by a more thorough discussion of the results in the context of implications for theory, research, and practice. The comprehensive discussion of implications will be followed by a brief review of the limitations of this study.

Correspondence of Results with the Relevant Literature

In reviewing the existing MFGT literature, support is found for 6 of the 35 essential elements identified in this study. In addition to MFGT research, researchers have explored essential elements for successful marriage and family therapy (White et al., 1997) as well as basic skills for marriage and family therapists (Figley & Nelson, 1989). In reviewing these two marriage and family therapy studies, 22 of the 35 essential

elements correspond and are noted in Table 6. The correspondence with the MFGT and the marriage and family therapy literature provides a foundation of support for corresponding variables and for highlighting elements unique to this study.

Within the therapeutic setting category, ‘the therapeutic setting is confidentially maintained’ was identified in both the MFGT and the marriage and family therapy literature. Based on clinical impressions, Black and Blum (1992) proposed the assurance of confidentiality as necessary for successful outcome. In addition to confidentiality being attained between the therapist and clients, MFGT clients need to discuss and obtain an assurance of confidentiality that extends outside the therapy context into the community. Confidentiality in an MFGT setting differs from family and group therapy settings, especially where children are present, as the assurance of confidentiality extended to community interactions may be difficult to attain.

As an identified essential client characteristic, ‘the client is in regular attendance’ is supported in both the MFGT and the family therapy literature. Hyde and Goldman (1993) recommended as part of an MFGT contract that the client be in regular attendance. As with family and group therapy contexts, regular attendance is necessary for change. In the MFGT context, being in regular attendance is also pertinent for the development of group relationships necessary for effective group interactions.

Researchers have recommended and reported the helpfulness of a co-therapist and the ability to effectively collaborate as a team member as very important for MFGT success (Behr, 1996; Black & Blum, 1992; Boylin et al., 1997; Brennan, 1995; Cwiakala & Mordock, 1997; Fristad et al., 1998; Kymissis et al., 1995; Marner & Westerberg,

1987; McFarlane et al., 1996; Polcin, 1992; Quinn et al., 1997; Wamboldt & Levin, 1995). The fact that the expert panel identified ‘a co-therapist is most helpful (usually) in this modality especially with MFGT with families’ as essential for the therapeutic setting and ‘the therapist has the ability to effectively collaborate as a team member with co-therapists to support both the MFGT as a whole and various components’ as a necessary therapist characteristic accentuates the complexity of MFGT interactions. With numerous group interactions, therapeutic relationships, and therapy content, co-therapists appear to be essential for successful MFGT.

The therapist characteristic, ‘the therapist is able to attend to the group process’, is supported in the MFGT literature. Many researchers have indicated the importance of group processes including: various group interactions (Cassano, 1989), development of peer and non-peer support systems (Brennan, 1995; Cwiakala & Mordock, 1997; Kymissis et al., 1995; Marner & Westerberg, 1987; Polcin, 1992), diminished isolation (Greenfield & Senecal, 1995; Marner & Westerberg, 1987), sense of hope (Bentelspacher et al., 1996; Quinn et al., 1997), altruism (Bentelspacher et al.), and confrontations (Cwiakala & Mordock, 1997; Polcin, 1992). In MFGT, therapists need to be knowledgeable and aware of not only family therapeutic processes but also of group therapeutic processes, as complex interactions occur within and between families.

As an identified MFGT interaction element, ‘the group has no violence and is minimally hostile’ is supported in both MFGT and family therapy literature. Researchers have documented the importance of group confrontations (Corey, 1995; Cwiakala & Mordock, 1997; Polcin, 1992; Yalom, 1985) in a non-violent and non-threatening manner

as an important factor for positive outcome in a group context. Peer confrontations can be a powerful group therapeutic process. It is very important that the therapeutic team facilitates and allows peers to confront each other while also maintaining physical and emotional safety.

The panel identified many elements found in the marriage and family therapy literature that were not identified in the MFGT literature. These appear to be common factors of therapy in general and include the following: a safe and respectful setting; the client being able to speak and understand the language being used; specific therapist qualities, abilities, and knowledge; a client/therapist relationship that has trust and acceptance; and MFGT interactions that affirm, maintain boundaries, involve humor, and where no one person controls the interactions.

Identified elements distinct to this study appear in each of the categories. Within the therapeutic setting, 'the therapeutic setting rules should be established and consistently held' highlights the clear structure needed in the MFGT context. Client characteristics distinctly identified include the client having no psychotic symptoms and in sufficient health to participate. In addition, the MFGT context may allow for a family's secret of abuse toward children to be shared with other families; children need to have protection from further abuse and neglect if it has previously occurred in the family.

As an identified, essential client characteristic, 'the client is willing to consider the need for change' is unique to this study. This element was distinguished by the panel from the following elements, which are supported as essential in the marriage and family therapy literature: 'the client is willing to change' and 'the client has a desire to change'.

The MFGT context and group interactions appear conducive for clients who are only willing to consider the need for change.

As ‘the therapist is able to establish a safe environment’ is a distinct therapist characteristic, distinct elements identified in the client/therapist relationship involve a safe relationship and the client’s recognition that the therapist values the client. Although these three elements are not unique to MFGT, their identification by the panel emphasizes the importance and value of the client/therapist relationship in the midst of the complex interactions not always present in group therapy and family therapy.

Elements identified specific to MFGT interactions include the therapist being supportive of the group, displaying leadership, and developing sound judgment as to when to intervene directly with clients and when to trust the group process. These elements again focus on the complexity of MFGT interactions not present in group therapy and family therapy.

Implications for Theory

Although there are numerous group therapy and family therapy theories that can be incorporated into a theoretical conceptualization of MFGT, a theory specific to multi-family group therapy does not exist. Group therapy theories can inform practice models for addressing therapeutic group processes (Agazarian, 1997; Corey, 1995; Vinogradov & Yalom, 1996; Yalom, 1985). However, when applying these group frameworks to groups of families instead of individuals, they become limited in addressing the complexity of interactions. Family therapy theories can also become limited in accounting for the numerous group processes within the group and family interactions. The results of this

study provide a foundation to further develop MFGT theoretical conceptualizations.

The family is a specific and continuous type of subgroup within the multi-family group; each family has a shared history as well as enduring relationships after MFGT sessions. An interaction on any level (therapist, group, subgroup, family, or individual) affects the interactions and dynamics of all levels. Group interactions have theoretical implications for families both during and beyond the MFGT context.

Therapeutic setting. The fact that confidentiality and safety were identified as essential components of the MFGT setting is not surprising as these elements appear throughout the therapy literature. From this researcher's MFGT experiences, when addressing issues of abuse and potential abuse, theoretical conceptualizations of therapy interactions and interventions are necessary in order to help ensure client safety both in and out of sessions. Theoretical considerations when establishing and adhering to the setting rules have ramifications for client safety. Setting rules regarding presenting problems, severity of abuse, which members will attend, emotional and physical safety in sessions, and group structure are aspects of MFGT that have theoretical implications.

Therapist characteristics. From the complexity of MFGT interactions, therapist characteristics identified by the experts emerged as pertinent in relation to theoretical implications. From my clinical experiences, there is a clear necessity for the therapist to be well versed in family systems theory, be able to attend to group process, and have experience providing family therapy. A theoretical implication of this study involves the continued examination of the multiple layers of systemic interactions within MFGT process.

This researcher suggests furthering the development of MFGT theory to account for the inter-relationships between group processes (i.e., stages of group development, subgroup formations, levels of group interactional patterns), family processes (i.e., stages of family development, family subsystems, presenting problem), the therapeutic system, and multiple system levels of interventions. For example, a family therapist may intervene by aligning with a specific individual to activate change within a family system. Whereas, in an MFGT context, the same therapist may intervene by aligning with an individual, a family subsystem, a family, a subgroup, and/or the group to activate change within an individual, a family, a subsystem, or even the group.

MFGT interactions. The therapeutic interactions within MFGT are complex and occur on numerous levels. The creation of subgroups (i.e., peer inter-family, non-peer inter-family) by the therapist has implications for theoretical development relating to the presenting problems and therapy goals. Through my experiences, the theoretical approach of the therapist(s) affects when and how the therapist interacts, displays leadership, and allows the group to directly intervene with various layers of the MFGT system. Integrating aspects of systems, family, and group therapy theories could provide additional theoretical foundations for deciding when to intervene directly with the client and when to trust the group process.

Theoretical advances could be used to create MFGT contexts related to interventions, theoretical orientations of the therapist(s), client presenting problems, goal development, and indicators of effectiveness. These theoretical developments could provide future directions for clinical decisions and research in addition to group therapy

and family therapy theories.

Implications for Research

Few studies in the relevant literature empirically examined the process and outcome of MFGT; many results and conclusions have been based on clinical impressions. This study was prudent as the Delphi method provided a preliminary investigation of elements essential for successful MFGT. The 35 elements identified by the expert panel serve as a foundation for future MFGT process and outcome research.

The results of this study enable further examination of MFGT dynamics. For example, the elements of ‘the therapist is able to attend to group process’ and ‘the client recognizes that the therapist values the client’ could be empirically investigated to understand how MFGT processes contribute to successful MFGT. The identified elements raise future research questions concerning what interpersonal dynamics are helpful within the MFGT process.

Building upon the foundation of the 35 elements identified in this study, future studies can also explore clinical effectiveness of MFGT in real life therapy situations. Necessary elements identified by the panel, such as ‘the therapist is understanding’ and ‘the client is in regular attendance’ could be examined to determine their impact on treatment outcome. Comparisons of MFGT can be made with other therapy modalities including group therapy, individual therapy, family therapy, and family educational groups. Future MFGT research and program evaluations could address the 35 essential elements identified in this study, and researchers could explore how MFGT is effective, with whom, and with which presenting problems MFGT is best implemented.

Implications for Practice

The list of 35 essential elements identified by the expert panel can serve as guidelines for current and future multi-family therapy groups. These elements are applicable to the formation of the MFGT context, client characteristics, therapist characteristics, and the therapy process.

Therapeutic setting. In forming the therapeutic context, the panel identified 5 essential elements as necessary for positive MFGT outcome. Similar to other therapy modalities, a therapeutic setting, which is safe, respectful, and confidential, was distinguished as very important. Also identified, especially when families participate in MFGT, is the use of a co-therapist. Moreover, an element with distinct implications for MFGT was identified: ‘the therapeutic setting rules should be established and consistently held’. Factors to consider in developing the setting rules may include the following: group structure, session frequency, session duration, minimum or maximum number of clients, client attendance, family attendance, therapist and co-therapist roles, client presenting problems, conjunction with other therapies, and client interactions outside of therapy. For example, Brennan (1995) reported a multi-family therapy group structure that was closed in that after the second session, no new members could join. Multi-family therapy groups can be open to new members, closed to new members, ongoing, or time limited. With the numerous factors to consider in developing a multi-family group, an important implication of this study is the clear establishment of the group structure and rules in the development of the therapy context and adherence to them during the MFGT process.

Client characteristics. The expert panel identified 6 client characteristics as essential for successful outcome of MFGT. Again, overlapping with other therapy contexts, these elements include the client being in sufficient health to participate and function, being able to speak and understand the language being used, being in regular attendance, and willing to consider the need for change. It is noted that similar elements, ‘the client is willing to change’ and ‘the client has a desire to work on problems’, were identified only as important and not essential by the panel. In addition, the panel indicated the necessity of the child client to be given protection from further abuse and neglect if abuse and/or neglect had occurred in the family. The panel indicated a contraindication for successful MFGT by identifying the client not be suffering from psychosis.

Therapist characteristics. The panel identified 12 therapist characteristics as essential for positive MFGT outcome. This researcher has divided these therapist characteristics into the following three categories: qualities, abilities, and knowledge. The majority of these therapist qualities, abilities, and knowledge have been identified in the MFGT and marriage and family therapy literature as essential for positive therapeutic outcomes.

The panel delineated essential therapist qualities of being non-judgmental, being understanding, being a listener, having empathy, and having flexibility. Therapist abilities specified as very important include the ability to be directive when necessary, to encourage and respect group members’ perspectives, to establish a safe environment, to effectively collaborate as a team member with co-therapists to support both the MFGT as a whole and various components, and to attend to the group process.

Specific therapist knowledge identified by the panel includes the therapist being well versed in family systems theory and the therapist having experience and knowledge of family therapy. The panel was not in consensus of ‘the therapist has experience and knowledge of group therapy’ as being essential. The knowledge of family systems theory may connote being able to apply systems theory concepts to not only families but also to groups and subsystems within the group. However, the ability to attend to group process may also connote knowledge of group therapeutic processes without having experience with group therapy. An awareness of MFGT interactional patterns and social processes (Cassano, 1989), basic group therapy processes (Corey, 1995; Yalom, 1985), subgroup formations (Agazarian, 1997), and group curative factors (Vinogradov & Yalom, 1996) may be pertinent for the ability of a therapist to attend to and conceptualize the complex group processes.

Client/therapist relationship. The expert panel identified 4 essential elements for positive MFGT outcome regarding the client/therapist relationship. As with other therapy modalities, the panel indicated the necessity of the client/therapist relationship to be safe, have trust, and have acceptance. In addition, the panel distinguished the importance of ‘the client recognizes that the therapist values the client’. In a context where an individual’s relationship with the therapist coincides with numerous other relationships, the panel emphasizes the importance of perceived value in each client relationship for successful outcome.

MFGT interactions. The expert panel identified 8 essential elements for positive MFGT outcome regarding the MFGT interactions. They indicated the importance of no

one person controlling the group interactions and the group having no violence and being minimally hostile. The panel determined that the therapist in relation to the group be supportive, affirming, have humor, maintain boundaries, display leadership, and develop sound judgment as when to intervene directly with the clients and when to trust the group process.

In summary, the expert panel identified 35 elements essential for successful MFGT that can be used as guidelines for current and future program development. Many of these elements overlap with characteristics already identified in the literature and with basic therapist qualities, skills, and knowledge. An important implication from this study is that many marriage and family therapists already have knowledge and skills necessary for conducting MFGT. However, the expert panel identified elements specific to MFGT. The panel emphasized the establishment and adherence to therapeutic setting rules. This includes the formation of the MFGT context with full consideration of the therapeutic system. Another pertinent implication is for therapists conducting MFGT to be well versed in family systems theory, have experience and knowledge with family therapy, and have awareness of group processes. The panel emphasized the therapist displays leadership and develops sound judgment as when to intervene directly with clients and when to trust the group process. The use of co-therapists and effective collaboration as a team member are essential.

Limitations of this Study

This study contains three limitations. First, a limitation occurs from the very nature of the Delphi method. The validity and application of the knowledge identified in

this study is directly related to the expertise, integrity, and formation the Delphi panel.

The results from the expert oracle are not meant to be taken as truth; instead, they are to be interpreted and considered as guidelines for future theory, research, and practice.

The second limitation concerns the composition of the expert panel. The validity of this study is directly related to the selection of panel experts. As there are few experts in multi-family group therapy, efforts were made to retain the identified panelists. Although the panel of this study appears diverse in theoretical orientations and experiences, little ethnic diversity exists. In addition, as Delphi studies can be time consuming, a series of two questionnaires was used to increase participation, prevent attrition, and reduce redundancy for the limited number of experts. Of the 20 potential panelists identified, 10 agreed to be in the study resulting in an initial response rate of 50%. Of these 10 panelists, 9 completed the first and second rounds of this study (45% of initial population).

The response rate of this study is better or equivalent to other Delphi studies conducted in the marriage and family therapy literature. Figley and Nelson (1989) had an initial response rate of 32% as 688 individuals meeting their criteria agreed to participate from 2,137 potential panelists. Of the 688 panelists who were sent both rounds of questionnaires, 429 completed the first round and 372 completed the second (20% and 17% of initial population, respectively). White and his colleagues (1997) used three rounds in a Delphi study. Of the 216 potential panelists, 108 panelists agreed to participate in the study, 87 completed the second round, and only 61 completed all three questionnaires (50%, 40%, and 28% of initial pool, respectively). Stone Fish and Piercy

(1987) conducted a Delphi study identifying 62 potential panelists. Of these, 46 agreed to participate and 32 completed the three questionnaires (74% and 52% of initial pool, respectively). Although the response rate of this study is comparable to previous Delphi studies, there were a limited number of panelists by definition of the inclusion criteria and the attrition process through self-selection.

Lastly, using the Delphi method, the diversity of responses is reduced in order to obtain consensus. Elements identified as only important yet having high consensus were not retained. Only two rounds of questionnaires were used in this study. An addition of a third questionnaire containing feedback of the median and interquartile ranges may have produced slightly different consensus results. However, it has been noted a tendency exists for responses to regress toward the mean as additional questionnaires are administered (Stone Fish & Busby, 1996); in other words, successive questionnaires often tend to decrease the richness of the data.

Summary

The purpose of this Delphi study was to explore and identify a panel of experts' opinions of essential elements for successful multi-family group therapy (MFGT) and to propose the identified elements as guidelines for future MFGT theoretical and program development. Multi-family group therapy continues to be implemented while there is little empirical research to support how it is effective and with what populations and presenting problems it is best employed. A panel of MFGT experts identified 35 essential elements for successful MFGT. Many of the identified elements coincided with elements identified in the relevant literature. However, elements specific to MFGT were

distinguished. The essential elements are presented as guidelines for MFGT theoretical and program development.

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APPENDICES

APPENDIX A

Initial Cover Letter

819 SW 5th St.
Corvallis, OR 97333
June 22, 2000

Panelist name
Panelist address
Panelist address
Panelist city, state, zip

Dear Panelist:

You are invited to participate in a research study of importance for family therapy researchers and clinicians. This study is designed to examine and explore the components of effective multi-family group therapy. You have been identified as having experience with this therapy modality and your perspective is valuable to this study.

The research method used will be the Delphi method, a technique for gathering group consensus from an expert panel. This study will consist of a demographics form and two questionnaires with a combined time commitment of one and a half hours. Upon summarizing all panelist responses from the first questionnaire, a second questionnaire will be sent for your consensus and feedback.

To participate, please complete and return the Demographics Form, Questionnaire I, and the Informed Consent Form. An extra copy of the Informed Consent Form is included for your records. It is hoped that you will complete and return the Demographics Form regardless of your willingness to participate in this study.

As an expert in the field and providing multi-family group therapy, your participation will be greatly appreciated. Through your assistance, this research will help identify key ingredients and processes for multi-family group therapy and aid in guidelines for program development. I look forward to working with you in the next few weeks.

Sincerely,

Scott Edwards, M.S.
Doctoral Candidate, Marriage and Family Therapy
Virginia Polytechnic Institute and State University
sedwards@vt.edu

APPENDIX B

Informed Consent Form

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Informed Consent for Participants

Title of Project: The Essential Elements of Multi-Family Group Therapy: A Delphi Study
Investigator: Scott Edwards, M.S.

Purpose of this Research:

This study is designed to examine and explore the essential components of effective multi-family group therapy. The identified elements will be proposed as guidelines for future program development.

Procedures:

The research method used will be the Delphi method, a technique for gathering group consensus from an expert panel. If you choose to participate, we will be asked to complete a demographics form and two questionnaires with a combined time commitment of one and a half hours. Upon summarizing all panelist responses from the first questionnaire, the second questionnaire will be sent for your consensus and feedback.

Risks and Benefits of this Project:

No risks or hazards or anticipated for the subjects. Benefits will include the results of the study as guidelines for program development.

Extent of Anonymity and Confidentiality:

Due to the nature of the Delphi method, your responses will be confidential and equal in value with other respondents. A code list which assigns a number to you will be generated for purposes of tracking received questionnaires and in subsequent mailings. The code list will be locked in a fire proof safe at the investigator's residence in Corvallis, Oregon. Your name will be deleted from the code list when your final questionnaire is received or if you decide to withdraw from the study. At such point, all information provided will become anonymous.

Compensation:

Upon completion of this study, a complete summary of the findings will be sent to you. Through your assistance, this research will help identify key ingredients and processes for multi-family group therapy and aid in guidelines for program development.

Freedom to Withdraw:

Your participation is completely voluntary and you may discontinue at any time. To withdraw, you can either contact the investigator or simply not respond to the questionnaires.

Approval of Research:

This research project has been approved, as required, by the Institutional Review Board (IRB) for Research Involving Human Subjects at Virginia Polytechnic Institute and State University, by the Department of Human Development.

Participant’s Responsibility:

I voluntarily agree to participate in this study. I have the responsibility of completing and returning in the enclosed envelope the Informed Consent Form, Personal and Professional Demographics Form, and Questionnaire I. I will retain a copy of the Informed Consent Form for my records. I further agree to complete and return a second questionnaire compiled of responses from Questionnaire I for the purpose of obtaining my feedback and group consensus.

Participant’s Permission:

I have read and understand the conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent for participation in this project.

If I participate, I may withdraw at any time without penalty. I agree to abide by the rules of this project.

Signature

Date

Should I have any questions about this research or its conduct, I may contact:

Scott Edwards, M.S.
Investigator

(541) 738-8191
Phone

Anne Prouty, Ph.D., LMFT
Faculty Advisor

(540) 231-7201
Phone

Tom Hurd
Chair, University IRB

(540) 231-5281
Phone

Thank you for your participation. Please return in the enclosed envelope.

APPENDIX C

Demographics Form

Code: _____

Demographics Form

Please complete the following information in full and return in the enclosed envelope. I hope you will complete and return this form even if you chose not to participate in this study.

Age: ____ Gender: _____ Ethnicity: _____ Years conducting therapy: ____

Professional Identity: _____

Primary Occupation: _____

Current clinical setting(s): _____

Degree(s) obtained and field(s): _____

State license(s)/certification(s): _____

Primary theoretical orientation: _____

Other theoretical orientation(s): _____

For the purposes of this study, multi-family group therapy (MFGT) is defined as therapy with a group of families, siblings, couples, and/or partners.

1. Please indicate your MFGT therapy experiences:

Current clinical setting(s): _____ Years: _____

Previous clinical setting(s): _____ Years: _____

2. Please indicate the average number for each of the following:

_____ Families per group. _____ Length of MFGT sessions (hours).

_____ People per group. _____ Frequency of MFGT sessions.

_____ MFGT sessions per family.

3. Please circle all that apply:

Structure of group: Limited number of sessions, Open/ongoing group, Other _____

Role(s) in MFGT: Facilitator, Supervisor, Program developer, Other _____

MFGT participants: Couples, Children/parents, Adolescents/parents, Other _____

MFGT participants' presenting problems: Homogeneous, Heterogeneous

4. What are some presenting problems for your MFGT participants?

5. What group therapy theories do you use in a MFGT context?

6. What family therapy theories do you use in a MFGT context?

Thank you for your participation. Please return in the enclosed envelope.

APPENDIX D

Questionnaire I

Code _____

Questionnaire I

For the purposes of this study, multi-family group therapy (MFGT) is defined as therapy with a group of families, siblings, couples, and/or partners.

Indicate what you believe are essential characteristics for positive therapeutic outcomes of MFGT. Please limit your responses to 5 items for each category. Please use the back of this form as needed.

1. Client Characteristics

2. Therapist Characteristics

3. Client/Therapist Relationship

4. Client/Group Interactions

5. Therapist /Group Interactions

6. Therapeutic Setting

7. Other Characteristics

Thank you for your participation. Please return in the enclosed envelope.

APPENDIX E

Questionnaire II

Questionnaire II

For the purposes of this study, multi-family group therapy (MFGT) is defined as therapy with a group of families, siblings, couples, and/or partners.

Please indicate what you believe to be the importance of each characteristic as essential for positive therapeutic outcomes of MFGT using the 5 point scale below:

very unimportant	unimportant	neutral	important	very important
1	2	3	4	5

Client Characteristics

The client is honest	1	2	3	4	5
The client is courageous	1	2	3	4	5
The client is creative	1	2	3	4	5
The client is motivated	1	2	3	4	5
The client has trust	1	2	3	4	5
The client has trust in the group process	1	2	3	4	5
The client has enough trust for alliance formation	1	2	3	4	5
The client is able to empathize and listen to others	1	2	3	4	5
The client has an open mind	1	2	3	4	5
The client is not psychotic	1	2	3	4	5
The client has vulnerability	1	2	3	4	5
The client is willing to learn from previous experiences	1	2	3	4	5
The client is able to sit up and control basic bodily movements and actions	1	2	3	4	5
The client is willing to change	1	2	3	4	5
The client has a desire to change	1	2	3	4	5
The client is willing to consider need for change	1	2	3	4	5
The clients have similar presenting problems	1	2	3	4	5
The clients are in similar stages of the life cycle	1	2	3	4	5
The clients are in similar stages of the family life cycle	1	2	3	4	5
The client perceives the presenting problems as impacting on the total family	1	2	3	4	5
The client is motivated to work on problems	1	2	3	4	5
The client is able to speak and understand the language being used	1	2	3	4	5
The client is in regular attendance	1	2	3	4	5
The client is able to control own behavior enough to participate appropriately	1	2	3	4	5
The client is in sufficient health to participate and function	1	2	3	4	5

very unimportant 1	unimportant 2	neutral 3	important 4	very important 5
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The client is bonded with, has loving care for, and is supportive of each family member	1	2	3	4	5
The client has commitment to their family	1	2	3	4	5
The client is willing to seek help	1	2	3	4	5
The client is screened individually (as family, couple, etc.) for readiness for group work	1	2	3	4	5
The client has commitment to help the 'identified patient' within his/her family	1	2	3	4	5
The client is able to be supportive of the needs of each family member within MFGT	1	2	3	4	5
The client has support for family and all family members after MFGT sessions for unresolved issues brought up within group sessions	1	2	3	4	5
The client is willing to support existent healthy independent and interdependent relationships	1	2	3	4	5
The client has hope and belief in the group's ability to help the family	1	2	3	4	5
The client is willing to seek spouse, child, and family education and counseling as resources	1	2	3	4	5
The client has sufficient respect and care for one's family members to want to appropriately support, protect, and care for the other members	1	2	3	4	5
The client is willing and able to identify and accept responsibility for actions and role function within his/her family	1	2	3	4	5
Participating 'identified patient' and family members in recovery collaborate with therapist to support their children's recovery	1	2	3	4	5
The child client has mild to moderate traumatic stress	1	2	3	4	5
The child client is in good-enough environments, whose rights are protected and basic and developmental needs are met	1	2	3	4	5
The child client's physical, mental, emotional, relational, and developmental needs are sufficiently and consistently met	1	2	3	4	5
The child client is given protection from further abuse and neglect if abuse and/or neglect has occurred in the family	1	2	3	4	5
The child client has capabilities that can be utilized to protect themselves and to grow within their families and the MFGT experience	1	2	3	4	5

very unimportant 1	unimportant 2	neutral 3	important 4	very important 5
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Therapist Characteristics

The therapist is warm	1	2	3	4	5
The therapist is non-judgmental	1	2	3	4	5
The therapist is caring	1	2	3	4	5
The therapist is growing	1	2	3	4	5
The therapist is able to think on one's feet	1	2	3	4	5
The therapist is able to attend to group process	1	2	3	4	5
The therapist has a strong theoretical framework	1	2	3	4	5
The therapist is able to maintain focus	1	2	3	4	5
The therapist is non-reactive	1	2	3	4	5
The therapist has empathy	1	2	3	4	5
The therapist has intuition	1	2	3	4	5
The therapist has a sense of humor	1	2	3	4	5
The therapist is understanding	1	2	3	4	5
The therapist is supportive	1	2	3	4	5
The therapist is consistent	1	2	3	4	5
The therapist is patient	1	2	3	4	5
The therapist is courageous	1	2	3	4	5
The therapist has leadership	1	2	3	4	5
The therapist is open	1	2	3	4	5
The therapist is a listener	1	2	3	4	5
The therapist has flexibility	1	2	3	4	5
The therapist is directive	1	2	3	4	5
The therapist is able to be directive when necessary	1	2	3	4	5
The therapist knows how to redirect conversations and doesn't let member(s) monopolize	1	2	3	4	5
The therapist has experience and knowledge of group therapy	1	2	3	4	5
The therapist has experience and knowledge of family therapy	1	2	3	4	5
The therapist is well versed in family systems theory	1	2	3	4	5
The therapist has clarity regarding which aspects of the interaction in therapy s/he will focus upon (a lot happens in MFGT)	1	2	3	4	5
The therapist has conviction that peer and non-peer help can assist clients - not just professional help	1	2	3	4	5
The therapist effectively leads therapy process and accepts there are aspects of the process s/he cannot control	1	2	3	4	5
The therapist is able to encourage and respect group members' perspectives	1	2	3	4	5

very unimportant 1	unimportant 2	neutral 3	important 4	very important 5
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The therapist is able to recognize and encourage positive group and couple processes	1	2	3	4	5
The therapist is able to establish a safe environment	1	2	3	4	5
The therapist has the ability to lead, serve, help, and co-learn in MFGT while modeling healthy family and group behavior with co-therapists and other group members	1	2	3	4	5
The therapist has an education and experiential background and ability to support one or more group segments of the group	1	2	3	4	5
The therapist has the ability to effectively collaborate as a team member with co-therapists to support both the MFGT as a whole and various components (individuals, families, women, men, adolescents, and children)	1	2	3	4	5
The therapist has the ability to effectively address the following family issues: pseudomutuality, parentification, marital schism, marital skew, triangulation, undifferentiated ego mass, disengagement, scapegoating and projection	1	2	3	4	5
The therapist has a basic understanding and ability to simultaneously provide group, family, and MFGT with an eclectic approach	1	2	3	4	5
The therapist is able to help family members address transference issues among their members	1	2	3	4	5
MFGT can be compared to an intricate web mobile in which all parts need to be supported by the therapist to keep balance	1	2	3	4	5
The therapist is able to seek assistance through supervisors and co-therapists for counter-transference issues	1	2	3	4	5
The therapist has an understanding of children's limited abilities and potential key roles in participating within MFGT	1	2	3	4	5

Client/Therapist Relationship

The client/therapist relationship has mutual respect	1	2	3	4	5
The client/therapist relationship is safe	1	2	3	4	5
The client/therapist relationship is nurturing	1	2	3	4	5
The client/therapist relationship has trust	1	2	3	4	5
The client/therapist relationship has listening and understanding	1	2	3	4	5
The client/therapist relationship has acceptance	1	2	3	4	5
The client and therapist sets goals (both)	1	2	3	4	5
The client/therapist relationship s flexible	1	2	3	4	5
The client/therapist relationship is cooperative	1	2	3	4	5

very unimportant 1	unimportant 2	neutral 3	important 4	very important 5
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The client/therapist relationship has openness	1	2	3	4	5
The therapist is directive in the client/therapist relationship	1	2	3	4	5
The therapist empathizes with each member of each family	1	2	3	4	5
The therapist can confront with respect - especially important with parental subsystems	1	2	3	4	5
The therapist focuses on client strengths and uses reframes to empower the client	1	2	3	4	5
The therapist demonstrates warmth and caring towards each member of each family	1	2	3	4	5
The therapist offers protection to each member of each family. Each person knows from the quality of their interactions with the therapist that no matter what happens in therapy, the therapist will deal with it competently.	1	2	3	4	5
The client recognizes that the therapist values the client	1	2	3	4	5
The client knows that the therapist will control the environment	1	2	3	4	5
The therapist supports parents and adult family members with family functioning and child rearing needs	1	2	3	4	5
The therapist identifies and collaborates with case management to provide needed services to the families and each individual members, including children	1	2	3	4	5
The therapist has support for each individual member maintained within each small group and total group process	1	2	3	4	5
The therapist protects children within the MFGT and afterwards	1	2	3	4	5
The therapist protects children from parentification	1	2	3	4	5
The therapist protects children from being the scapegoat within the family	1	2	3	4	5

Client/Group Interactions

The group is respectful	1	2	3	4	5
The group accepts diversity	1	2	3	4	5
The group has openness	1	2	3	4	5
The group is honest	1	2	3	4	5
The group has constructive feedback	1	2	3	4	5
The group is patient	1	2	3	4	5
The group is supportive	1	2	3	4	5
The group has security	1	2	3	4	5
The group has trust	1	2	3	4	5

very unimportant 1	unimportant 2	neutral 3	important 4	very important 5
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The group has safety for each and every group member	1	2	3	4	5
The group has no violence and is minimally hostile	1	2	3	4	5
The group is willing to listen	1	2	3	4	5
The group has acceptance	1	2	3	4	5
The group has appropriate confrontation	1	2	3	4	5
The group has non-paranoid participants	1	2	3	4	5
The group is willing to participate	1	2	3	4	5
The group is open to new ideas and experiences	1	2	3	4	5
The group is willing to agree to disagree	1	2	3	4	5
The client must perceive a commonality with other persons and families as this is critical in developing a constructive culture in the treatment system	1	2	3	4	5
The client must develop constructive peer interaction within and across families	1	2	3	4	5
The client must develop constructive non-peer interaction within and across families	1	2	3	4	5
The client needs to be aware they can assist others in the group and such participation is encouraged and reinforced	1	2	3	4	5
The social network formation among the MFGT members is sanctioned provided it does not become an obstacle within the treatment system	1	2	3	4	5
The group is able to both support and confront each other	1	2	3	4	5
The group is able to take each others' perspectives	1	2	3	4	5
The group members have sufficient mental and emotional health, and bonding with their family members, especially children	1	2	3	4	5
The group has respect for each member and the contributory role of each member	1	2	3	4	5
The group has respect and encouragement of co-teaching and positive role modeling by each member	1	2	3	4	5
The group has respect and support for the varying journeys within families and in various roles in families	1	2	3	4	5
The group is able to reframe from scapegoating, parentifying and projecting one's issues onto other families	1	2	3	4	5
The group has sufficient respect of adult family members to care for and want to appropriately support, protect, and care for children	1	2	3	4	5
The group is able to learn through the modeling and sharing of other group members	1	2	3	4	5
The group is willing and able to use needed outside supports including: play counseling, child case management, and support services	1	2	3	4	5

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The group has encouragement and respect for each member's strengths and contribution regardless of age, sex, position in family, ethnicity, education, race, financial status and diagnosis	1	2	3	4	5
The group has respect for every member's choice to observe without pressure	1	2	3	4	5

Therapist /Group Interactions

The therapist is supportive of the group	1	2	3	4	5
The therapist is in charge of the group	1	2	3	4	5
The therapist is potentially directive of the group	1	2	3	4	5
The therapist affirms	1	2	3	4	5
The therapist asks questions	1	2	3	4	5
The therapist offers suggestions	1	2	3	4	5
The therapist points out process	1	2	3	4	5
The clients respond to the therapist	1	2	3	4	5
The therapist is charming, concerned, supportive, and intelligent	1	2	3	4	5
The therapist displays leadership	1	2	3	4	5
The therapist stays on topic	1	2	3	4	5
The therapist has great speaking skills	1	2	3	4	5
The therapist has great listening skills	1	2	3	4	5
The therapist is consistent with rules	1	2	3	4	5
The therapist maintains boundaries	1	2	3	4	5
The therapist is patience	1	2	3	4	5
The therapist has openness	1	2	3	4	5
The therapist has humor	1	2	3	4	5
The therapist is not a lecturer	1	2	3	4	5
The therapist presents topic and elicits group interactions	1	2	3	4	5
While the therapist facilitates, indicating group members know how to apply knowledge and help each other understand	1	2	3	4	5
The therapist works to make explicit commonalties among the members of the treatment system regardless of family role and/or role in presenting problem	1	2	3	4	5
In the beginning, the therapist is active and provides structure and direction	1	2	3	4	5
Later, the therapist may be less active but still intervenes directly with those clients who require assistance from the therapist in his/her expert role	1	2	3	4	5

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The therapist provides an opportunity for experiential exercises, role playing, and tasks (in and out of session) to facilitate the treatment process and goal attainment	1	2	3	4	5
The therapist develops sound judgment as to when to intervene directly with clients and when to trust the group process	1	2	3	4	5
If MFGT is time limited, the therapist may maintain a more active role throughout therapy in order for goal attainment to be realized in the agreed upon number of sessions	1	2	3	4	5
The therapist and group have mutual respect	1	2	3	4	5
The group is able to confront the therapist	1	2	3	4	5
The therapist is able to confront the group	1	2	3	4	5
No one person controls the group	1	2	3	4	5
The therapist allows children to have their own play therapy session separate from the adults therapy session and be an intricate part of the MFGT, not just attending and ignored within session	1	2	3	4	5
The designated goals and objectives are reasonable and can be achieved	1	2	3	4	5
The therapist identifies each family and family members strengths while providing a multicultural sensitive and intercultural learning experience	1	2	3	4	5
The therapist provides opportunities for all family members to tell their children appropriate stories of their backgrounds including: recovery stories, racial, cultural, community, wisdom, spiritual, neighborhood, and family stories	1	2	3	4	5
The therapist separates ages and focuses appropriate groups to prepare for the large MFGT process (i.e., ages 3-7, 8-12, 13 -17, and 18-20)	1	2	3	4	5
The therapist forms an effective MFGT team using the resources of therapists and group members to keep the MFGT sessions moving along safely with positive healing	1	2	3	4	5
The therapist addresses the needs of all group members with the help of additional therapists observing and supporting each member	1	2	3	4	5
The therapist is able to work on achievable goals of the MFGT within the group of sessions and help members maintain focus on the projected goals while flexible enough to seize serendipitous opportunities	1	2	3	4	5
The group needs to be homogeneous enough to focus on the specific goals of the group	1	2	3	4	5
The therapist is able to approach goals in a circular, as well as a linear way, using 'detours' productively	1	2	3	4	5

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The therapists need to be sensitive to the group and individual needs and when it is productive to allow the group to diverge on a productive topic	1	2	3	4	5
The therapist has support for addressing issues of various family process issues (scapegoating, pseudomutuality, parentification, marital schism, marital skew, triangulation, undifferentiated ego mass, enmeshments, disengagement)	1	2	3	4	5

Therapeutic Setting

The therapeutic setting is warm	1	2	3	4	5
The therapeutic setting is comfortable	1	2	3	4	5
The therapeutic setting is homelike	1	2	3	4	5
The therapeutic setting is quiet	1	2	3	4	5
The therapeutic setting is safe	1	2	3	4	5
The chairs are in a circle (no barriers)	1	2	3	4	5
The therapeutic setting is respectful	1	2	3	4	5
The therapeutic setting is nurturing	1	2	3	4	5
The therapeutic setting is supportive	1	2	3	4	5
The therapeutic setting is limited only by space constraints and ability to get family members to attend	1	2	3	4	5
The therapeutic setting is preferably in a non-Mental Health setting where it can be too threatening and sterile	1	2	3	4	5
The therapeutic setting is in a central location for clients	1	2	3	4	5
The therapeutic setting is free of distractions (may need separate room for small children)	1	2	3	4	5
The therapeutic setting rules should be established and consistently held	1	2	3	4	5
The therapeutic setting is private	1	2	3	4	5
The therapeutic setting is confidentiality maintained	1	2	3	4	5
Especially in MFGT where there is a disparate system (families and maybe siblings depending on age range) the therapist repeatedly makes explicit that each person regardless of family role has something of value to contribute to the treatment process	1	2	3	4	5
Empathy among members of the treatment system is fostered within and across families	1	2	3	4	5
A co-therapist is most helpful (usually) in this modality especially with MFGT with families	1	2	3	4	5

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The physical setting is important with a therapy room of adequate size and comfortable, moveable furniture	1	2	3	4	5
The length of sessions may vary depending on age range of child clients	1	2	3	4	5
The group size is appropriate so as not too large or too small	1	2	3	4	5
The chairs are of appropriate size for all family members	1	2	3	4	5
The therapeutic setting is pleasing esthetically with window or some pictures for relaxed atmosphere	1	2	3	4	5
The therapeutic setting has enough space for comfort and closeness	1	2	3	4	5
The therapeutic setting is in a round format, if possible, in which everyone can see each other	1	2	3	4	5
The therapeutic setting has a snack or meal, if appropriate	1	2	3	4	5
The group is small enough for participation of all members who wish to within a reasonable amount of session time	1	2	3	4	5

Other Characteristics

MFGT works best when children are of similar ages (within 2-3 years)	1	2	3	4	5
Screening for group readiness is essential as some members may need individual/family therapy first	1	2	3	4	5
MFGT must have the right balance of professional help, peer help, and non-peer help; this balance needs to be individualized and would differ for disparate groups (families) and monogeneous groups (couples)	1	2	3	4	5
Communication and listening skills are addressed	1	2	3	4	5

Thank you for your participation. Please return in the enclosed envelope.

APPENDIX F

Questionnaire II Cover Letter

819 SW 5th St.
Corvallis, OR 97333
September 1, 2000

Panelist name
Panelist address
Panelist address
Panelist city, state, zip

Dear Panelist:

I appreciate your participation in this study examining the essential components of effective multi-family group therapy (MFGT). Thank you for completing the first of two questionnaires. Your experience and perspective with MFGT continues to be valuable to this study.

Enclosed, you will find Questionnaire II which was created from the responses of all panelists, including your own. To continue your participation in this Delphi study, please complete and return Questionnaire II by rating the importance of each variable for effective outcomes.

As an expert in the field, your continued participation will be greatly appreciated. Through your assistance, this research will help identify key ingredients and processes for MFGT and aid in guidelines for program development.

I look forward to working with you in the next few weeks and providing you the results of this study. Thank you in advance for your prompt reply. If you have any questions, please contact me at (541)738-8191.

Sincerely,

Scott Edwards, M.S.
Doctoral Candidate, Marriage and Family Therapy
Virginia Polytechnic Institute and State University
sedwards@vt.edu

VITA

Scott A. Edwards

EDUCATION **Virginia Polytechnic Institute and State University, Blacksburg, Virginia**
Family and Child Development, Marriage and Family Therapy.
Doctorate of Philosophy, May 2001.

Auburn University, Auburn, Alabama
Family and Child Development, Marriage and Family Therapy.
Master of Science, December 1996.

Cornell University, Ithaca, New York
College of Arts and Sciences, Psychology.
Bachelor of Arts, January 1991.

PROFESSIONAL **American Association for Marriage and Family Therapy.**
MEMBERSHIPS

- ♦ Clinical Member.
- ♦ Approved Supervisor in Training.

Oregon Association for Marriage and Family Therapy.

- ♦ Treasurer (elected term): 2000.
- ♦ Legislative Committee: 1999.

Virginia Association for Marriage and Family Therapy.

- ♦ Student/Associate Representative (elected term): 1997-1999.

Alabama Association for Marriage and Family Therapy.

- ♦ Student/Associate Representative (elected terms): 1995-1997.

Kappa Omicron Nu, National Honor Society: 1995.

Cornell University Alumni Admissions Ambassador Network: 1999.

REFEREED **Edwards, S. A., Bermudez, J. M., Canady, D. L., & Protinsky, H. O.**
PUBLICATIONS (2000). Interviewing a therapist in the presence of a couple: A description of the
therapeutic process. Contemporary Family Therapy, 22, 223-232.

White, M. B., **Edwards, S. A.**, & Russell, C. S. (1997). The essential
elements of successful marriage and family therapy: A modified Delphi study. The
American Journal of Family Therapy, 25, 213-231.

NON-REFEREED PUBLICATIONS **Edwards, S. A.** (1999). Recent LMFT regulations change: Implications for non-licensed members. Caring for the Commonwealth: The Newsletter of the Virginia Association for Marriage and Family Therapy, 4(1), 2.

Edwards, S. A. (1998). Claiming identity of MFT. Caring for the Commonwealth: The Newsletter of the Virginia Association for Marriage and Family Therapy, 3(4), 1.

Edwards, S. A. (1998). From the Student/Associate Representative. Caring for the Commonwealth: The Newsletter of the Virginia Association for Marriage and Family Therapy, 3(3), 4.

Edwards, S. A. (1998). Note from the Student/Associate Representative. Caring for the Commonwealth: The Newsletter of the Virginia Association for Marriage and Family Therapy, 3(2), 6.

RESEARCH EXPERIENCE

Interviewing a Therapist in the Presence of a Couple: A Qualitative Inquiry of the Therapeutic Process, 1998-1999

Virginia Polytechnic Institute and State University, *Blacksburg, Virginia*

- ♦ Qualitative and collaborative inquiry for enhancing therapy effectiveness.

Cardiac Therapeutic Rehabilitation and Family Therapy, 1998

Virginia Polytechnic Institute and State University, *Blacksburg, Virginia*

- ♦ Interdisciplinary research team of the Family Therapy Center and the Therapeutic Exercise and Community Health graduate programs.
- ♦ Facilitated case-consultations of program participants.
- ♦ Presented seminar on basic interviewing skills for joint project.
- ♦ Produced and directed training tape and manual of basic interviewing skills.

Masters Thesis, December, 1996

Auburn University, *Auburn, Alabama*

- ♦ "Late Adolescent Males' Interpersonal Competence and Romantic Relationship Quality: Influences within the Parent/Son Relationships on Son/Intimate Relationship Development"

INVITED PRESENTATIONS WORKSHOPS

Anger Management for a Multi Family Group Context, August 30, 2000

Linn County Mental Health, Child and Family, *Albany, Oregon*

Narrative Therapy with Adults, Children, and Families, June 21, 2000

Linn County Mental Health, *Albany, Oregon*

Narrative Therapy with Substance Abusing Teens, February 16, 2000

Linn County Mental Health, Alcohol and Drug, *Albany, Oregon*

Bermudez, M., Edwards, S. A., Canady, D. L., & Protinsky, H. O.

Externalizing Clinical Narratives: A Qualitative Study, October 8, 1999

AAMFT 57th Annual Conference, Poster Presentation, *Chicago, Illinois*

Bermudez, M., Edwards, S. A., Canady, D. L., & Protinsky, H. O.
Interviewing a Therapist in the Presence of a Couple: A Qualitative Inquiry of the Therapeutic Process, *April 8, 1999*
24th Annual Southeastern Symposium Conference on Child and Family Development, University of Tennessee, *Knoxville, Tennessee*

Basic Interviewing Skills, *July 17, 1998*
Virginia Polytechnic Institute and State University, *Blacksburg, Virginia*
♦ Co-developed and presented to Cardiac Therapy and Intervention Center.

Systems and Family Theories in the Medical Profession, *May 18, 1998*
College for Health Services, *Roanoke, Virginia*

Communication and Listening Skills, *April 29, 1998*
Blacksburg High School, *Blacksburg, Virginia*

Home Based Family Therapy Program Retreat, *August 8, 1997*
Auburn Family Therapy, *Auburn, Alabama*
♦ Developed and presented Home Based Family Therapy Program Manual.

Postponing Sexual Intimacy, Developing Emotional Intimacy, *June, 1997*
The Safe and Drug Free Schools Program, *Columbus, Georgia*
Conference: A Toolbox for Healthy Kids and Healthy Communities
♦ Co-developed and presented seminar at conference for school professionals.

Home Based Family Therapy Program, *March 27, 1997*
Lee County School Counselors, *Opelika, Alabama*

Substance Dependency and Co-dependency, *March 12, 1997*
Parents Without Partners, Auburn Chapter, *Auburn, Alabama*

Home Based Family Therapy Program, *March 4, 1997*
Lee County Schools, *Opelika, Alabama*

Drug and Alcoholic Dependent Families, *January 23, 1997*
Lee County Department of Human Resources, *Opelika, Alabama*
♦ In-Service training program for social workers and staff.

The Marriage Connection, *Spring 1996; Fall 1996; and Spring 1997*
Auburn United Methodist Church, *Auburn, Alabama*
♦ Co-developed and facilitated three, eight week premarital workshops.

Emotional, Physical, and Sexual Abuse / Sexuality, *October 17 and 31, 1996*
The Safe and Drug Free Program, *Columbus, Georgia*
Peer Helper Conference
♦ Developed and presented seminar to 7th and 8th grade peer helpers.
♦ Developed and presented seminar to 9th through 12th grade peer helpers.

TEACHING
EXPERIENCE

Instructor: Children in Changing Families November 2000 to present
Adjunct Faculty: Linn-Benton Community College, Albany, Oregon
Old Mill Center for Children and Families, Corvallis, Oregon

- ♦ Facilitate program developed for divorcing parents that focuses on the well-being of their children.
- ♦ Coordinate with Linn-Benton Domestic Relations Mediation Program.
- ♦ Communicate and collaborate with colleagues.
- ♦ Provide community resources for participants.
- ♦ Instruct parents on reactions to stress.
- ♦ Explore facts concerning the effects of divorce on children at various developmental stages.
- ♦ Educate parents on active listening skills to help children adjust.
- ♦ Outline construction of a Parenting Plan required by Oregon law.

Instructor FCD 4324: Families and Children Under Stress Summer 1998
Virginia Polytechnic Institute and State University, Blacksburg, Virginia

- ♦ Examined theory, research, and practical application literature related to stress, families, children and resilience.
- ♦ Instructed undergraduate and graduate students in course objectives.
- ♦ Administered in-class, individual, group, and written assignments.
- ♦ Assessed and evaluated student participation and performance.

Graduate Assistant: Professional Seminar August 1997 to May 1999
Virginia Polytechnic Institute and State University, Blacksburg, Virginia

- ♦ Assisted in lecturing and evaluating 300 students per semester.
- ♦ Instructed students on professional, resume, and interview skills.
- ♦ Scheduled and supervised a three week Seminar Series each semester.
- ♦ Communicated with faculty regarding mock interviews for each student.
- ♦ Liaison between course instructor and students.
- ♦ Conducted mock interviews of students.
- ♦ Managed course web-page.
- ♦ Implemented plans for special-case students.
- ♦ Developed and activated criteria for student scholarships.

Teaching Assistant, Psychopathology Fieldwork August 1989 to December 1990
Cornell University, Ithaca, New York

- ♦ Instructed students in therapeutic listening skills during weekly seminars.
- ♦ Supervised each students' client-focused relationship as an adjunct to therapy.
- ♦ Coordinated fieldwork program with an agency supervisor.
- ♦ Graded weekly assignments and final papers.

ADDITIONAL
TEACHING
EXPERIENCE

Guest Lecturer, Human Sexuality, *June 2, 1999*
Virginia Polytechnic Institute and State University, *Blacksburg, Virginia*
"Internet Sex and Pornography"

Guest Lecturer, Introduction to Human Services, *November 13, 1998*
Virginia Polytechnic Institute and State University, *Blacksburg, Virginia*
"Possible Career Paths as a Marriage and Family Therapist"

Graduate School Preparation Seminar, *September 4 and 14, 1998*
Virginia Polytechnic Institute and State University, *Blacksburg, Virginia*

Guest Lecturer, Human Sexuality, *June 8, 1998*
Virginia Polytechnic Institute and State University, *Blacksburg, Virginia*
"Communication, Listening, and Intimacy in Couples"

Graduate School Interviewing Seminar, *March 18, 1998*
Virginia Polytechnic Institute and State University, *Blacksburg, Virginia*

Preparing for Graduate School Seminar, *October 15, 1997*
Virginia Polytechnic Institute and State University, *Blacksburg, Virginia*

CLINICAL
EXPERIENCE

Clinical Psychology Intern, Crisis Team October 2000 to present
Linn County Department of Mental Health *Albany, Oregon*

- ♦ Provide individual and family crisis intervention therapeutic services.
- ♦ Communicate with crisis team members.
- ♦ Assess crisis for appropriate interventions.
- ♦ Respond to emergency room consultation requests.
- ♦ Develop and coordinate crisis plans.

Clinical Psychology Intern September 1999 to 2000
Linn County Department of Mental Health, Child and Adolescent *Albany, Oregon*

- ♦ Develop and facilitate multi-family group therapy sessions.
- ♦ Participate in weekly multidisciplinary team meetings.
- ♦ Assist in utilization reviews and utilization management decisions.
- ♦ Provide family and individual therapy sessions.
- ♦ Develop treatment plans and coordinate case management.
- ♦ Attend weekly group and individual supervision sessions.
- ♦ Provide crisis intervention therapeutic services.

Resident Intern in Marital and Family Therapy January 1998 to June 1999
Family Therapy Center, Virginia Tech *Blacksburg, Virginia*

- ♦ Provide family, couple, and individual therapy sessions.
- ♦ Attend weekly group and individual supervision sessions.
- ♦ Develop and maintain treatment plan for each case.
- ♦ Complete case-notes on each session.
- ♦ Review video tapes of my sessions to increase skills and supervision.
- ♦ Communicate and coordinate treatment plans with professionals.

- Multi-Family Group Therapist** December 1996 to August 1997
Alchemy, New Horizons Columbus, Georgia
- ♦ Provide multi-family group therapy sessions for families with adolescent chemical dependence at residential facility.
 - ♦ Formulate and implement multi-family group therapy component.
 - ♦ Maintain casenotes and treatment plans for each case.
 - ♦ Conduct weekly consultation staffing sessions.
 - ♦ Coordinate treatment plans with family and individual counselors.
- Marriage and Family Therapist** August 1996 to August 1997
Auburn Family Therapy, Brenda Dozier, Ph.D. Auburn, Alabama
- ♦ Provide home-based therapy sessions for families, couples, and individuals.
 - ♦ Develop manual for home-based therapy services.
 - ♦ Formulate and maintain treatment plan for each case.
 - ♦ Complete assessments, casenotes, and treatment summaries.
 - ♦ Attend weekly individual supervision sessions.
 - ♦ Communicate and coordinate treatment plans with community professionals.
 - ♦ Facilitate social worker meetings with Department of Human Resources.
- Practicum in Marital and Family Therapy** April 1995 to August 1996
Glanton House, Auburn University Auburn, Alabama
- ♦ Provided family, couple, and individual therapy sessions.
 - ♦ Attended weekly group and individual supervision sessions.
 - ♦ Developed and maintained treatment plan for each case.
 - ♦ Completed casenotes on each session.
 - ♦ Reviewed video tapes of my sessions to increase skills and supervision.
 - ♦ Communicated and coordinated treatment plans with professionals.
 - ♦ Attended and testified at client court hearing as requested.
- Internship in Substance Abuse Family Therapy** August 1995 to June 1996
The Family Treatment Program, New Horizons Columbus, Georgia
- ♦ Attended weekly supervision meetings.
 - ♦ Provided diagnostical assessment, family, and individual therapeutic sessions.
 - ♦ Developed and maintained an Individual Service Plan for treatment.
 - ♦ Completed casenote documentation of each session.
 - ♦ Communicated and coordinated treatment plans with community agencies.
 - ♦ Referred applicable cases to Department of Family and Child Services.
- Assistantship in Adolescent Family Therapy** August 1995 to May 1996
East Alabama Medical Center, Psychiatric Units Opelika, Alabama
- ♦ Attended daily treatment team meetings with psychiatrist and clinical staff.
 - ♦ Integrated group, family, and individual sessions for adolescent patients.
 - ♦ Provided therapeutic family sessions for in-patient adolescents.
 - ♦ Led group therapy for adults and adolescent patients.
 - ♦ Referred cases to community professionals.
 - ♦ Completed appropriate charting and documentation on each session.

ADDITIONAL
CLINICAL
EXPERIENCE

- Senior Counselor** February 1994 to August 1994; May 1991 to July 1993
Eckerd Family Youth Alternatives Hendersonville, North Carolina
- ♦ Provided group therapeutic experiences for emotionally disturbed adolescents by utilizing Reality Therapy and Control Theory.
 - ♦ Formulated realistic goals with clients and counselors.
 - ♦ Ensured physical safety of the group.
 - ♦ Coordinated and guided extended hiking and canoeing trips.
 - ♦ Enhanced clients' education, confidence, and self-esteem.
 - ♦ Submitted written evaluations on clients' progress.
 - ♦ Communicated with family workers and families on progress.

- Mental Health Assistant** July 1993 to February 1994
Inner Harbour Psychiatric Hospital Douglasville, Georgia
- ♦ Provided group therapeutic experiences for chemical dependent and emotionally disturbed in-patient adolescents.
 - ♦ Developed realistic goals with clients, family therapists, and social worker.
 - ♦ Documented clients' daily activities and progress.
 - ♦ Actively participated in the clients' group psychotherapy.

ADDITIONAL
EXPERIENCE

- Founder/Director of Soccer League** August 1988 to January 1991
Tompkins County YMCA Ithaca, New York
- ♦ Founded league due to need of youth soccer program in Ithaca.
 - ♦ Incorporated YMCA policies and dogma into program.
 - ♦ Coordinated community members and college students for coaching.
 - ♦ Developed and instructed coaching clinics.
 - ♦ Officiated and coached games for 80 annual participants.

- Production Director** June 1989 to January 1991
Cornell Concert Commission Cornell University
- ♦ Produced 14 Cornell concerts including Branford Marsalis, Indigo Girls, Joe Jackson, Erasure, Midnight Oil, and Little Feat.
 - ♦ Negotiated with Artist regarding contractual and technical details.
 - ♦ Prepared and managed budgets ranging from \$20,000 to \$65,000.
 - ♦ Subcontracted production equipment and labor.
 - ♦ Supervised all 150 local working personnel.
 - ♦ Established operating procedures with Police and Emergency Services.

PROFESSIONAL
CONFERENCES

Family Therapy: The Millennium Summit, November 2-5, 2000
AAMFT National Conference, *Denver, Colorado*

Family Therapy in the Mainstream, October 7-10, 1999
AAMFT National Conference, *Chicago, Illinois*

Working with Difficult Couples, Cloe Madanes, October 2, 1999
OAMFT Division Conference, *Portland, OR*

Building our Future Together, April 15-18, 1999
AAMFT Leadership Conference, *Bethesda, Maryland*
♦ Lobbied U.S. Congress for VAMFT and AAMFT.

24th Annual Southeastern Symposium Conference on Child and Family Development, April 7-9, 1999
University of Tennessee, *Knoxville, Tennessee*

Bring a Leader, Build a Leader, October 15, 1998
AAMFT Divisional Leadership Development Institute, *Dallas, Texas*

Preventive Family Therapy, October 16-18, 1998
AAMFT National Conference, *Dallas, Texas*

Leadership for our Envisioned Future, April 16-19, 1998
AAMFT Leadership Conference, *Reston, Virginia*

Inquiring Voices, March 27-28, 1998
College of Human Resources and Education Graduate Research Conference,
Virginia Polytechnic Institute and State University, *Blacksburg, Virginia*

23th Annual Southeastern Symposium Conference on Child and Family Development, April 2-4, 1998
Auburn University, *Auburn, Alabama*

7 Habits of Highly Effective Families Consultation, Fall 1997
Covey leadership consultation prior to publication, *Auburn, Alabama*

Creative Horizons in Family Therapy, September 19-21, 1997
AAMFT National Conference, *Atlanta, Georgia*

Valuing Family Therapy, June 13-14, 1997
ALAMFT Division Conference, *Gulf Shores, Alabama*

Brief Therapy for Managed Care, December 1-2, 1996
Cloe Madanes, *Atlanta, Georgia*

AAMFT National Conference, October, 1996
Toronto, Canada

AWARDS Outstanding Service Award for Cornell University, 1989-1990.
Distinguished Service Award for Cornell Concert Commission, 1989-1990.

CERTIFICATION PREPARE/ENRICH, 1997