Perceived Benefits of a Multiple Family Group for Children with Behavior Problems and their Families

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Abstract

Multiple family groups (MFG) have shown to have promising results for children with behavioral difficulties. The 4Rs and 2Ss is a curriculum-based multiple family group model for families of children with disruptive behavior disorders, who live in poverty-impacted communities. This study aimed to explore group processes and caregiver perceptions of the benefits of participating in the 4Rs and 2Ss MFG. Caregivers participating in the MFG were asked to complete a 29- item questionnaire which collected information about the perceived benefits of the MFG upon Yalom's therapeutic factors, including group cohesion, universality, interpersonal learning, guidance, catharsis- and self-understanding. Data were analyzed using SPSS 25, and descriptive statistics were performed for each sub-scale. Responses of open-ended questions were reviewed and coded by two of the authors. Thirty-two caregivers completed the survey. Results indicated that the MFG offered multiple benefits that alignwith Yalom's therapeutic factors, such as creating a sense of universality, catharsis, group cohesion, and interpersonal learning. Future research is needed to determine whether such therapeutic factors are associated with changes in child outcomes and family functioning.

Introduction

Group work has had a long history as a therapeutic approach in social work; it was offered as a course in schools of social work as early as the 1930's, and was formally embedded within the profession in the 1950's as one of five major practices of the newly formed National Association of Social Workers (Andrews, 2001). Groups are purported to have many benefits-Yalom, a major developer of group work, identified 11 therapeutic mechanisms attained through group therapy, including fostering *universality*, which refers to when members in the group can recognize and share similar feelings, thoughts and problems with fellow group participants; *cohesiveness*, defined as feelings of belonging, understood and accepted by group members, *interpersonal learning,* which involves members gaining

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personal insight about their interpersonal impact through feedback provided by other participants, and *self-understanding*, which involves members gaining insight into the psychological motivation underlying their behavior and emotional reactions (Yalom, 1995; Yalom & Leszcz, 1995).

The Multiple Family Group (MFG) model is a type of group work that is composed of several families, including the identified clients (Gritzer & Okun, 1983; Jackson, 2015). An integration of group and family therapy (Gritzer & Okun, 1983; Jackson, 2015), multiple family groups may include psychoeducation, emotional support, communication and parenting skills, problem-solving strategies, and other therapeutic components depending on the intervention (McDonell et al., 2006; McKay et al., 1995; Ruffolo et al., 2005). Multiple family groups are theorized to hold unique benefits beyond usual group work; by bringing multiple clients and their families together, MFGs are proposed to foster peer support, decrease social isolation, facilitate optimism and morale, and enhance interpersonal and coping skills (McFarlane et al., 1995). Multiple family groups have also been purported to enhance engagement in services through decreasing stigma (McKay et al., 1995), although studies have not consistently supported this relationship (Ingoldsby, 2010; McDonell et al., 2006).

The MFG model has been implemented for families and adults with schizophrenia (McFarlane et al., 1995), posttraumatic stress disorder (Weine et al., 2008), alcohol and substance abuse (Schafer, 2008), as well as for children and adolescents with eating disorders (Scholz & Asen, 2010), depression and bipolar disorder (Fristad et al., 2003) and disruptive behavior disorders (McKay et al., 2002; Ruffolo et al., 2005). Results are promising; research suggests significant decreases in relapse rates among individuals with schizophrenia (McFarlane et al., 1995) and decreased externalizing and internalizing behaviors among children with a history of sexual offending (Keiley et al., 2015). McDonell and Dyck (2004) found multiple positive effects of MFGs in their review of child models with respect to both internalizing and externalizing disorders, although they caution the methodological rigor of many of the studies was lacking. In addition to improvements in mental health, MFGs may be a cost-effective alternative to individual treatment; one study, by Cunningham et al. (1995), found MFGs for families of youth with conduct problems to be over six times more cost effective in comparison to individual treatment offered in clinic settings.

Over two decades ago, McKay and colleagues developed a multiple family group model called the 4 Rs and 2Ss for Strengthening Families (4 Rs and 2 Ss) for families of children with disruptive behavior disorders (DBD)s who are impacted by poverty. DBDs are disproportionately represented in low-income communities whereupon youth and their families are faced with compounding challenges related to socioeconomic disadvantage such as unstable housing, community violence, high caregiver stress, and social isolation (Appleyard et al., 2005). Despite the presence of public mental health clinics in many low-income communities, access to and utilization of services are often met with barriers related to engagement (Acri et al., 2018). Furthermore, interventions aimed at reducing DBDs, including behavioral parent training programs, which are the most effective treatments for DBDs, can be challenging to deliver in socioeconomically disadvantaged communities in

which resources are limited and families often experience social isolation and high stress (Chacko et al., 2015; Gopalan et al., in press).

Studies of the 4 Rs and 2 Ss have consistently demonstrated significant improvements in child behavior, caregiver stress and depression in comparison to services as usual (Chacko et al., 2015; Gopalan et al., 2015, in press). However, there is not much information about how families perceive MFGs, and whether they are viewed as promoting the therapeutic values and benefits that theorists such as Yalom (1995) purported. Additionally, it is not clear whether the 4 Rs and 2 Ss multiple family group conveys the same unique benefits found in other MFGs, including enhancing peer support and decreasing feelings of isolation, improving optimism and morale, and facilitating skill-building (e.g., McFarlane et al., 1995).

Accordingly, the purpose of this study is to explore caregiver perceptions of the benefits of participating in the 4 Rs and 2 Ss as they align with Yalom's (1995) therapeutic factors proposed to facilitate therapeutic change in the group setting, as well as whether the benefits caregivers report align with the literature about MFGs. The rationale for undertaking this study was driven by the promising impact MFGs have across mental health conditions for both clients and their families, yet lack of understanding about how families view this innovative group model. Answering these questions can further the knowledge base, and ultimately lead to the examination of the relationship between perceived benefits and client and family outcomes, including attendance in services and therapeutic change.

Method

This is a sub-study of a larger National Institute of Mental Health (NIMH)-funded study that is examining a multiple family group model entitled the *4 Rs and 2 Ss (4 Rs and 2 Ss) for Strengthening Families.* Briefly, the 4 Rs and 2 Ss is a manualized, curriculum-based group that integrates common elements of evidence-informed treatments for conduct problems into a coordinated set of practices in order to decrease problem behaviors, strengthen families, and increase engagement in treatment (Acri et al., 2017; Chacko et al., 2015; McKay et al., 2002). This sub-study investigated group processes and perceived benefits of the group model among 32 caregivers of children between seven and 11 years of age who participated in a 4 Rs and 2 Ss for Strengthening Families MFG between September, 2017 and July, 2018. Depending on the clinic, families either participated in a 16-week multiple family group in which each session topic was covered over two sessions, or an adapted 8-week group in which each session topic was covered in only one session.

Procedure

Eligible caregivers were informed of this study by a member of the research staff during their follow-up assessment for the larger study. Briefly, all caregivers who received at least one group session were contacted by the research team upon their group completion. Caregivers who participated in a 16-week group were contacted for a survey 16 weeks from baseline, and caregivers who participated in the 8-week group were contacted eight weeks from baseline. If the caregiver expressed interest in the study, the staff member provided a thorough description and secured consent by phone. Once caregivers provided consent, they

completed a questionnaire by phone consisting of 23 questions that tapped into potential perceived benefits of the group and which specific content was the most helpful. Participation took between 15 and 25 minutes, and caregivers were mailed a $10.00 gift card for their participation.

4 Rs and 2 Ss For Strengthening Families

The 4 Rs and 2 Ss for Strengthening Families is a multiple family group model for children between seven and 11 years of age who meet diagnostic criteria for a disruptive behavior disorder (DBD) and their families. In this model, six to eight families including adult caregivers and siblings over six years of age meet in weekly sessions with the identified client. The targeted skills and processes are referred to in the curriculum as the 4 Rs (Rules, Responsibility, Relationships, and Respectful Communication). Session content also addresses lack of social support and high stress (the 2 Ss), which are two factors known to hinder treatment attendance (Acri et al., 2017; Chacko et al., 2015; Gopalan et al., 2015; McKay et al., 2002).

The 4 Rs and 2 Ss is co-delivered by two mental health clinicians or a clinician and parent advocate, who is a trained caregiver who has prior experience navigating the mental health service system. Children who receive the intervention are eligible to receive additional services at the clinic, including pharmacology and individual treatment while participating in the group intervention.

Inclusion/Exclusion criteria

Caregivers were enrolled in the current study if they attended   1 group sessions.

Caregivers were excluded from the study if they could not provide verbal consent or if they never attended the MFG.

Measures

Demographic variables were collected via a general sociodemographic questionnaire used in prior studies (e.g. Chacko et al., 2015; Gopalan et al., 2015) that assessed familial factors (e.g., child and caregiver age, gender, race/ethnicity, and family income).

Perceptions of the 4 Rs and 2 Ss for Strengthening Families multiple family group intervention was measured via measurement developed by the authors consisting of 29 total items. Seventeen(n=17) close-ended quantitative items targeted the perceived presence of six therapeutic factors: cohesion (3 items), universality (1 item), catharsis (3 items), interpersonal learning (4 items), self-understanding (2 items), and guidance (4 items). All responses were ranked using a 5-point likert scale ranging from *strongly disagree* (1)to *strongly agree* (5). Multi-item sub-scale scores were computed as a mean with higher scores indicating greater agreement that the group intervention experience was providing the therapeutic factor of focus. Chronbach's alphas for the 6 multi-item sub-scales were .83 (cohesion), .85 (catharsis), .92 (interpersonal learning), .79 (self-understanding), and .89 (guidance). Additionally, 7 open-ended qualitative questions asked caregivers to elaborate on

their perceptions of group benefits (e.g. "in what ways did you feel connected to the group?") Finally, five questions assessed for specific content areas and experiences which were found to be the most helpful and meaningful.

Confirmatory Factor Analysis (CFA) was performed in Mplus8 to assess the factor structure of each of the six multi-item sub-scales (cohesion, catharsis, interpersonal learning, self-understanding, and guidance). Each sub-scale model independently demonstrated good fit per global ($\chi^2 > .05$ or χ^2/df ratio less than 3.0, root mean square error of approximation (RMSEA) < .08, standardized root mean square residual (SRMR) < .05, and comparative fit index (CFI) > .95) and focused fit indices (standardized residuals <|2| and modification indices <|4|). All items loaded significantly onto their respective factors, independently, with loadings ranging from .98 to 1.2 for cohesion, 1.0 to 1.1 for catharsis, .78 to .84 for interpersonal learning, .55 to .99 for self-understanding, and .05 to .91 for guidance. As a result of the CFA findings in conjunction with the Chronbach's alphas of .83, .85, .92, .79, and .89 respectively, treating the items as unidimensional sub-scales were determined to be reasonable.

Weekly attendance was tracked by group facilitators, and ranged from 1 to 16 sessions.

Data Analysis

Data were analyzed using SPSS 25 and Mplus8. Descriptive statistics (e.g., sums, means and standard deviations) were performed for each of the six therapeutic factor sub-scales. As mentioned above, Cronbach's alphas were evaluated in addition to confirmatory factor analysis for all multi-item sub-scales. Responses to open-ended questions were reviewed and coded by two of the authors (K.L., M.G.) with oversight from the main author. Any disagreements in categorization were discussed among all of the authors until consensus was reached. Frequencies and percentages were calculated. Institutional Review Board approval was obtained.

Results

Forty-three (n=43) caregivers were contacted by phone to complete a follow-up assessment: Of them, 33 (77%) caregivers were successfully reached, and 32 of the 33 provided consent to participate in the study. Table 1 presents the sample's demographic characteristics. Caregivers were 42 years of age on average (*SD = 11.47*), primarily female (n=29, 91%), and almost two-thirds self- identified as the child's mother (n=18, 61%). Over half of caregivers reported their racial status as Black/African American (n=13, 52%), followed by 11 (44%) caregivers who identified as White. Eighteen (n=18, 67%) caregivers reported their ethnic status as Non-Hispanic/Latino.

Almost half of caregivers reported being single (n=13, 43%), just over one-quarter completed high school (n=8, 27%), and almost half worked full-time (n=14, 47%). One-third of caregivers reported a household income of over $50,000 a year (n=9, 33%), followed by seven (30%) caregivers who reported an annual household income of less than $9,999.

The average age of the identified child was nine (SD = 1.39) and the majority were male (n=22, 70%). Almost half of the children were Black/African-American (n=13, 57%), followed by 8 (35%) who were White. Over half of the sample of children were Non-Hispanic/Latino (n=18, 58%).

Caregivers who participated in the eight-week group format attended 5.6 sessions on average (SD=2.09), and caregivers who participated the 16-week group format attended 10 sessions (SD=4.24) on average. Six (n=6, 19%) caregivers across both formats completed the entire group.

Therapeutic Factors

Group Cohesion

On average, caregivers endorsed a mean score of 4.30 (SD= .58) in alignment with agreement (4th point on the Likert scale) about the group providing a sense of cohesion amongst its members Twenty-nine (n=29, 91%) participants provided 34 unique responses regarding the ways in which the achieved this aim. Most commonly, cohesion was attained through a sense of shared experiences (n=17, 50%), followed by through interpersonal learning about parenting (n=8, 24%), by fostering a family-like environment (n=5, 15%), and via open communication between group members (n=4, 12%). With respect to shared experiences, one caregiver stated, *"Many of [the other caregivers] were going through the same behaviors I was going through with my child. They understood how difficult it was to understand my child."*

Universality

On average, caregivers endorsed a mean of 4.13 (SD= .75) for the single-item in alignment with agreement (4th point on the Likert scale) that the group process conveyed a sense of universality. A total of 27 (84%) participants described 27 responses regarding the ways in which they felt that the group facilitated this therapeutic factor. Most responses (n=18, 67%) indicated the group provided a platform to share experiences, followed by five (19%) responses pertaining to the group discussions and group problem solving (n=5, 19%), and three (11%) responses regarding the group fostering a sense of openness and trust (n=3, 11%). As noted by one caregiver, *"The kids had a lot of similarities in behaviors we all had the same problems dealing with the kids and at home situations. We all connected with the same things."* A second remarked *"Through our conversations and body language, we all were on the same page."*

Catharsis

On average, caregivers endorsed a mean score of 4.04 (SD= .68) in alignment with agreement (4th point on the Likert scale) that the group yielded a feeling of catharsis. Almost all caregivers agreed (n=19, 59%) or strongly agreed (n=10, 31%) that they felt comfortable expressing their feelings to other members of the group. Twenty-four (n=24, 75%) participants provided 29 responses of the ways in which they felt the group process helped them express their feelings. Fourteen (n=14, 48%) responses indicated that the sharing of experiences and group discussions helped caregivers express themselves, while twelve

(n=12, 41%) responses suggested that open communication and feelings of safety and comfort in a non-judgmental setting fostered trust and allowed caregivers to express their emotions. As exemplified by one caregiver who noted a supportive environment, "*The group was very open and the people in the group no matter the situation were always welcoming and made you feel comfortable.*"

Interpersonal Learning and Self-Understanding

On average, caregivers endorsed a mean score of 4.21 (SD= .58) in alignment with agreement (4th point on the Likert scale) that the group fostered interpersonal learning. As for self-understanding, on average, caregivers endorsed a mean score of 4.13 (SD= .56) in alignment with agreement (4th point on the Likert scale) that the group encouraged self-understanding. The majority of caregivers strongly agreed (n=9, 29%) or agreed (n=20, 65%) that they learned about their strengths as a parent/caregiver by sharing with others; 18 caregivers (58%) agreed and 10 (32%) strongly agreed that they learned ways to improve their parenting; and 18 participants (58%) agreed and 9 participants (29%) strongly agreed that they after participating in the group, they felt more trustful of groups and other people The majority of the sample also agreed (n=18, 58%) and many strongly agreed (n=9, 29%) that they identified areas where their parenting practices could improve based upon the group. Finally, the majority of the sample agreed (n=20, 65%) and many strongly agreed (n=7, 23%) that they came to understand the connection between their emotions and their behavior as a parent/caregiver.

Twenty-three (n=23, 72%) participants provided 27 responses about how the group facilitated learning about themselves as a parent/caregiver. Responses included learning techniques to increase positive interpersonal communication (n=9, 33%), the identification of personal strengths (n=7, 25%), and recognizing maladaptive patterns in child and caregiver interpersonal communication (n=5, 18%). One caregiver indicated "*I need to do less yelling when speaking to my son.*" Another caregiver who learned techniques to increase positive interpersonal communication with their child indicated that by watching other caregivers in the group, "*I learned how important it is to watch how I speak to my children, to try to remain calmer to keep them calm.*"

Guidance

On average, caregivers endorsed a mean score of 4.04 (SD= .61) in alignment with agreement (4th point on the Likert scale) that the group and group facilitators provided guidance about parenting and managing their child's behavior. When asked whom participants preferred to received feedback from, there was a discrepancy between the closed and open-ended responses. When responding to the close-ended question, five (n=5, 16.1%) of respondents strongly agreed, and 8 (26%) of respondents agreed, that they preferred to receive suggestions and feedback by group facilitators. One caregiver stated that they "*Preferred the group facilitators because they [the group facilitator] would explain with an example as to why trying something new would work better, and also because the facilitators are explaining it easily to my son.*" On the contrary, 3 (10%) caregivers strongly agreed, and 6 (19 %) agreed that they preferred group members, citing the importance of other parents' lived experience. A caregiver who preferred the importance of other parents' lived

experience stated, "*I want to say I learned more from the other group members because they were experiencing the same thoughts and feelings as me as a parent.*"

However, most of the 18 open-ended responses indicated no preference (n=13, 72.2%), followed by three (16.7%) responses that favored the group facilitators, and two (11.1%) that favored group members.

Meaningful Aspects of the Group and Content

Finally, caregivers reported that the most meaningful aspects of the group were conveying the feeling that they were not alone (n=21, 66%) and that they were understood (n=15, 47%). Most caregivers (n=29, 91%) believed the group was helpful to them, that they learned something (n=29, 91%), and that they would recommend the group to others (n=30, 94%). Of the content areas, Rules (n=25, 78.1%) and Respectful Communication (n=21, 65.6%) were perceived as the most helpful to their own experience, and Respectful Communication (n=24, 75%) and Rules (n=22 22,68.8%) for their child.

Twelve (n=12, 38%) participants provided overall feedback on the 4 Rs and 2 Ss. Five (n=5, 31%) caregivers reported positive feedback as one caregiver stated: "*[It] was a wonderful experience to learn with my child to better communicate.*" Two (n=2, 13%) caregivers stated that they would participate again in the 4 Rs and 2 Ss. One caregiver (n=1, 6%) cited the importance of having shared experiences with others stating, "*The group was fun, I learned to laugh, most of the other parents were very helpful with sharing their experiences.*" Four (n=4, 25%) participants referred to both positive and negative aspects of activities embedded within the group, stating "*the roadwork [homework] ideas seemed so simple yet helpful,*" whereas another participant stated "*some of the activates were very hard to get my family to do.*" One participant (n=1, 6%) referred to having an issue with the facilitator's approach, and two participants (n=2, 13%) referred to group dynamics, stating "*my daughter was the only girl in the group and I think that deterred her activity in the group.*" See Table 2 for the full results of the survey.

Discussion

The purpose of the study was to examine the perceptions of a multiple family group model for child behavior problems on behalf of caregivers participating in the 4 Rs and 2 Ss. Children living in communities that are impacted by poverty are at heightened risk for disruptive behavior disorders, yet they are the least likely to access or remain in services. Their caregivers commonly report feelings of social isolation and blame for their child's problems: High levels of stress related to parenting and depression are common. Multiple family groups have been proposed as a way to decrease social isolation and enhance support, facilitate the exchange of skills, and foster hope and morale for families, as well as potentially enhance engagement in services (Acri et al., 2017; Acri et al., 2018; Chacko et al., 2015; Gopalan et al., in press; McKay et al., 1995).

The main findings of this study align with these benefits. Specifically, caregivers overwhelmingly reported a sense of group cohesion and a universality of experiences. They frequently referred to the group members as family, with a shared understanding of the

difficulties dealing with child behavior problems. In fact, caregivers reported that the most meaningful aspects of the group were that they felt they were not alone and that they were understood.

Additionally, group members gained insight into themselves, their parenting practices, and the connection between their emotions and their behaviors as a caregiver. They saw areas of their parenting that could be strengthened, and critically, learned techniques provided through the content and group experience to enhance the quality of their parenting and their relationship with their child.

These findings suggest that the 4 Rs and 2 Ss offered multiple benefits that align with Yalom's (1995) therapeutic factors, such as creating a sense of universality, catharsis, group cohesion, and interpersonal learning. While informative, one limitation of this study is that not all of Yalom's factors were assessed. Additionally, the child's perspective was not captured. Consequently, it is not known how youth perceived the group with respect to the remaining therapeutic benefits such as instilling hope, how youth perceived the group, and if their perceptions align with the benefits of a MFG model and proposed therapeutic factors. Future research capturing all group participants would aid in a fuller understanding of the strengths of MFG's and the possible agents of change for children with disruptive behaviors and their families.

These findings also support the unique benefits of the MFG model, in that bringing several families together who have a shared experience of caring for a child with disruptive behavior problems may be a powerful mechanism of support. Theoretically, peer-to-peer models, in which there are shared experiences, is proposed to be a powerful way in which to align and support individuals experiencing similar difficulties (Hoagwood et al., 2010). Yet, in seeming contrast, an unexpected finding was that a sizable number of caregivers preferred to hear feedback from group facilitators over their peers. As stated previously, results of the closed-ended question found five (n=5, 16%) strongly agreed, and 8 (n=8,25%)caregivers agreed, that they preferred to receive feedback from the group facilitators.. In contrast, 18 (72.2%) responses to the open-ended question found caregivers had no preference regarding whom they preferred to receive feedback from, three (16.7%) preferred the group facilitator, stating *"Group facilitators are more experienced. They studied for this,"* and *"[group facilitators] would explain with an example as to why trying something new would work better,"* and two (11.1%) preferred group members, citing the importance of other parents' lived experience. They stated, *"I learned more from the other group members because they were experiencing the same thoughts and feelings as me as a parent,"* and *"Watching other parents gave me ideas."*

It is not immediately clear why these findings were contradictory-the number of responses may be indicative; 31 participants answered the close-ended question, while only 18 individuals provided a response to the open-ended question, and there were only 18 unique responses. Yet, it may be that caregivers preferred to receive specific types of information from group facilitators versus peers. Additional research is needed to discern the benefits of peer support and whether there are different preferences and expectations for peers versus mental health professionals.

A final finding of import was that the most helpful skills and components to caregivers and their children were Rules and Respectful Communication, while Social Support and Stress ranked among the least helpful to the caregiver and the child. This result was somewhat counter to expectations, given families who are impacted by poverty often report high rates of social isolation and stress (Chacko et al., 2015), and that many of the responses provided by caregivers about the benefits of the MFG reflected the supportive nature of the group setting.

One interpretation of this finding is that families engaged in the group because of their child's difficulties, and may not have identified the importance of the role in supporting parental emotional health and support within this context.

There is a considerable literature that shows that the quality of parenting and the parent/child relationship is affected by caregiver stress and lack of social support (Acri et al., 2018). However, caregivers may not see this connection, and view support provided by the group to be an additional benefit to the treatment, but not a primary focus. Indeed, most parenting programs for children with behavior problems focus on skill acquisition, and literature indicates only moderate parental involvement in child treatment (Haine-Schlagel & Walsh, 2015). Providing information about how parenting is influenced by caregiver factors such as stress and social isolation may help caregivers gain awareness of this relationship; providing support to caregivers in the context of child mental health services may alleviate distress and subsequently enhance parenting and the quality of the parent/child relationship.

Implications for Social Work Practice and Research

Collectively, these findings suggest that a multiple family group modality may scaffold high-risk families living in poverty-impacted communities who are at high risk for parental distress, lack of social support, and behavior disorders among youth. Given the potential benefits of MFG models upon therapeutic outcomes and cost effectiveness, the multiple family group intervention has much to offer families of children with behavioral health problems. Many of the benefits noted, such as peer support and learning from other parents would not be possible in a one-on-one setting. Practice would benefit from the incorporation of these models within clinic and community settings. Incorporating caregiver support and education could also potentially improve outcomes. Future research testing these models and gaining the perspective of all participants has the potential to bolster our understanding of MFGs.

Limitations

Alongside the limitations noted earlier, several factors must be taken in account when interpreting the findings of this study. First, a substantial number of caregivers who were potentially eligible for inclusion were not able to be contacted, which compromises the generalizability of the findings. Likewise, we focused on primary caregivers, but did not include additional family members or the child's perspective-these are all potential avenues for future research.

Additionally, all of the participants agreed to receive the group intervention; thus, they may have already held favorable views of group work. Along these lines, we did not survey caregivers who did not attend the group-they may have held alternative views about the group not captured in this study.

Another limitation of the study is that there was no psychometric testing of the validity of the measure. Although we believe that triangulating the close-ended items with participants' open-ended responses enhanced the validity of the findings, future research is necessary to examine its psychometric properties beyond the reliability of the measure, Further, while several therapeutic factors were evident in the findings, it was beyond the scope of the study to tie them to child outcomes or engagement. Future research is needed in order to determine the reliability and validity of the measure, and whether Yalom's (1995) therapeutic factors are associated with actual change in client and family health and functioning, in order to advance our knowledge about the benefits of multiple family group models. Accounting for these limitations, this study is a hopeful step towards discerning the benefits of a multiple family group intervention for families who have been impacted by poverty and are at the highest risk for conduct problems and lack of access to care.

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Table 1

Demographic Characteristics of Participants

Characteristic	Mean	SD	n	%
Child Age	8.63	1.39		
Caregiver Age	41.74	11.47		
Primary Caregiver				
Mother			18	60.6
Mother and Father			6	20.0
Grandparent			3	10.0
Other			3	10.0
Caregiver Gender				
Female			29	90.6
Male			2	6.3
Caregiver Nativity				
Born in US			20	62.5
Not born in US			10	31.3
Caregiver Race				
Black/African American			13	52.0
White			11	44.0
Native Hawaiian/Pacific Islander			1	4.0
Caregiver Ethnicity				
Non-Hispanic			18	66.7
Hispanic/Latino			9	33.3
Caregiver Marital Status				
Single			13	43.3
Married			10	33.3
Domestic Partnership			2	6.7
Divorced			2	6.7
Common Law			1	3.3
Separated			1	3.3
Widowed			1	3.3
Education				
8th grade or less			2	6.7
Some high school			4	13.3
Completed high school/GED			8	26.7
Some college			3	10.0
2-year associate degree			5	16.7
4-year bachelor degree			5	16.7
Some graduate or professional school			2	6.7
Completed graduate or professional school			1	3.3
Caregiver Employment				
Full-time			14	46.7

Characteristic	Mean	SD	n	%
Part-time			3	10.0
Retired			3	10.0
Disabled			2	6.7
Unemployed			5	16.7
Other			3	10.0
Family Income				
Less than $9,999			7	25.9
$10,000 to $19,999			2	7.4
$20,000 to $29,999			3	11.1
$30,000 to $39,999			3	11.1
$40,000 to $49,000			3	11.1
Over $50,000			9	33.3
Child Gender				
Male			22	69.8
Female			10	31.3
Child Race				
Black/African American			13	56.5
White/Caucasian			8	34.8
American Indian/Alaska Native			1	4.3
Native Hawaiian/Pacific Islander			1	4.3
Child Ethnicity				
Non-Hispanic/Latino			18	58.1
Hispanic/Latino			13	41.9

Table 2

Open-Ended Responses

Question/Respondents	Total Responses	Codes	n	%
Cohesion				
1. What were the ways that the group facilitated cohesion (n=29)	34	Shared experiences	17	50%
		Interpersonal learning	8	23.5%
		Familiarity/sense of family	5	14.7%
		Open communication	4	11.8%
2. Ways group did not facilitate cohesion	11	Group dynamics	5	45.5%
		Lack of trust	3	27.3%
		Attendance issues	2	18%
		Other	1	9.1%
Universality				
3. Ways participants felt they were not the only one in the group experiencing difficulties with their child (n=27)	27	Shared experiences	18	66.7%
		Discussions/group problem solving	5	18.5%
		Openness/trust	3	11.1%
		Other	1	3.7%
Catharsis				
4. Ways the group helped caregivers express their feelings (n=24)	29	Shared experiences/Group discussions	14	48.3%
		Supportive environment/Open communication	12	41.4%
		Other	3	10.3%
Interpersonal Learning				
5. Ways in which the group facilitated learning about caregivers' self as a parent (n=23)	27	Learned techniques to increase interpersonal learning	9	32.1%
		Identification of personal strengths	7	25%
		Recognized maladaptive patterns in communication	5	17.9%
		Universality/Shared experiences	4	14.3%
		Recognized positive patterns in communication	1	3.6%
		Other	1	3.6%
Guidance				
6. Preference to receive feedback from group members or group facilitators group facilitators (n=18)	18	No preference	13	72.2%
		Group facilitator	3	16.7%

Question/Respondents	Total Responses	Codes	n	%
		Group members	2	11.1%
Overall Feedback				
7. Additional comments (n=12)	16	Positive experience	5	31.3%
		Activities	4	25%
		Group dynamics	2	12.5%
		Would participate again	2	12.5%
		Issues with facilitator approach	1	6.3%
		Shared experiences	1	6.3%
		Other	1	6.3%