Multifamily Therapy Group for ADHD Children and Their Families:

A Delphi Study

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Abstract

Attention Deficit Hyperactive Disorder (ADHD) is a chronic disorder characterized by primary symptoms of inattention, impulsivity and sometimes hyperactivity. ADHD children suffer not only from these primary symptoms, but also from secondary negative impacts including poor peer relationships, increased conflict within family interactions as well as diminished academic achievement and increased classroom disruptions. In order to target these concerns, a 12 week pilot Multifamily Therapy Group curriculum was developed for implementation in a social service agency setting with ADHD children aged ten to twelve and their families. Using the Delphi Method, a panel of experts evaluated the curriculum, treatment process, and modality applicability. Findings and recommendations from the expert reviews will be discussed.

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Chapter One: Introduction

Attention Deficit Hyperactivity Disorder

Attention Deficit Hyperactivity Disorder (ADHD) is a disorder that affects as many as 5-7% of the general population (Johnson, Franklin, Hall & Prieto, 2000). Usually present from infancy, ADHD is characterized by developmentally inappropriate levels of inattention, impulsivity, or hyperactivity. Inattention symptoms include distractibility, forgetfulness and difficulty maintaining attention. Hyperactivity presents as talking too much, fidgeting or excessive physical energy, while impulsivity symptoms include interrupting others, blurting out and struggles with waiting one's turn (Mrug, Hoza & Gerdes, 2001). Viewed as chronic, ADHD can negatively impact a child's psychosocial functioning (Anastopoulos, Barkley, Sheldon, Hibbs & Jensen, 1996). According to Barkley et al. (2002) "there is no doubt that ADHD leads to impairments in major life activities, including social relations, education, family functioning, occupational functioning, self-sufficiency, and adherence to social rules, norms, and laws" (p. 96).

Follow-up data from clinical studies indicate that ADHD children are at greater risk than neurotypical children to:

> "drop out of school (32–40%), not complete college (5–10%), have few or no friends (50–70%), underperform at work (70–80%), engage in antisocial activities (40–50%), and use tobacco or illicit drugs more than normal. Moreover, children growing up with ADHD are more likely to experience teen pregnancy (40%) and sexually transmitted diseases (16%), to speed excessively and have multiple car accidents, to experience depression (20–30%) and personality disorders (18–25%) as adults, and in hundreds of other ways mismanage and endanger their lives" (Barkley et al., 2002, p. 97).

Children with ADHD often experience academic underachievement, conduct problems and difficulty interacting with peers and adults. ADHD children's hyperactive and aggressive behaviors, together with their inattentiveness and academic struggles, seem to be the chief causes of their vast peer rejection (Mrug et al., 2001). Relationships with teachers are often strained, further contributing to difficulties in school for children with ADHD. Problematic parent-child interactions are also common (Barkley, Edwards, Laneri, Fletcher & Metevia, 2001).

The impact of ADHD on a family with an ADHD child can be significant. Children with ADHD are less cooperative when given directives from their parents, are obedient for shorter time periods, are less likely to stay on task, and display more negative behavior compared to same-aged peers (Wells et al., 2006). When children display less responsive or more disruptive behaviors, parents often become more directive and disapproving which may contribute to children further engaging in negative behaviors (Wells et al., 2006). Thus, parents and children with ADHD can easily become entrenched in negative patterns of interaction. This may be compounded by the fact that parents of children with ADHD may be predisposed to increased marital distress as well as their own psychopathology (Anastopoulos et al., 1996). Difficulties in parent-child and family relationships represent a considerable source of stress that may be the impetus for parents of ADHD children to seek treatment (Cunningham, 2007).

Further, since ADHD is a heritable disorder (Griggs & Mikami, 2011), there is a higher likelihood that children with ADHD may have at least one parent who also suffers from symptoms of the disorder. Chronis-Tuscano et al. (2011) report that mothers with significant ADHD symptoms may have more difficulty using skills taught in behavioral training due to their inability to inhibit negative reactions to their ADHD child's behavior, and this may explain the

diminished reduction in child behavior problems following treatment (Chronis-Tuscano et al., 2011).

Although there is a plethora of research on ADHD there is little consensus about how to treat the numerous effects of ADHD, including improving a child's relationships with peers and family members. Some researchers report stimulant medication alone as the most successful treatment modality for children with ADHD. Yet, there are risks and side effects to medications that lead many parents to choose not to medicate their child. Medication alone addresses only the core symptoms of ADHD children, therefore some researchers propose augmenting it with behavioral interventions to address secondary problems such as difficulties with peers and family relationships. Still others propose parent coaching alone, intensive individual behavioral interventions, or cognitive behavioral social skills training. While there is no consensus on the recommended approach, including a systemic component and including family members is empirically supported.

Importance of Systemic Intervention

Systemic interventions that include family members and children have been recommended as components of treatment programs for ADHD children (Anastopoulos et al., 1996). Although research is mixed on the effects of behavioral interventions in the short-term, systemic interventions play an increasingly significant role (Carr, 2009). Anastopoulous et al. (1996) emphasize the importance of targeting not only the child's primary ADHD behaviors, but also co-occurring problems, such as conflictual family relationships, oppositional-defiant behavior and conduct problems. It is also important to incorporate the parents of ADHD children into the treatment plan to support children towards sustained changes.

Multiple Family Group Therapy

Multifamily therapy was developed in the 1950's as a cost-effective, systemic alternative to individual family therapy (Keiley, 2002). Multifamily groups often utilize family systems and family stress theories as their theoretical basis, interweaving elements of structural family therapy, group therapy, behavior modification, parent education and crisis intervention (Meezan & O'Keefe, 1998). More recently, multifamily group therapy has been developed for use with families of oppositional or conduct disorders, many incarcerated. One of the basic systemic precepts utilized in developing multiple family therapy is the concept that difficulties in relationships are a consequence of dysfunctional feedback loops across subsystem boundaries (Asen, 2002). Family members can learn from each other, as well as facilitators which allows for multiple avenues of awareness. Multiple family treatment research indicates significant decreases in disruptive behavior as well as hyperactivity and impulsivity (McKay, Gonzales, Quintana, Kim, & Abdul-Adil, 1999). ADHD children may benefit from the framework of multiple family therapy groups, offering support both for the ADHD child and other family members.

Theoretical Framework – Family Systems Theory

One of the basic assumptions of family systems theory is that the locus of pathology lies not within the person, but within the system (Smith, Hamon, Ingoldsby, & Miller, 2009). Diverging from an intrapsychic perspective of a person's problem existing within that person, systems theory attributes the dysfunction to the system itself. By definition, many tenets of Family Systems Theory appear to fit the mold for this study. Elements within the system are unavoidably interdependent, patterns within a system are circular rather than linear, feedback loops guide behavior, and perhaps most importantly, rules and patterns dictate the interactions

across the subsystem boundaries (Smith et al., 2009). Perhaps the homeostatic features that maintain the stability of family patterns along with enforcing its rules of redundancy are intrinsic to the complexity of determining effective treatment modalities for ADHD children and their parents.

Purpose of the Study

This study aimed to evaluate a proposed curriculum for a multifamily group for ADHD children and their families for use in a social service agency setting. A pilot curriculum was developed for expert review and data were collected from expert reviewers in an effort to reach consensus on critical aspects of the constructed treatment manual including the modality, program goals, session structure, and interventions. Furthermore, this study intended to reach expert consensus on other factors thought to be relevant to successful treatment such as appropriate demographics for participation in the program, including age of the ADHD child.

Research Question

What is the consensus view on the proposed ADHD multifamily group curriculum developed for implementation in a social service agency setting?

Chapter Two: Literature Review

The aim of this study is to explore experts' views on a proposed multifamily therapy group for ADHD children and their families. The literature review first seeks to explore current research on ADHD, various treatment modalities for ADHD children, comorbidity, support for a systemic approach, a brief history of multifamily group therapy, and a proposed treatment model.

ADHD

ADHD is included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000) under the work group category as a disorder usually first diagnosed in infancy, childhood or adolescence and is characterized as a pattern of inattention and/or hyperactivity-impulsivity greater than is typically observed in individuals of comparable developmental levels. The DSM-IV-TR delineates three subtypes of the disorder, predominately inattentive, predominately hyperactive-impulsive and combined type. The subtype is specified based on the principal symptom pattern over the previous six months. Critical to the diagnosis is that the symptoms present as maladaptive and inconsistent with developmental levels and are present in two or more settings, for instance home, work or school. Also key to diagnosis is clear evidence of clinically significant impairment in social, academic or occupational settings (DSM-IV-TR, 2000).

Interestingly, proposed changes to the fifth edition of the DSM (DSM-V) appear to move ADHD away from being listed as a disorder in children into being a neurodevelopmental disorder with a childhood onset (Dalsgaard, 2013). In the 1990's, the disorder was believed to be mainly a childhood disorder. However, studies have reported that many children with ADHD continue to have symptoms in adolescence and as adults, impairing functionality (Kessler et al., 2005; Barkley, 2004). Another proposed change to the diagnostic criteria is the increase in age

of onset of ADHD symptoms from age 7 to age 12 years old. Finally, the proposed changes allow for the diagnoses of ADHD co-occurring with Autism Spectrum Disorder. These proposed changes expand both the age range and scope of symptoms for the disorder, potentially increasing the number of children and adults who may be diagnosed with ADHD in the future.

Comorbidity and Duration of Disorder

Until the 1980's there was a lack of research on ADHD adolescent children. Smith, Waschbusch, Willoughby and Evans (2000) report that the dearth of research was because ADHD was believed to be a childhood disorder with symptoms diminishing after puberty. We now know that adolescents with a history of childhood ADHD suffer increased interpersonal and academic problems as well as have an elevated risk for car accidents and higher rates of criminal activity and dropping out of school (Smith et al., 2000). Children with ADHD are also likely to suffer from other mental health disorders simultaneously. For example, findings suggest that comorbid Oppositional Defiant Disorder (ODD) occurs in 45–65% of the cases of ADHD diagnosed in childhood (Barkley, Guevremont, Anastopoulos, Fletcher & Kenneth, 1992). ADHD/ODD children not only are associated with greater family conflict, but also exhibit higher incidence of early substance experimentation and abuse than children diagnosed with ADHD without ODD (Barkley et al., 1992). Furthermore, research suggests that the effect of family conflict is a significant predictor of concurrent and later adolescent psychological well-being (Shek, 1998).

Findings from intervention studies researching ADHD adolescents possessing comorbidity with other psychological disorders have indicated limited effects. Barkley et al. (2001) studied 97 ADHD/ODD adolescents aged 12-18 utilizing two treatment modalities: Problem-solving Communication Training (PSCT) alone compared with a combination of PSCT and Behavior Management Training (BMT). PSCT is a family-based program designed to

address familial conflict where both teen and parents are active participants in the treatment. Problem solving, communication and cognitive restructuring are the three major components of PSCT. BMT, originally designed for younger children, teaches parents to utilize cost benefit management methods for modifying inappropriate behavior and increasing desired behavior, for instance point systems, tokens and time-outs. Participants were either assigned to 18 sessions of PSCT or 9 sessions of BMT followed by 9 sessions of PSCT (BMT/PSCT). Barkley et al. (2001) did not report reliable group-level changes or significant differences between treatment modalities. In fact, the only significant finding was a greater number of families dropped out of PSCT treatment as compared to BMT/PSCT. This study did not require both parents to attend the treatment (Barkley et al., 2001) which may have limited the effects of the treatment.

Treatment Modalities

Although there are numerous treatment modalities for ADHD, medication management and behavioral interventions are the most commonly used and researched. Parent training has been placed under the umbrella of behavioral interventions, primarily as a way to support ADHD child behavioral interventions but also in combination with other treatment modalities or as a stand-alone treatment. Treatment modalities target different components of ADHD, sometimes aimed at reducing the core symptoms of inattention, impulsivity or hyperactivity, whereas others target relational struggles of ADHD children and focus on either peer relationships or family strife.

Medication management. There has been a plethora of research conducted on the efficacy of medication management on the reduction of symptoms for ADHD children in the United States. The most common method of ADHD treatment is medication with stimulants (Pelham & Hoza, 1996). Approximately 80% of children receiving pharmacotherapy agents for

the management of ADHD are prescribed stimulants (Daly, Creed, Xanthopoulos, & Brown, 2007). Medication alone has been reported to reduce both the frequency and intensity of problematic behaviors correlated with ADHD along with providing increased self-control and better regulation of attention (Klassen, Miller, Raina, Lee & Olsen, 1999). Researchers report that stimulant drugs (methylphenidate and amphetamine) are predominantly effective in the treatment of ADHD because they are dopamine (DA) agonists. According to Swanson et al. (2013), "These drugs act by increasing synaptic DA (by blocking the [Dopamine transmitters] DAT or increasing release of DA from presynaptic terminals), which is assumed to correct an underlying neural deficit in individuals with ADHD" (p. 132). Deficits in working memory are frequently found in ADHD children and often improve with psychostimulant treatment (Wong & Stevens, 2012).

However, there are limitations to medication management as a modality for ADHD children. First, approximately 30% of children do not respond to ADHD medications (Wagner & McNeil, 2008). Furthermore, effects of stimulant medication is typically short-term, as the treatment works while the child is taking the medication but may not affect all secondary areas of functioning, in particular peer functioning or negative interactions with family members (Pelham, Wheeler & Chronis, 1998). Also, stimulant medication has been reported to significantly stunt growth in young children (Swanson et al., 2006). Another limitation to medication management for ADHD children are two reported side effects: diminished appetite and insomnia (Efron, Jarman & Barker, 1997). Furthermore, although stimulant medication may reduce ADHD symptoms for children, the side effects of diminished appetite and insomnia may impact family functioning, increasing familial problems during meals and bedtime (Cunningham,

2007). Finally, parents often discontinue pharmacological interventions for their ADHD child even when the medication has appeared effective (Cunningham, 2007).

Behavioral interventions. Behavioral interventions as a treatment modality for ADHD children have been studied extensively as well, with interventions geared toward the child, parents, or both. Included in this review is a discussion of the more recent research in this area.

Curtis (2010) conducted a study of a pilot ten-week behavioral intervention for families with children ages 7-10 diagnosed with ADHD combined type. The pilot consisted of a combination of the Family Skills Training for ADHD related symptoms (Family Stars) and Behavior Parent Training (BPT). Treatment included ten, one-hour sessions: children and parents met separately for the first 45-50 minutes of each session. The last 10 to 15 minutes included the parents, child and clinician, where first the therapist modeled, then the parent and child practiced skill building for behavior management, followed by a discussion of weekly therapy assignments. The child component used behavioral motivation techniques and sessions were focused on a targeted behavior with a specific benchmark for performance. The clinician recorded the frequency of the designated targeted behavior, such as paying attention, interrupting appropriately and recognizing personal space. Children received reinforcers if they met the benchmark and if a weekly worksheet was completed and returned. BPT is a component of STARS designed to increase parents' self-efficacy for behavior management techniques. The parent component was geared towards psychoeducation about ADHD and teaching skills to promote desired childhood behaviors using positive and negative reinforcement. Comparing baseline to post-treatment functioning, Curtis (2010) reported clinically significant improvement for behavioral symptoms.

Webster-Stratton, Reid and Hammond (2001) conducted a study of 99 children aged 4-8 years old with early-onset conduct problems, utilizing a social skills and problem solving training curriculum. This study was directed towards children diagnosed with ODD and CD, however due to the high comorbidity of ADHD with these disorders, children with ADHD were included in the sample. At the conclusion of treatment, 62.5% of children classified as ADHD at baseline were classified as non-ADHD at post-treatment. However, children who had a parent with a negative risk factor, defined as demonstrating critical behavior or physical punishments showed significantly fewer improvements compared with children who did not have a parent with a negative risk factor. It is possible that social skills programs may result in limited results without a parental training component. Webster-Stratton et al. (2001) state: "Children with conduct problems whose parents have positive skills seem to benefit from the added child training, even if they also show ADHD symptoms, whereas those who still have negative and punitive interactions modeled at home will be less likely to succeed with the child training alone" (p. 951). These studies support including a family component to ADHD treatment for children.

The Multimodal Treatment Study of Children with ADHD (MTA) was a cooperative treatment study conducted by six independent research teams in collaboration with the National Institutes of Health. The MTA included 2,517 children, aged 7-9.9 at the start of the study. Randomized clinical trials compared the relative effectiveness of medication management, behavioral intervention, and the combination of medication management and behavioral interventions (Wells et al., 2006). Initial studies reported significant advantages of medication management and combination of medication management and behavioral interventions over either behavioral medication and community care for ADHD symptoms at 14 and 24 months

(MTA Cooperative Group, 1999). However, as described below, follow-up studies of MTA produced mixed results.

Wells et al. (2000) examined parent-rated measures of negative parenting across the treatment groups within the MTA study and reported that all MTA interventions resulted in decreased negative parenting compared to the standard community treatment. Interestingly, the three MTA treatments did not differ significantly from each other on this domain. Nor were differences noted among the four groups on positive parenting or on family stress variables. In other words, parents and children reported improvements across the board – but that it could not be separated out where the gains were made (Wells et. al., 2000). This study was limited by a reliance on self-report measures. In response to this limitation, Wells et al. (2006) conducted a follow-up study and utilized trained observers to code videotaped parent-child interactions. In this MTA study, Wells et al. (2006) studied laboratory observations of parent-child interactions which were coded by researchers who were blind to their treatment group. Although earlier studies using parent and child self-report measures did not confirm increased positive reports for combination treatment, this study found significantly greater improvements in parental use of proactive parenting strategies from the multimodal approach (the combination group) than the medical management or community groups (Wells et al., 2006). When parents utilize a planned and proactive approach to managing challenging behaviors, there is reduced negative emotional reactivity and greater consistency in appropriate responses to negative ADHD childhood behaviors (Wells et al., 2006).

In an effort to fill gaps in understanding long-term ADHD outcomes and their relationship to medication persistence, Jensen et al. (2007) conducted a three year follow-up study to MTA. Four hundred eighty five of the original 579 (83.8%) ADHD children

participated; participants were 10 – 13 years old at the time of the follow up study. Treatment groups at 36 months did not differ significantly on any measures; this was in contrast to the significant advantage of Medication Management and Combination of Medication Management with behavior therapy over Behavior Therapy and Community Care for ADHD symptoms at 14 and 24 months. By 36 months, the earlier advantage of having had 14 months of medication was no longer apparent. However, this study did find that all four groups showed significant improvements from baseline to 36 months in symptoms and overall functioning (Jensen et al., 2007). These results point to the need for further longitudinal studies.

In an effort to continue examining the longitudinal effects of ADHD treatments in the MTA Study, Molina et al. (2009) studied whether symptom trajectory through three years predicted outcome in the following years as well as a comparison of functioning of ADHD adolescents and their non-ADHD peers. Molina et al. (2009) reported that neither the type nor intensity of 14 months of ADHD treatment for children 7 – 9.9 years old was predictive of functioning 6–8 years later. Instead, ADHD symptoms in early childhood, despite symptom improvement during treatment that is largely maintained afterwards, continued in adolescence, specifically in areas of arrests, delinquency, grade retentions, academic performance (grades), and psychiatric hospitalizations. Molina et al. (2009) recommends targeted approaches specific to adolescence, as well as those that facilitate adult functioning. Although initial MTA studies reported ADHD symptom reduction, longitudinal studies suggest ADHD childhood impairment persists regardless of treatment modality. Multifamily group treatment for children 10-12 years old may bridge this gap between earlier childhood interventions and adolescence.

Peer Difficulties

Initial studies from the MTA did not address peer-assessed outcomes. Noting the premise that ADHD children have difficulty in peer relationships, Hoza et al. (2005) points out that the mechanisms driving these problems remain a mystery. As such, Hoza et al. (2005) conducted a follow-up MTA study researching 2,517 children-285 ADHD child participants of the MTA and their same-sex classmates. Peer-assessed outcomes were studied at the conclusion of treatment, fourteen months from the onset of MTA. Analyses indicated that children in all groups remained significantly compromised in their peer relationships after 14 months of treatment (Hoza et al., 2005).

Although social skills' training has been developed with the goal of improving peer relationships, it is based on the assumption that a lack of social skills results in fewer positive peer interactions and therefore a lower social status (Mrug et al., 2001). Although researchers do not concur about the impact of social skills problems, research supports that children with ADHD frequently suffer from a plethora of social and interpersonal problems (Uekermann, et al., 2010). There have been mixed results reported on social skills training and ADHD children which has led recent researchers to question whether or not the peer rejection that ADHD children experience is in fact due to a lack of social skills, or perhaps to other behaviors associated with the disorder. Pelham, Fabiano and Massettiquin(2005) found that traditional social skills training produced minimum effects, therefore questioning the validity of the interventions (Pelham et al., 2005). Barkley (2004) reports that peer rejection and unsuccessful social interactions is not due to a deficit of skill or knowledge, but rather a disorder of performance, 'doing what one knows rather than knowing what to do.' Therefore, Barkley suggests that treatment for ADHD will be helpful when treatment interventions are geared to a

particular point in time – so that a child may then learn to choose the appropriate behavior to be successful (Barkley, 2004). A multifamily group, such as the one proposed, that is experiential and process oriented and is designed to address a behavior as it is occurring meets Barkley's concern.

Rationale for including family members in treatment - Systemic Interventions

Although many modalities include family members as part of a treatment program, most consider the identified patient to be the child and include parents to support the individual treatment. However, there is a strong rationale for providing treatment to the family members as a group. Since ADHD is thought to be a highly heritable disorder, impulsivity and inattention may be modeled by parents and could send mixed signals to the ADHD child. Furthermore, an ADHD child is at greater risk for experiencing family conflict, especially with parents who themselves may be susceptible to greater parental stress, marital discord and psychopathology (Barkley et al., 1992). Anasopoulos et al. (1996) point out that parent training outcome studies target the ADHD child symptoms, the child functioning, whereas family and parent functioning may be improved from parental training. In one study, 36 clinic-referred children and their mothers received Anastopoulos, DuPaul and Barkley's (1991) ten step Parent Training (PT) treatment program. Participants reported improvements in overall severity of their child's ADHD symptomology, as well as improvements in parent functioning, reduced parental stress and increased parent self-esteem. Limits to this study included no reports from fathers or the ADHD children themselves.

Another study focused on ADHD adolescents and their parents. Anastopoulos et al. (1996) hypothesized that parent-adolescent conflicts may contribute to increased parental distress and marital discord, which is often observed in ADHD families. Therefore, family-based,

systemic treatment which includes interventions geared toward parents and adolescents should be beneficial. Research by Barkley et al. (1992) compared three family-based psychosocial treatment modalities with ADHD adolescents. Over a three year period, 64 adolescents aged 12-17 and their parents participated in the study. They were randomly assigned to one of three family-based interventions: 1) Problem Solving Communications Training (PSCT); 2) Parent Behavior Management Training (BMT); or 3) Structural Family Therapy (SFT). Each modality was scheduled for 8-10 treatment sessions. Barkley et al. (1992) reported participant improvement at post-treatment and three month follow up across all three modalities in family functioning, including fewer parent-adolescent conflicts, less anger and intensity, and more effective communication.

Sperry and Duffy (2002) label ADHD and its impact on family dynamics as one of a learning-disordered family syndrome, which they define as a cluster of behaviors. For example, impulsive and inattentive students may disrupt a classroom and the consequences related to such events can then affect family functioning. Sperry and Duffy (2002) state that it is important to recognize that the ADHD child may be the identified patient, yet the impact of ADHD may be far reaching within family interactions. Furthermore, there may be subtler manifestations including the ADHD child avoiding chores or homework, being forgetful or underachieving academically. Because usually the ADHD child is the family member presenting with the performance issues, treatment is generally individually focused, and as we have seen in earlier studies, many times including multiple modalities with many different professionals. However, this may be at a cost to the family system as siblings may be given less time and attention, spouses may quibble over the care and the dynamics of the family system are impacted.

Therefore, including the family unit in treatment has been recommended (Sperry & Duffy, 2002).

Family therapy for ADHD focuses on assisting families to create and develop patterns of organization which encourage cooperation (Anastopoulos et al., 1996). These patterns of organization may include establishing supportive parental problem-solving, maintaining clear boundaries within the family, as well as nurturing supportive family relationships, with specific emphasis or additional services required during transitional developmental stages, and in particular as an ADHD child enters adolescence (Carr, 2009).

These studies support the inclusion of a systemic component to a treatment modality for ADHD children as well as including parents in the treatment. Furthermore, including the family in multifamily group treatment addresses the difficult relationships between ADHD children and their parents.

Brief History of Multiple Family Therapy Groups

In the 1950's, Multiple Family Therapy Groups (MFTG) emerged as a new treatment modality, primarily in hospitals and institutional settings. MFTGs emerged out of necessity, both due to cost and to a scarcity of therapists in hospitals (Benningfield, 1978). Multifamily therapy groups are a psychosocial modality addressing patterns of interfamilial interactions as well as intra-familial cycles of interaction. Originally implemented in hospitals and with schizophrenic patients and family members, MFTG is a modality that is often utilized with challenging populations and in particular when working with clients who present with behavioral problems or who suffer from severe psychological disorders. Often these families feel isolated socially, and MFTG offers participants a support system within the group as well as an

opportunity to gain insight into their own family patterns as they observe others (Thorngren, Christensen & Kleist, 1998).

While most early research in multifamily work focused on special populations affected by schizophrenia, alcoholism, affective disorders and behavioral problems (Thorngren et al., 1998), recent models have been developed for eating disorders and co-occurring problems (Asen, 2002). Research on multiple-family group treatment for children is limited and even more sparse is research on ADHD focused multifamily groups (McDonell and Dyck, 2004). Recently, studies have been conducted utilizing multifamily therapy for at risk children to reduce recidivism for incarcerated adolescents (Keiley, 2007).

Meezan and O'keefe (1998) compared the effectiveness of multifamily group therapy (MFGT) with traditional family therapy for improving negative child behaviors. The sample included 81 families referred by the LA County Department of Children and Family Services; each family in the study had an open case of maltreatment within the department. The treatment model for the experimental group included 75% scheduled meeting time allocated to MFGT activities. Six to eight families convened with four clinicians weekly for eight months. The comparison group received traditional family therapy composed of structural, behavioral and CBT techniques. Treatment efficacy was measured using a combination of interviews and the Child Behavior Checklist, a questionnaire completed by parents. Results suggested improvements in family functioning and reduction in critical areas of child abuse and neglect. Participants in the MFGT group reported more improvements compared to controls in family functioning and child behavior. Furthermore, children in the experimental MFGT group reported fewer overall behavior problems and greater social competence compared to children receiving family therapy (Meezan & O'keefe, 1998).

A component of a residential rehabilitation treatment program for people with severe substance abuse disorders in Auckland, New Zealand included multifamily group therapy. Ninety minute weekly sessions were conducted for 18 weeks by a staff member as well as a family therapist from outside the facility. A qualitative study of 11 current or former residents indicated that their MFTG helped them to 'move on' and change old dysfunctional family patterns, reporting positive changes in their relationships with their family members and partners (Schaefer, 2008). Specifically, participants reported increased communication skills and an ability to integrate those skills into more positive interactions with family members. Furthermore, participants reported increased closeness to family members who attended group therapy. However, the results of the study are limited by the small sample size.

Fristad, Gavazzi and Soldano (1998) examined a six session multifamily psychoeducation program for families of children or adolescents with a mood disorder. The treatment model was designed to test the assumption that if family members increased their understanding of their child's illness, treatment compliance would increase and, in turn, family conflict surrounding the child's disorder would decrease. The study reported participant satisfaction with the intervention as well as improvements in family atmosphere, particularly from fathers. Once again, however, a limit to this study was its small sample size, nine families.

Further studies of the program were conducted over several years. Fristad, Goldberg-Arnold and Gavazzi (2003) conducted a study of a multifamily psychoeducation group for 8-11 year old children with mood disorders and their parents. The sample included 35 children and 47 parents and the therapy group met weekly for six weeks, 75 minutes per session. Measurements were obtained at six months following the treatment, and results indicated increased parental

knowledge about childhood mood disorders as well as an increase in positive family interactions as reported by parents.

To date, there have only been a few studies of multifamily groups which included ADHD children and these programs were designed to address behavioral issues of urban children living in inner-cities, not ADHD specifically. These programs were designed explicitly for implementation in inner-city, community based settings. Inattention, impulsivity and hyperactivity were measured but families were recruited to the programs because parents were seeking support for managing the behavioral issues of their children. Three studies (McKay et al., 1999; McKay, Harrison, Gonzales, Kim & Quinantan, 2002; and Stone, McKay & Stoops, 1996) all focused on separate samples of the same multifamily group model described by McKay, Gonzales, Stone, Ryland and Kohner (1995). In this model, groups of four to five families convened for ninety minutes once a week for eight weeks. Each session had five components. Group sessions began with an opportunity for family members to interact and report on topics that arose during their week. Next included thirty minutes of didactic instruction, discussion of a specific topic addressed that week, family exercises and homework. Rules, consequences, rewards, roles, communication and family relationships were key concepts in the program. The remainder of the group was divided into group discussion, family practice exercises correlated to an issue of the week and an explanation of the group homework (McKay et al., 1995). Regarding the findings, Stone et al. (1996) studied 22 families and assessed conduct, hyperactivity, impulsivity and learning at intake and termination (Stone et al., 1996). Parents reported reduction in childhood symptoms of aggressive or inattentive behavior at the conclusion of the treatment. However, a limitation of this study was its small sample size and lack of control group (McDonell & Dyck, 2004). McKay et al. (1999; 2002) replicated the Stone

et al. (1996) study, however doubled the number of sessions to sixteen. McKay et al. (1999) studied 88 children and reported reduced childhood conduct problems, impulsivity, learning problems and hyperactivity as compared to the group receiving individual therapy. Seventy percent of parents of children who attended the multifamily group identified improvements in their child's behavior, compared to 54% of parents from the comparison group. McKay et al. (2002) indicated that families who participated in the multifamily groups attended a significantly greater number of sessions than families who participated in either individual or family psychotherapy. Although limited in sample size and not designed specifically to be used within an ADHD population, these studies support the use of a multifamily group for ADHD children and their families.

The Multiple Family Group Intervention (MFGI) is an eight week psychoeducation program based on attachment and affect regulation that was developed for incarcerated adolescents and their families in an effort to reduce recidivism and to decrease coercive family interactions. Keiley's (2007) study of 140 participants included 73 adolescents and 67 caretakers. Data were collected a pre-intervention, post- intervention and six month follow-up. The six month follow-up assessment demonstrated a recidivism rate of only 44% as compared to the national norm of 65- 85%. Furthermore, adolescents and caregivers reported that the adolescents' externalizing behaviors reduced significantly over time. However, although adolescents reported a significant decline in drug and alcohol use and a decrease in internalizing symptoms, caregiver reports showed no change in these areas. Yet, of note was that adolescents reported improved attachment to their parents, mothers in particular, and improved affect regulation abilities (Keiley, 2007).

A systemic, experiential multifamily group was developed in Dresden, Germany and was designed specifically for utilization for eating disordered families. A study of adolescents diagnosed with eating disorders and their families was conducted at an inpatient facility in Dresden, Germany to evaluate a multiple family therapeutic treatment program (Scholz & Asen, 2001). Treatment included six to eight patients and their families and consisted of up to twenty days over 12 – 18 months. Findings revealed positive results following multifamily therapy. These include: symptomatic improvements, reduction of the length of inpatient stays, reduction of relapses, quicker recovery after relapses and more engagement in work on family issues including conflict (Scholz & Asen, 2001). This multifamily group model is experiential, and influenced Asen and Scholz's (2010) five-step model developed at the Marlborough Family Service in London. Asen and Scholz's five-step model is included as a component of the proposed multifamily curriculum for ADHD children and their families.

Current Recommendations for Treatment

Although there is a plethora of research on ADHD there is little consensus of what is effective as an intervention to improve a child's ADHD symptoms and interactions with peers and family members. A child with ADHD presents myriad of complexities and often comorbidity with other psychological disorders and the latest research indicates that ADHD symptoms often continue through adolescence to adulthood, as supported by the recommended DSM-V proposed changes. Often ADHD children and their families experience familial dissonance, whether due to symptoms of the disorder, comorbidity of other psychological disorders, a parent suffering from ADHD, inconsistent parenting or family conflict. Including family members in treatment and using a systemic approach is supported in research. Experiential, process oriented groups have reported significant findings with specific

populations, including eating disordered and oppositional youth. Although multifamily groups for ADHD have not been studied directly, multifamily groups developed for inner-city families struggling with behavioral issues have been researched, and a reduction in ADHD symptoms has been reported, demonstrating further support for this modality.

Proposed Model

Why multifamily group for ADHD children and their families? A multifamily group for ADHD children and their families was proposed for multiple reasons. Multiple family groups may foster common themes of increased awareness for children and their family members about the disorder as well as provide social support in a cost-effective manner (Thorngren et al., 1998). Multifamily groups offer support to many families who feel isolated, creating a mechanism for families to maintain close proximity to each other; being tasked with similar assignments increases the permeability of the family boundary (Cooklin, Miller & McHugh, 1983).

Including family members in treatment for the ADHD child is supported. ADHD is believed to be a highly heritable disorder, and therefore inattention and impulsivity may be modeled to the ADHD child. Also, family members have different perspectives on an ADHD child, which could potentially impact the family environment and the effects of treatment (Cunningham, 2007).

ADHD children are at greater risk for experiencing family conflict, in particular with their parents (Barkely et al., 1992). Wells et al. (2006) reports that when parents are consistent, applying planned and proactive strategies to manage challenging behaviors, ADHD children exhibit reduced negative emotional reactivity. Sperry and Duffy (2002) state that it is key to acknowledge that the ADHD child may be the identified patient, yet the impact is extensive within family interactions. The multifamily group setting provides support and a sense of safety

to family members. Communication and social support is important to the treatment of children with ADHD and their families and this medium provides that (Thorngren et al., 1998).

Multifamily group therapy also offers an adult perspective other than that of a child's parents, which can be useful when family relationships are strained. A goal of multifamily therapy is to achieve a better mutual understanding and empathy between generations as adult-child relationships are nurtured across family boundaries. Leichter and Schulman (1974) state: "While it is very difficult for children and parents to change the image they have of each other, in the multifamily therapy group adults and young people have a chance to experience the universality of human needs and emotions across family boundaries" (p. 3).

Another advantage of a multifamily group is the peer interaction component of treatment. Coughlin and Wimberger (1968) report that peers are a powerful support and influence in multifamily therapy, particularly for the ADHD child. The peer component of multifamily groups may help ADHD children in two ways. First, social support is a goal of group therapy; for ADHD children who frequently lag behind their peers, this may provide them with an opportunity to experience more positive peer relationships. Asen (2002) reports that peer support and peer criticism are known to be powerful dynamics that can promote change. Peers and other families may help de-stigmatize the ADHD child - being with other families battling similar issues creates a sense of commonality and camaraderie. Asen (2002) points out that in multifamily therapy, professional staff is in the minority which promotes a family atmosphere rather than a medical one. This may help diminish the feeling of being observed. In a multifamily setting, group members work side by side, and may compare notes and learn from each other. Children can be supportive to each other, yet hold each other responsible and at times, even challenge each other more effectively than adults (Asen, 2002).

The second reason a peer component was recommended is because ADHD children often struggle with their peers. Mrug et al. (2001) states that a significant factor to peer difficulties for ADHD children is their hyperactive, domineering interaction, featured with aggressive and controlling behaviors. This is problematic as peer difficulties have been reported to be predictive of future adjustment problems including academic and occupational impairments, risk for development of other psychological disorders, and substance abuse (Hoza et al., 2005). Furthermore, traditional social skills training for ADHD children have produced mixed results. In fact, Mrug et al. (2001) reports that social skills training, which focuses on increasing pro-social behavior is not targeting the issue most problematic for ADHD children--excessive negative behaviors. Therefore, it is important to investigate alternative methods to improve ADHD peer relations and perhaps a multifamily group is a useful medium.

ADHD children have difficulty assessing their own behavior and do not perceive themselves as less socially effective than other children (Hoza et al., 2005). This poor self-awareness coupled with the reluctance to view themselves party to negative outcomes leads to less motivation to change behavior (Mrug et al., 2001). In fact, Barkley (2004) refers to ADHD as a disorder of self-regulation, not an issue of lack of skill or knowledge but rather of performance. Therefore, it is important for ADHD children to become more aware of their own behavior and its consequences. Barkley et al. (2002) recommends therapeutic settings engineered to enable ADHD child performance, not simply to impart knowledge. An experiential model would seem appropriate, in essence addressing behaviors as they occur. Again, a multifamily group setting seems appropriate to meet these needs, offering multiple arenas for practicing and increasing the possibility of positive reinforcements.

Theoretical basis. Systems theory guided the selection of the multifamily therapy modality. Specifically, it aligns well with the ADHD literature indicating the spillover effects of the disorder into the family system and provides an opportunity to target ADHD as well as the related concerns within family relationships that stem from the symptoms of the disorder. Providing the overarching framework, systems theory assumes that no one individual is responsible for the interactional patterns, nor should an individual be blamed for family distress. Nichols and Schwartz (2008) state: "From a systems perspective, it would make little sense to try and understand a child's behavior by interviewing him, without the rest of the family" (p. 101).

The curriculum and process of treatment is based on Narrative Therapy and Experiential Therapy. Experiential Family Therapy emphasizes here-and now experiences (Connell & Russell, 1987). Working from the inside out, Experiential Therapy aids family members to discover their authentic emotions first, and then to shape more genuine family connections out of this heightened authenticity (Connell, Mitten & Whitaker, 1993). The didactic structure of utilizing a co-therapist and team, in this case a multifamily group, is informed by an experiential model. Furthermore, focus on the process of familial interactions rather than problem solving is guided by Experiential Therapy (Giat, 1991).

The process oriented segments of the program are guided by Narrative Therapy, a postmodern approach. Following the tenets of hermeneutics, Narrative Therapy assumes there are multiple interpretations and multiple truths as well as multiplicity of being - reality is believed to be socially constructed (Payne, 2006). Externalizing the problem, separating the problem from the person is key in Narrative Therapy, and in this curriculum externalizing ADHD from the child is a therapeutic technique. Nichols and Schwartz (2008) highlight this distinction: "Instead of clients having a problem or being a problem, they are encouraged to think

of themselves as struggling against their problems" (p. 379). Other narrative techniques incorporated into this curriculum include the use of reflecting teams and metaphors, and telling and retelling stories with communities of support, in this case other participating families. This curriculum also directs therapists to maintain a collaborative stance, as families will co-create their preferred way of being, not directed by the therapist. Guided by Narrative Therapy, the curriculum directs the therapist to use presumptive language, as well as coach family members to use evocative or tentative language when serving on reflecting teams – the reflections must have the quality of tentative offerings, not declarations (Anderson, 1987).

Proposed multifamily therapy group. The first multifamily groups developed were psychoeducational, for families facing similar challenges as one member suffered from a psychological disorder. This followed the idea that people who face similar problems can share their experiences and advice and support one another (Asen & Schuff, 2006). Today, some multifamily groups continue to be psychoeducational, certain groups combine a psychoeducational component prior to a process-oriented element, and a third type of multifamily groups are designed to be primarily process driven (Gehart, 2010). The process-oriented groups are experiential by design, structured to utilize specific systemic techniques to facilitate change (Asen & Schuff, 2006). The proposed multifamily group curriculum was developed for ADHD children and their families to provide pschoeducational material in the first few sessions and then transition to a process-oriented approach. The middle sessions of the curriculum are process-oriented, including experiential in vivo interventions that were influenced by Asen's (1997) five-step model. The ending sessions continue to be process-oriented, and are designed to involve less facilitator direction and encourage families to work together to co-create new stories for preferred modes of interacting.

Goals of the program and support for the model. There are several goals for the proposed multifamily group for ADHD children and their families. First, one goal is to increase knowledge of ADHD and its effects on family interactions. This goal will be addressed in the initial psychoeducational component of the model. Through didactic sessions, therapists will facilitate discussions about ADHD symptoms, opening up conversations for parents to learn from the experiences of other parents, and children from other children. A second goal of the proposed program is to learn strategies to decrease ADHD symptoms. This goal will also begin to be addressed in the psychoeducational sessions as ADHD children and their families will be presented approaches and strategies. As families continue through the middle sessions of the program, new strategies will be presented and practiced as well.

Increasing peer support and fostering peer interactions is the third goal of the proposed curriculum. Multiple family groups increase the opportunity to build a sense of community and social support, while decreasing the stigma that families may feel associated with mental health services (Yalom, 2005). The informal pre-group thirty minute segment, the initial psychoeducational sessions and the fishbowl sessions are all designed to increase peer support. This goal will continue to be a focus through the middle sessions as feedback for the enactments is designed to separate children from parents, again to provide increased peer support.

The fourth goal is to learn new and more satisfying ways of interacting with family members, leading directly to the fifth goal – creating new stories for preferred ways of relating to themselves and their family members. Continuing in the middle and then final sessions of the group, these goals will be addressed through in vivo and enactments. As Thorngren and Kleist (2002) state: "combining a family systems approach with the therapeutic factors of group process will provide the fertile ground for exploring individual behaviors in the context of interpersonal

relationships and for increasing the social support necessary to make the desired behavioral changes" (p168), an aim that is supported through prior findings on children with ADHD.

Following is an overview of the proposed curriculum including goals, techniques and recommended therapeutic stance. To view the entire proposed curriculum, see Appendix A. The curriculum is delineated into three segments – beginning, middle and then closing sessions. Because the proposed multifamily group follows an experiential framework, an allowance for facilitator discretion not only within a session but moving from session to session is recommended. As a facilitator interrupts a family's negative cycle of interaction in the room, for example, it may be processed at that moment, thus deviating from a scripted agenda.

Beginning group - first three sessions: goals and support. The initial goal of the first sessions is to achieve group cohesiveness, so that the multifamily group setting may become an optimal working instrument for therapeutic purposes. Snacks will be provided and the group room available for the thirty minutes prior to each session to create an environment conducive to socialization and joining - allowing families to intermingle and offer updates about matters that impacted their families during the week (Stone et al., 1996). Once the group meeting convenes, parents and children will be separated for a portion of the first three sessions so that the subsystems' members may be offered peer support - parents connecting with other parents, ADHD children connecting with other ADHD children, and siblings connecting with siblings. Meeting separately at first was proposed as a mechanism to create safety within the therapeutic setting. Keiley (2002) reports that the first three sessions of the MFGI are intended to assist group members with socializing to group work, establishing rules and developing a sense of safety. Coughlin and Wimberger (1968) created separate sessions for children and parents for the first hour of a multifamily group in an effort to provide peer identification and support before the

parent-child relationship was explored in later group sessions. The subgroups rejoined the full group for the final segment, which is what was proposed in this curriculum for the first three sessions.

Psychoeducational component. Although the proposed multifamily group is process oriented, until safety is ensured there is a psychoeducational component integrated into the first few sessions. The goals of this are two-fold: to increase the sense of cohesiveness within the group as each family and each family member is functioning either as a child struggling with ADHD or as a sibling or parent of an ADHD child, and secondly to increase participant's knowledge about the disorder and its effects. A therapy group composed of strangers differs in dynamics from a group in which some members belong to the same family. In the multifamily group, each family represents a subsystem with a shared history and in this case a shared current life stressor, ADHD. This creates a multifaceted process, as each subsystem interacts with the other subsystems at the same time (Leichter & Schulman, 1974). Increased knowledge and perspective around ADHD and its role in the family will be addressed through a psychoeducational format.

Psychoeducational children's segments will focus on normalizing the experience and providing education about symptoms (Fristad et al., 1998; Mcdonell & Dyck, 2004). Communication and problem-solving skills will be emphasized in parent sessions (Thorngren et al., 1998; Stone et al., 1996). Consequences and rewards, roles and responsibilities within families, and respectful communication and relationships within and between family subsystems are topics which may be addressed in the parental psychoeducational component (Thorngren et al., 1998).

Middle sessions: experiential – play therapy activities and role plays. Beginning with the fourth session, all parents and children will meet together. The middle sessions are focused on experiential interventions - working in the moment. Following a key tenet of cybernetics theory that change occurs when the normal limits of intensity of interaction have been exceeded, there will be activities that intentionally precipitate crises under "relatively controlled conditions" oftentimes via role plays (Cooklin, et al., 1983). These interventions contribute to a less structured approach than other forms of multifamily group therapy (Asen & Schuff, 2006). The intent is to work in vivo – in the moment – which follows the premise that ADHD kids may benefit more from experiential as well as in the moment. The overall goal of the middle experiential sessions of this proposed curriculum is to interrupt old and unhelpful patterns of interacting and to explore new and more satisfying ones.

The middle sessions are guided by Asen & Scholz's (2010) five-step therapeutic model. This model was developed for individual family or multiple family groups and has been recommended to be utilized in vivo during group sessions, integrating intra- and interfamily interactions (Asen & Scholz, 2010). Asen and Scholz's (2010) five step therapeutic interventions specify:

1. Observing and 'punctuating' problematic observations and communications
2. Checking perceptions
3. Inviting evaluation
4. Determining the wish to change
5. Encouraging experimentation and action (p. 14)

The first step of the model is to observe and highlight problematic interactions. An initial goal of the middle sessions is to identify current problematic patterns of interactions and communications – and this is accomplished through systemic interventions (Asen & Scholz, 2010). Asen and Schuff (2006) describe using play as a way to help address issues that are too

risky to bring up directly - through clay, drawings or mini-role plays. These exercises were designed to be injected spontaneously into the group, to deepen, magnify or shift levels of interactions. Although this curriculum encourages in vivo interactions, the play therapy techniques proposed, specifically the scribble drawings, are not intended to be used in this way, but rather are written into the curriculum week five as a mechanism to highlight family dynamics and to bring problematic interactions to the forefront. In other words, the activity is the vehicle to observe habitual patterns (Asen & Scholz, 2010). Playful activities may be used to facilitate emergence of patterns, which allows families to relax while encouraging and learning from each another - allowing families to experience with new ideas for behaving in a safe setting (Asen & Scholz, 2010).

In this first step, the therapist may identify what he or she sees as a pattern (Asen & Scholz, 2010). For this curriculum, group leaders are referred to as facilitators rather than experts because their role has moved from a didactic to a collaborative stance (Asen & Scholz, 2010). Language use is important as feedback should be given from a therapeutic stance of not knowing, using presumptive wording. "I wonder if" is a phrase which may be offered to a family member by a therapist checking her observation. It is worth noting that this observation is also offered to the group in step two of the model, checking perceptions: "Did I get that right?" If not, the facilitator simply asks for clarification.

If the family concurs that the observational comment was accurate, the facilitator may proceed to step three which is to invite evaluation from family members. In fact, each family member is directed to answer the same question, "Are you happy that it is this way?"--in essence, determining if individual family members find this pattern of behavior agreeable. The goal of this step is for the therapist and family members to work together, and for each person to

begin to understand the advantages and disadvantages of specific behaviors. This step is not an attempt to solve but rather to begin to see consequences from behaviors and to consider the pros and cons of action or inaction (Asen & Scholz, 2010).

Finally step four offers family members a chance to speak about desiring change. Asen and Scholz (2010) suggest: "So, if you do not want things to continue in this way, how would you like it to be?" (p. 15). This highlights a family's wish to change which leads directly into step five - the facilitator asking individual family members to name a way they might view the interaction differently. This fifth step encourages family members to name their role in potentially changing towards increased positive interactions. Asen and Scholz (2010) suggest therapeutic questions for this step: "What would you have to say or do now to make it be the way you want it to be? What would be the first step? What is stopping you from doing what you think you should be doing? What is the first little thing you might need to do? Who else here has some ideas?" (p. 15).

These steps are repeated throughout the remaining weeks during other play exercises, role plays and in session processing to highlight familial patterns and begin to have family members see alternative ways of behaving. Involving all family members and inviting other group members to give their perspectives and suggestions throughout these steps also creates a sense of families becoming consultants to each other. Asen (2002) refers to this as a metaphor of a Greek chorus, where members act as the protagonists, sharing their story or enacting a scene in front of a group of people who are then asked to provide feedback. Continuing with the metaphor, Asen (2002) states: "The chorus amplified and intensified the action on the stage, reflecting on what went on from different perspectives and inviting the spectators to join these reflections" (p. 13). In Asen's and Scholz's (2010) five-step model, the therapist invites

comments from other family members, attempting to create the same effect – to help families find their own solutions through support and suggestions from other families struggling with similar issues. Initially it may be difficult for families to view and comprehend themselves in relationship to their own system. Leichter and Schulman (1974) suggest that viewing someone else's family's struggles first may, over the course of time, help individuals connect to their own family's struggles, eventually enabling them to apply what they see in others to themselves. Describing the group as a mirror in which the family is able to view themselves, Benningfield (1978) states: "The group encourages, challenges, supports and reflects so that the family members can become who they want to be in relationship to each other" (p. 33).

An important assumption of this model is that families have the resources themselves and that the role of the therapist is to facilitate the emergence of these solutions (Asen & Scholz, 2006). In a sense, the therapist has to shift towards a role of not being an expert, instead waiting for ideas to surface. As the group continues through the middle sessions, the therapist role is less central, more catalyst than leader, enabling an interaction to happen through enactments and intensification. Families and staff members become part of a multidimensional conversation of emerging perspectives and ideas.

Reflective teams. Reflective Teams are the therapeutic tool utilized to create and enhance the mirror effect. Derived from Anderson's (1987) model which was utilized as a behind the mirror technique primarily by other therapists, Asen and Scholz (2010) modified the reflecting team technique to include other family members in addition to therapists. Other families may add to a person or family narrative as they share experiences from their own lives. In a sense, this allows every group member to resonate with a story in the moment. Over time, the emphasis shifts from the details to opening up new perspectives. The goal of the reflecting teams is to aid

family members to see things differently following the assumption that outsiders view things in other ways than those directly involved in the experience (Asen & Scholz, 2010).

This technique is used in different ways in the ADHD multifamily curriculum to create different audiences. First, in Week four, a fishbowl group will be created (Steinglass, Ostroff & Steinglass, 2011; Asen & Scholz, 2010). The purpose is to allow family members to gain appreciation of different viewpoints and emotions generated by ADHD children in the family. The room is set up with an inner and outer circle; initially the ADHD children will sit in the inner circle, serving as the goldfish. Parents sit around the children in an outer circle, in a sense the cats. Children and parents are encouraged to listen to each other and observe and then switch seats, reflecting on the discussion they just heard. This furthers interfamily interactions (Asen & Scholz, 2010).

Role plays. Reflective teams are also used for role plays, as family members enact problem scenarios and other families serve as their reflective teams. In fact, this ADHD multifamily curriculum includes various configurations of role plays and reflective teams. During certain sessions, children serve to reflect other children and other times families reflect other families. Before group participants are asked to provide feedback, a facilitator teaches a segment on validation and how to provide feedback in a constructive manner. Families are encouraged to be positive as well as challenging, emphasizing developing empathy and reflection (Asen & Scholz, 2010).

The goal of role plays is to experiment with new and more creative interactions and ways of communicating. Initially, role plays will serve to highlight current patterns of interaction. However, as families practice with strategies, working first with therapists and then as other families provide support, the role plays and feedback are intended to serve as the catalyst to new

behaviors and increased positive family interactions. Family members are encouraged to listen and be listened to with humor and openness, allowing stories to be seen in a different light. Reflecting teams may utilize phrases such as: I noticed that…it made me think that… Temporary new contexts are created, allowing individual family members to be part of different subgroups and thus able to view themselves differently (Asen & Scholz, 2010).

The final stage – movement towards multiple perspectives. The last two process-oriented sessions, 10 and 11, propose role plays taking place concurrently with reflective team observer families providing the sole facilitation, as therapists simply monitor to ensure safety. This follows Asen & Scholz (2010) model of families taking over and groups practically running themselves by their conclusion. This mirrors growth in families – allowing families and therapists to be part of a multiplicity of emerging perspectives and ideas. Multiple perspectives arise and group members do not need to rely on the facilitators. As families may now be discovering their own insights and as families inspire one another, over time the group becomes a system itself, a community or even a social network, as families become consultants to one another (Asen & Scholz, 2010). In this way, new stories may be created for preferred ways of relating to family members – resulting in more satisfying ways of interacting.

The final session is a celebration and includes certificate presentation and an opportunity for group members to voice their comments and suggestions for improvements to the program.

Chapter Three: Methods

Design of the Study

For this study, the literature on ADHD treatment was examined and used to develop a curriculum for ADHD children and their families to be implemented in a social service agency. This study aimed to determine expert consensus regarding the evaluation of the curriculum and program logistics such as recommended age of children, length of program, process of group, length of sessions and modality. Experts were asked to engage in two rounds of review of the proposed treatment manual in an attempt to come to consensus on any recommended revisions.

The Delphi method. The Delphi technique is a method that is used extensively for amassing group consensus from a panel of experts (Fish & Busby, 2005). There are many advantages of the Delphi method including its assuredness of anonymity of responders and decreased group pressure for conformity. In essence, this method is utilized when a researcher is interested in pooling the opinions of experts on a specific topic in an effort to obtain agreement (Fish & Busby, 2005). From a practical perspective, the Delphi method affords researchers the opportunity to glean advice and consensus from many sources without the necessity of face to face interface. However, unlike traditional surveying, this approach does not simply gather professionals' opinions, the Delphi approach allows for interaction of ideas through feedback and multiple layers of the process. Due to the exploratory nature of the program, the Delphi Method was chosen to gather consensus on any proposed changes to the model.

Philosophical assumptions. The Delphi method is based on the philosophical assumption of synergy, two heads are better than one. This method provides a panel of experts a structure to enable communication regarding a complex problem (Fish & Busby, 2005). Interestingly how a

researcher utilizes the Delphi method is not deemed as critical or important as the philosophical assumptions, as the method rests on the supposition that not only is it possible but it is perceived as valuable to reach consensus through an intellectual process. Important in its philosophical roots is a postmodern perspective that truth is relative. In fact, Fish and Busby (2005) state that the method "attempts to negotiate a reality that can then be useful in moving a particular field forward" (p. 239).

History. The Delphi method was developed in the 1950's and 60's by researchers at the RAND corporation in an effort to gather expert opinion on future directions in specific fields of study and to examine long range trends (Dawson & Brucker, 2001). The Delphi method is intended to provide structure and hone a vast quantity of information into a workable framework in an attempt to achieve professional consent and move forward with decision-making (Dawson & Brucker, 2001). Historically, the Delphi method included a series or 'rounds' of questionnaires, starting out broad and becoming more specific with each level of inquiry. Data from the first round is generally qualitative in nature and each round's data is summarized and a new questionnaire is designed based on the results of the summary. Participants then receive the summary as well as the new questionnaire. The idea being that the experts benefit throughout the process because they are able to reflect on their responses and how their perspective compares to other experts (Keeney, Hasson & McKenna, 2006).

Advantages of Delphi method. One of the advantages of the Delphi method is that the researcher is provided a diverse group of experts from differing areas who are in a sense working side by side to achieve consensus. However, each person's input is deemed equal as no one person is the perceived expert holding more power. Furthermore, a benefit to the Delphi Method is that experts are able to see other experts' input and responses to their own recommendations

and analysis, enriching their own experience as well as providing them more background for their future recommendations (Dawson & Brucker, 2001). This process of receiving feedback from other panelists allows the experts to engage in dialogue about the topic without assembling in one setting. Furthermore, because there is anonymity of panelists, a dissident view can be expressed without fear of reprisal or negative criticism (Sori & Sprenkle, 2004).

Another advantage of using the Delphi Method is that it is well suited for bridging the gap between research and practice. The model does not require large sample sizes or financial resources making it available to a greater population of users and the model does not require significant statistical expertise. For these reasons, clinicians can use the Delphi method to survey myriad of experts for a multitude of reasons. The experts may be clients or referral sources or any group of individuals whose opinion is deemed important. Lastly, not only is the model more approachable for a clinician, but the questionnaires of the respondents are presented in their own words, providing more accessibility and understanding across a broad arena of backgrounds (Fish & Busby, 2005).

Limitations of Delphi method. Although there are many advantages to the Delphi Method, there are limitations as well. One limitation is that there is regression towards the mean, in essence there may be a penchant for participants to alter their comments to be nearer to the consensus. Although coding can address this as a researcher may be able to seek 'camping' of responses, it still may prove to be a threat to validity. Another potential disadvantage of using the Delphi method could be in the narrow viewpoint given because of the specific and refined criteria of the panelists. Last, is the significant amount of time required of participants in this type of study, which requires the researcher to be aware and sensitive to the potential panelist

weariness (Dawson & Brucker, 2001). If there is dropout due to fatigue or other factors, there may be a sense of false consensus or weak data analysis.

Delphi panel selection. One of the most critical components of a Delphi study is the selection of panel experts because the validity of the study is directly linked to the selection process. In a sense, the actual level of knowledge of the panelists determines the credibility and validity of the study. Furthermore, the questions must be pertinent to the panelists and relevant as this is another threat to validity. In contrast to other research designs, randomization is not justified nor welcome as the selection and number of panelists is not determined by statistical means or measures (Dawson & Brucker, 2001).

For this study, the sample consisted of panelists from various professionals in the health care arena including family therapists and social workers who work with ADHD children. Also included were therapists who run multifamily therapy groups, family therapy groups as well as social skills groups for children. Through a search of membership directories of professional social service organizations, professional websites and recommendations from colleagues, 30 experts were identified as potential participants in the study (Godfrey, Haddock, Fisher & Lund, 2006). To qualify to participate, panelists had to have at least five year's clinical experience treating children diagnosed with ADHD, be a licensed clinician (i.e., LMFT, LPC, LCSW, PhD or PsyD) and have met a second criteria from the following list: 1) at least five years facilitating family therapy groups; 2) at least five years clinical experience counseling children in family therapy; 3) at least five years facilitating therapy groups; or 4) published two articles on ADHD clinical research (Fish & Busby, 2005; Sori & Sprenkle, 2004).

Invitations to participate as experts in the study were sent via email to the 30 potential panelists. Of those 30 potential panelists, 14 did not respond, six indicated their schedules did not

allow them to participate or they were unavailable, two stated they did not qualify as experts, and one person responded after the deadline that she had been out of the office and had not seen the invitation. A total of seven panelists agreed to participate in the study, representing 23.33% of the initial expert pool. All seven panelists completed both phases of the Delphi study, representing 100% participation in both questionnaires, with no attrition of experts. In each phase of the study, reminders were sent to experts when the deadline for completion was approaching.

A small sample size was acceptable due to the stringent criteria and high level of expertise required (Khanna, McDowell, Perumbilly and Titus, 2009). Referring to Delphi method, Keeney et al. (2006) state that there is "no magic formula to help researchers decide on who are the experts and how many there should be" p. 209. The decision is often based on "funding, logistics and rigorous inclusion and exclusion criteria."

Delphi procedures. An advantage of the Delphi Method is its flexibility in data collection, allowing the researcher or clinician the possibility of modifying the traditional Delphi method from three to two rounds of questionnaires (Sori & Sprenkle, 2004). In this study, a modified Delphi model was followed as two rounds of questionnaires were sent out, both of which were completed via email. This was done in an effort to limit attrition from the survey due to fatigue as well as to increase the likelihood of participation.

As mentioned above, a cover letter was sent via email to potential panelists asking them to participate as experts in the study (see Appendix B). The cover letter explained the purpose of the study, expert panelist criteria, the requirements of participation, and how data would contribute to the ADHD research for children and their families. Attached to the cover letter was a consent form (see Appendix C). Panelists were asked to first read the consent form and then

read the manual which was also attached to the cover letter. The letter then directed potential panelists to a website URL so that they could complete the first questionnaire (Q1) (See Appendix D). The letter explained that completing the survey would imply consent to participate as an expert in the study. The panelists were informed that their participation was voluntary and there was no remuneration for their participation (Godfrey et al., 2006) (See Appendix E, IRB approval letter). Seven panelists completed Q1; each panelist received a confirmation email from the researcher informing the panelist that the completed survey was received and notifying the panelist that another email would be sent with instructions on how to proceed to Q2.

Survey results from Q1 were reviewed and the researcher read through the panelists' responses to ensure that each expert met the criteria to participate in the study. The first section of Q1 queried panelists for basic demographic information (see Table 1). The panel of experts was comprised of five females and two males, mean age 47, all meeting the first criteria to be a panelist as they were all licensed clinicians: four LCSW, two LMFT, and one LPC. The panel of experts each exceeded the five-year minimum clinical experience criterion for the study, each reporting at least seven years clinical experience treating children diagnosed with ADHD, and at least eight years clinical experience counseling children in family therapy. Six of the seven panelists reported eight or more years' experience facilitating therapy groups, yet only two panelists had five or more years' experience facilitating family therapy groups. *Table 1* displays expert panel demographics, means and medians computed from the first questionnaire. Expert panelist experience facilitating family groups varied greatly, evident by the median calculated as one year while the mean was greater than seven years.

Table 1
Expert Panel Demographics

	Mean Yrs.	Median Yrs.
Age	47.57	48
Number of years licensed therapist	11.79	11
Number of years treating children with ADHD as licensed therapists	11.50	9
Number of years' experience facilitating therapy groups	15.43	9
Number of years facilitating family therapy groups.	7.29	1
Number of years clinical experience counseling children in family therapy	15.57	11

Following the basic demographic questions, panelists were asked about their clinical experience working with ADHD children. Three of the seven panelists reported 50 - 75% of their clinical time included treating children, however only one panelist reported spending 50 - 75% of their clinical time treating ADHD children (see Table 2).

Table 2
In clinical practice, percentage of time experts spent treating children, ADHD children

Participant	Time treating children	Time treating *ADHD* children
1	50-75%	50-75%
2	50-75%	25-50%
3	25-50%	–
4	25-50%	25-50%
5	–	25-50%
6	50-75%	25-50%
7	0-25%	0-25%

Table 3 delineates expert panelists work with ADHD children by treatment modality. Although six of the seven panelists reported working with ADHD children in family therapy at least 25% of time, only two panelists reported engaging in group therapy more than 25% of their work hours. Furthermore, all seven panelists identified using family group therapy 25% or less of the time they treated ADHD children. Although the panel of experts reported extensive experience working with ADHD children in family therapy, and most professed to extensive

experience facilitating groups, experts may not have had any experience facilitating family groups.

Table 3
Of the time spent treating ADHD children, percentage of time utilizing different modalities

Participant	Individual therapy for child	Family therapy	Group therapy	Family group therapy
1	75-100%	25-50%	0-25%	0-25%
2	50-75%	25-50%	25-50%	0-25%
3	0-25%	50-75%	0-25%	0-25%
4	0-25%	0-25%	0-25%	0-25%
5	25-50%	25-50%	0-25%	0-25%
6	25-50%	25-50%	25-50%	0-25%
7	0-25%	50-75%	0-25%	0-25%

Once the researcher ensured that all seven participants met the criteria to participate as experts in the study, the data from the remaining questions from Q1 were analyzed, themes emerged and Q2 was created. As mentioned above, panelists were emailed instructions on how to proceed to the URL to complete Q2. Again, panelists were informed that they could withdraw from the study at any time.

Delphi data analysis. There are multiple phases of data collection using the Delphi method. In the first stage, qualitative methods were utilized to analyze the expert panel's responses to the questions listed in Q1. The information from the questionnaire responses were first consolidated into specific themes (Godfrey et al., 2006). Thematic analysis was used to analyze the qualitative data and multiple coders were employed. The coders searched for themes and patterns in the responses, categorizing responses and eliminating redundant answers. Effort was made to retain the experts' words and original meaning (Godfrey et. al., 2006). From the data collected in the first stage, a second questionnaire (Q2, see Appendix F) was developed using the incorporated information and themes, posing more pointed questions. This

questionnaire was distributed via email to the same panelists who participated in the first segment (See Appendix G). Panelists were asked to rate the importance of items pertaining to an initial question from the first questionnaire. This questionnaire used a 7 point Likert-scale, which enabled analysis through calculating medians, quartiles and interquartile ranges for each item (Fish & Busby, 2005). Calculating the medians is important in the Delphi method because it points to the central tendency of respondents, thus highlighting consensus or agreement. If for instance, all respondents give an item a high ranking, a high median would result. To measure variability, interquartile ranges (IQR) were measured, computing the difference between the 75th and 25th percentiles. This allowed for extreme scores to be noted, and if there is strong consensus on an item, a lower interquartile range was evident (Godfrey et al., 2006). Median scores of six or higher and IQRs of 1.5 or less were used to demonstrate consensus (Jenkins & Smith, 1994). This analysis was conducted in an effort to reach expert consensus regarding the ADHD family group module for children and their parents. Items that met the criteria for expert consensus were compiled into a final profile. The panel of experts received the final profile for participating in the research.

Chapter Four: Results

This study sought expert consensus on an evaluation of a proposed multifamily therapy group for children with ADHD and their families for implementation in a social service agency setting. To obtain expert consensus, the Delphi method was employed and seven panelists completed two rounds of surveys by completing two questionnaires, Q1 (Appendix D) and Q2 (Appendix F).

In Q1, panelists were asked to describe their reaction to the proposed Multifamily Therapy program for ADHD children and their families, including strengths and potential obstacles. Furthermore, panelists were asked if they felt a multifamily therapy group was an appropriate modality for children with ADHD. Five goals potentially effecting change in families with ADHD children were presented and panelists ranked them in order of importance. The program was designed to have a psychoeducational component in the first three sessions, with parents and children meeting separately. The remaining nine sessions were experiential and consisted of role plays and other activities with group members serving as reflective panels. Panelists were queried about their reaction to this format. Finally, panelists were asked to comment on the parameters of the program: appropriate age of the ADHD child, length of sessions, format of sessions and length of program.

Five goals which may effect change in families of ADHD children were presented in Q1; experts were asked to rank the goals in order of importance, ‘1 being most important to 5 being least import.’ Table 4 displays the panelists’ responses. Interestingly, the goal “to increase peer support and foster peer relations” did not receive a ranking above a three from any of the panelists, indicating this goal was not deemed as important as others. Five of the seven panelists ranked the goals “to increase knowledge of ADHD and its effect on family interactions” and “to

learn new and more satisfying ways of interacting with family members" as either first or second in importance. In fact, three of the seven panelists ranked "to learn new and more satisfying ways of interacting with family members" as the most important goal to effect change in families of ADHD children. Although two panelists ranked "to create stories for preferred ways of relating to themselves and their family members" as either first or second in importance, the other five panelists ranked this goal no higher than third; three panelists ranked this goal as least important. Lastly, "to learn strategies to reduce ADHD symptoms" was ranked first by two experts, yet the other five panelists ranked this lower - as third or fourth in importance.

Table 4

Which of the following goals do you feel would effect change in families of ADHD children? Ranked in order of importance with 1 being the most important to 5 being the least important.

Participant	To increase knowledge of ADHD and its effect on family interactions	To learn strategies to reduce ADHD symptoms	To increase peer support and foster peer relations	To learn new and more satisfying ways of interacting with family members.	To create new stories for preferred ways of relating to themselves and their family members.
1	1	4	5	2	3
2	2	4	5	1	3
3	2	3	4	1	5
4	2	1	4	3	5
5	2	1	3	4	5
6	5	3	4	2	1
7	3	4	5	1	2

In the first part of data analysis, qualitative methods were used to analyze the expert panel's responses to the short answer questions listed in Q1 (Dawson & Brucker, 2001). Survey responses were read through once for comprehension and then organized so that responses to each question could be read sequentially, allowing patterns of responses to emerge. The data

were consolidated from the first questionnaire into specific themes and patterns of responses (Godfrey et al., 2006; Sori & Sprenkle, 2004). An independent coder was used and responses were categorized and redundant answers eliminated (Jenkins & Smith, 1994). Statements were developed representing each theme identified by the panel, retaining the experts' language wherever possible and omitting redundancies while attempting to capture statements that would represent the ideas put forth by the panel. Effort was made to retain the experts' words and original meaning (Godfrey et al., 2006). The panelists indicated rich variations in their responses.

Several themes emerged from the responses to Q1. Themes that arose included: systemic family approach; increasing knowledge of ADHD; strategies to reduce symptoms; peer support; learning new and more satisfying ways of interacting; creating new stories for preferred ways of relating; program strengths; program parameters; experiential program format; process and safety of group; and potential obstacles. Following is a review of these themes.

One theme that was prevalent was systemic family approach. This theme included supportive comments about utilizing a multifamily therapy group as a modality for ADHD children because ADHD affects the whole family, providing families a shared experience. Furthermore, panelists commented about how ADHD impacts the dynamics of the whole family, at times straining the relationship between the parent and child. The family focus of the program was highlighted as a strength, because this would allow facilitators an opportunity to observe how families interact, intervene and then educate participants.

Several themes surrounded the importance of proposed goals for an ADHD multifamily group. Specifically, panelists suggested the importance of increasing knowledge about ADHD and its impact on family members. Learning strategies for reducing ADHD symptoms also emerged as a theme as panelists stressed the significance of teaching specific skills to help

participants – communication, positive limit setting, time management and setting realistic expectations. Peer support was a theme that emerged and was repeated by many panelists. Comments clustered around how a multifamily group provides peer support for parents, children and families, offering a shared experience. Creating new stories for preferred ways of relating was the last theme related to a goal for ADHD children and their families.

Program strengths and obstacles each emerged as themes from Q1. Support and normalization were repeated as strengths in the program, suggesting that the program would reduce isolation while increasing social support and education of participants. The family focus was also identified as a strength as was the shared experience the program would provide, reducing the feeling of being alone in their struggles, isolation. Potential obstacles organized into two categories, those one might encounter due to a child or family member's ADHD symptoms, and obstacles one might face running any multifamily group. Panelists identified ADHD children's lack of focus and hyperactivity as potential impediments to the program as well as the genetic predisposition of ADHD – parents displaying ADHD symptoms, perhaps leading to parental conflict within the group. The effects of stimulant medication wearing off were raised as a potential impediment if the program was held late in the day. Individual negativity, family conflict or participants monopolizing sessions were also suggested as potentially impacting group cohesion.

Many panelists commented on program parameters, suggested length of each session, appropriate target age of the ADHD child, and duration of program. Process and safety of the group emerged as a theme as numerous panelists commended the psychoeducational component of the program, having parents and children meet separately for the first three sessions. Panelists highlighted the importance of building cohesion - creating safe subsystems of parents and

children while allowing group norms to be established. Screening assessments were recommended to ensure participant stability prior to entering the group and the importance of facilitators creating an environment safe enough for participants to be authentic and to self-disclose was professed.

The last theme that emerged surrounded the experiential portion of the program. Some panelists identified the experiential activities as an opportunity for families to interrupt negative cycles of interaction as they are occurring, offering a chance for participants' strengths to shine when they are often feeling like nothing is going well. However, the fishbowl technique was mentioned as being unsuitable, either because of ADHD children's' symptoms of inattention and hyperactivity or because the children would be too young to interact with adults of other families.

Themes generated from Q1 guided the creation of the template for Q2, as themes became section headings organizing the panelists' statements. Q2 contained a total of 64 items, gleaned from Q1 panelist comments. Panelists were asked to indicate their level of agreement or disagreement for each item using a 7-point Likert scale, with one representing "strongly disagree" and seven representing "strongly agree." Using a Likert scale enabled Q2 quantitative analysis, generating data which would then be analyzed after calculating medians and interquartile ranges to determine expert consensus on the proposed program specifically and utilizing a multifamily group in general, panelists were asked to rate the statements. To identify expert consensus, data analysis consisted of calculating the median and interquartile range (IQR) for each Q2 statement (Fish & Busby, 2005). A median score of six or higher indicates that most of the panelists ranked the statement as important or very important and an interquartile range of 1.5 or less suggests a high degree of consensus among the panelists. Following is a discussion of

the Q2 analysis. These criteria were used to determine which statements were included in the final profile, representing expert panel consensus (Fish & Busby, 2005). Forty-two of the 64 statements (65.63%) are included in the final profile.

Systemic Family Approach – A Multifamily Therapy Group

One of the strongest findings of this study was that panelists generally believed in a systemic approach, utilizing a multifamily therapy group as a modality for treating ADHD children and their families. Each of the four statements in this thematic category qualified for inclusion in the final profile (see Table 5). In other words, consensus was met. The first statement was delineated from an expert's response to being queried about whether or not a multifamily group is an appropriate modality for children with ADHD: "I think a multifamily therapy group is an appropriate modality for children with ADHD. "ADHD impacts the dynamics of the whole family and at times parental child relationships are strained" (Participant 2). "ADHD impacting the dynamics of the whole family" was rich text that was intentionally retained and included in the second questionnaire and the highest possible level of consensus was reached on this statement, 7.00. However, the interquartile range was 1.25 indicating that there was some degree of variability in the experts' opinions.

Table 5
Systemic Family Approach – utilizing a multifamily therapy group as a modality for treating ADHD children

	Median	IQR
A multifamily therapy group is an appropriate modality for children with ADHD as ADHD impacts the dynamics of the whole family and strains the parent/child relationship.	7.00	1.25
A multifamily therapy group gives family members a chance to see current patterns of interaction and learn to practice more positive ways of interacting.	6.75	1.13
A multifamily therapy group is appropriate because ADHD affects the entire family.	6.75	1.25
A multifamily therapy group is appropriate as an adjunct to family therapy.	6.83	0.75

Goals

Increasing knowledge of ADHD and its effect on family interactions. Each goal ranked in Questionnaire I was listed on Questionnaire II for experts to rate. Expert statements pertaining to a particular goal were listed below the goals, creating themes. Experts agreed that a goal to increase knowledge of ADHD and its effect on family interactions may effect change in families of ADHD children (see Table 6). A median of 7.00 was calculated for this goal and there was limited variability in response as the interquartile ranges were small. In fact, the statement "An ADHD multifamily group normalizes kids' and families' experiences, reducing isolation – helping them understand that they are not alone" achieved the highest possible scores displaying expert agreement and consensus: median of 7.00 and 0.00 interquartile range.

Table 6
Goal which may effect change in families of ADHD children: to increase knowledge of ADHD and its effect on family interactions.

	Median	IQR
A goal of increasing knowledge of ADHD and its effect on family interactions is important in an ADHD multifamily group.	7.00	0.13
Including the whole family helps facilitators observe and intervene with how the family is responding to and managing symptoms of the disorder.	7.00	0.13
An ADHD multifamily group provides strong support and education and a place to share interventions/solutions to parenting children with ADHD.	7.00	0.63
An ADHD multifamily group normalizes kids' and families' experiences, reducing isolation - helping them understand that they are not alone.	7.00	0.00

Learning strategies to reduce ADHD symptoms. Experts also reached consensus on another suggested goal - learning strategies to reduce ADHD symptoms may effect change in families of ADHD children (see Table 7). Experts were in greatest agreement and highest consensus for this goal. Experts also concurred that specific skills should be taught in an ADHD

multifamily group for children and families to help manage ADHD symptoms and their effects. Both this goal and statement achieved the highest possible expert agreement and consensus: median of 7.00 and 0.00 interquartile range. Experts agreed that family structuring and communication skills are both important to include in a multifamily therapy group curriculum.

Table 7
Goal which may effect change in families of ADHD children: to learn strategies to reduce ADHD symptoms

	Median	IQR
A goal of learning strategies to reduce ADHD symptoms is important in an ADHD multifamily group.	7.00	0.00
Specific skills should be taught in an ADHD multifamily group for kids and families to help manage ADHD symptoms and their effects.	7.00	0.00
Family structuring should be taught in an ADHD multifamily group –promoting family structure, time management, responsiveness, empathy, positive limit setting and setting realistic expectations.	7.00	0.25
Communication skills are important to include in an ADHD multifamily group curriculum.	7.00	0.25

Support. Support for ADHD children and their families was a theme that emerged from the first questionnaire. In particular, the importance of peer support for parents was repeated by different experts: "I feel that parents would particularly benefit from the support of other families managing parenting ADHD children, especially if education were provided to promote empathy and realistic expectations for their child's diagnosis" (Participant 4). "I know there is a great benefit for families to have a shared experience and that support provided can be helpful" (Participant 1).

Although each expert statement pertaining to the proposed goal of increasing peer support and fostering peer interactions as important in an ADHD multifamily group reached expert consensus, experts did not agree that the goal itself was important for an ADHD multifamily group (See Table 8). Experts repeatedly commented about how multifamily groups offer support and this was reinforced by panelist consensus reached in each individual goal

statement. Providing peer support for parents, children, other families and a shared experience for family members all received expert consensus. Experts agreed that the proposed program would provide support in many areas. Interestingly though, they did not agree that peer support is important in ADHD treatment.

Table 8
Goal which may effect change in families of ADHD children: to increase peer support and foster peer interactions.

	Median	IQR
A multifamily group provides peer support for parents.	7.00	0.25
A multifamily group provides peer support for children.	6.83	0.13
Parents benefit from the support of others parenting ADHD children, especially if education were provided to promote empathy and realistic expectations for their child's diagnosis.	7.00	0.13
A multifamily group offers families a shared experience	7.00	0.13
A multifamily group offers support from other families.	7.00	0.63
A multifamily group offers family members a chance to learn and reflect with each other.	6.83	0.75

To learn new and more satisfying ways of interacting with family members.

Expert consensus was achieved on the goal to learn new and more satisfying ways of interacting with family members and for the three supporting statements identified by the expert panelists (see Table 9). Providing family members a chance to see current patterns of interaction, an opportunity to learn and practice more satisfying ways of interacting and a multifamily group offering families a chance for positive interactions received consensus, with minimum variances in scores. However, the last goal proposed, "to create new stories for preferred ways of relating to themselves and their family members" is not included in the final profile as experts did not agree the goal was important. Furthermore, this goal did not produce any supporting statements by expert panelists.

Table 9
Goal: To learn new and more satisfying ways of interacting with family members.

	Median	IQR
A goal of learning new and more satisfying ways of interacting with family members is important for an ADHD multifamily group.	6.75	1.13
A multifamily group provides family members a chance to see current patterns of interaction.	6.50	1.13
A multifamily group provides family members an opportunity to learn and practice more satisfying ways of interacting.	6.75	1.13
A multifamily group offers families a chance for positive interactions.	6.75	1.13

Strength of the Curriculum

Although 6 of 7 panelists (86%) responded "yes" to the question in Questionnaire I that they felt this module is a good fit for treating children with ADHD in a social service setting, consensus was not reached on this statement in Questionnaire II. Interestingly, each statement surrounding the strength of the curriculum did reach expert consensus (see Table 10). Strengths of the program which met consensus by the panel included peer support for parents and support to participants as they navigate a challenging diagnosis, the normalizing effect of the program on families, reducing isolation and increasing social support and education. Providing families a shared experience while reducing the feeling of being alone in their struggles reached maximum median consensus of 7.00 as did the comment stating that the family focus of the program is a strength because it allows facilitators to observe how families interact together so that facilitators can educate participants and intervene in family interactions. One participant reported that the program would allow families to increase their information and knowledge about the disorder and provide them with an opportunity to test out new behaviors and assess how effective they might be" (Participant 7). Of note, the expert statement that a strength of the program is the process-oriented activities received expert consensus.

Table 10
Strengths of Curriculum

	Median	IQR
This program provides support to participants as they navigate a challenging diagnosis.	6.75	1.25
Peer support for parents is a strength of this program.	7.00	1.13
This program could have a normalizing effect on families, reducing isolation and increasing social support and education.	7.00	0.63
The process oriented activities are a strength of the program.	6.75	1.25
The family focus of the program is a strength because it allows facilitators to observe how families interact together so that facilitators can educate participants and intervene in family interactions.	7.00	0.63
This ADHD multifamily group provides families a shared experience, providing support while reducing the feeling of being alone in their struggles.	7.00	0.25

Experiential Format

Although the expert statement identifying the process-oriented activities as a strength of the program did meet expert consensus, only one of the eight expert statements presented to the panel under the theme of experiential format met the criteria for consensus. The statement "An experiential component offers an opportunity for participants' strengths to shine when they are often feeling like nothing is going well' received a median of 6.38 and IQR 1.06, demonstrating both consensus and agreement, with minimal variance in scores. Many statements regarding the experiential components of the program would have met consensus according to the median score; however, there were high degrees of variability in these scores, representing divergent expert opinions.

Program Parameters

Nine statements regarding program parameters were included in the second questionnaire. These included comments regarding target age, length of session and duration of program. This is the area with fewest statements endorsed by the experts. Only one statement

met expert consensus: 10-12 is an appropriate target age for this program because children are beginning to push for independence which can cause conflict with parents, yet they are vulnerable socially and need the support of their families (Median 6.25, IQR 1.42).

Five of the seven expert panelists gave the proposed format the highest ranking (see Table 11).

Table 11

Which of the following formats do you feel would be most efficacious for a multifamily group for ADHD children and their families? Ranked in order of importance with 1 being the most recommended to 4 being the least recommended.

Participant	First three sessions split 1/2 and 1/2 - first hour in subgroups of parents and children, followed by a break and second hour meet as one group. Sessions ***4-12*** meet all together	First six sessions split 1/2 and 1/2 - first hour in subgroups of parents and children, followed by a break and second hour meet as one group. Sessions ***7-12*** meet all together	All 12 sessions split 1/2 and 1/2 - first hour in subgroups of parents and children, followed by a break and second hour meet as one group.	All 12 sessions all together - no subgroups, break between hours.
1	1	2	4	3
2	1	2	3	4
3	1	2	3	4
4	3	2	1	4
5	1	2	3	4
6	2	3	4	1
7	1	2	3	4

Process and Safety of Group – Psychoeducational component leading to process oriented systemic sessions

This category was created after coding the results from the first questionnaire. These items did not fit under any of the established categories, but were deemed important enough to be included in the final profile. Each statement refers to either a safety issue raised by a panelist or the process of the group (see Table 12). Experts strongly recommended using screening assessments to determine sufficient parental skills and childhood stability for group participation as well as the importance of facilitators creating an environment safe enough for participants to be authentic and to self-disclose. These safety statements received the highest possible expert consensus, median 7.00 and IQR 0.00, demonstrating both high consensus and little variance. Separating children and parents during the first three sessions was supported by experts, following the theme of safety – creating safety for later sessions when participants would be sharing personal details with one another and giving feedback. Separating children during the early sessions was also recommended as a way for the group to join and build cohesion, as a whole and within the subsystems, allowing group norms to be established. Also supported by the experts were clear delineations about punctuality and consistent attendance so that expectations are known, as well as including a discussion following subsystem sessions to help children and parents share what they learned with each other.

Table 12
Process and safety of group-Creating safe subsystems: Psychoeducational component leading to systemic process oriented sessions.

	Median	IQR
Before the group begins, screening assessments should be used to determine if parental skills and abilities are sufficient and children are stable enough to participate in group.	7.00	0.00
Punctuality and consistent attendance need to be addressed so that expectations are known.	7.00	0.63
It is important for facilitators to create an environment safe enough for participants to be authentic and self-disclose.	7.00	0.00
Separating children and parents in the first three sessions allows subgroups to bond and feel comfortable with each other –creating safety for later sessions when participants are sharing personal details with one another and giving feedback.	6.75	1.25
Separating children and parents for portions of the first three sessions is a good way to join and build group cohesion with the whole group and within the subsystems, allowing for group norms to be established.	6.83	0.75
10-12 is an appropriate target age for this program because children are beginning to push for independence which can cause conflict with parents, yet they are vulnerable socially and need the support of their families.	6.25	1.42
An experiential component offers an opportunity for participants' strengths to shine when they are often feeling nothing is going well.	6.38	1.06
A discussion following each subsystem session would help children and parents share what they learned with each other.	6.75	1.13

Obstacles

All five obstacles identified by expert panelists related to a participant's ADHD met expert consensus (see Table 13). Experts recognized that parents having the disorder could pose a potential impediment. They foresaw another impediment – the likelihood that ADHD medication would have worn off by the time the group met. Furthermore, experts noted that the program needed to be structured to account for the child's ADHD symptoms, including challenges with focus and attention, overstimulation and hyperactivity, such as managing transitions during the program as well as being more active and interactive. However, only two of the five obstacles identified by the experts there were not specific to the child's ADHD

reached expert consensus. Parental conflict possibly impeding family growth and the chance that group members might monopolize sessions received expert consensus while the potential negativity of one family member or parents balking at a process oriented modality did not meet consensus.

Table 13
Obstacles

	Median	IQR
The beneficial effects of ADHD medication on the children may be absent if the group is held late in day.	6.83	0.38
The program needs to have a structured plan to help children manage their ADHD symptoms (hyperactivity, overstimulation, lack of focus/concentration) in a therapeutic environment, i.e. managing transitions during program.	6.83	0.38
The program needs to be more active and interactive to meet the needs of ADHD child with limited attention spans: need to be more creative – find two or three activities to modify for group to include during each session.	6.70	0.33
Parents having the disorder, resulting in conflicts with their spouse and a desire to talk about that which will need to be refocused to another setting.	6.50	0.56
Parental conflict may impede family growth.	6.17	0.58
Group members may monopolize sessions.	6.75	0.63

Summary

The final profile includes items from the Q2 that contained the highest level of agreement and the greatest consensus (See Table 14). Forty-two of the 64 statements (65.63%) are included in the final profile. These items met the criteria recommended by Fish and Busby (2005), with medians of 6.0 or higher, and IQRs of 1.5 or lower. Out of 64 items generated from Q1 listed on Q2, 42 items (65.63%) met this standard. The profile is delineated by themes which arose from panelist responses to Q1 which met consensus from Q2. Strength and potential obstacles of the program module statements have been incorporated into the specific thematic headings listed above.

Table 14
Final Profile

	Median	IQR
Multifamily Therapy Group – A Systemic Family Approach		
A multifamily therapy group is an appropriate modality for children with ADHD as ADHD impacts the dynamics of the whole family and strains the parent/child relationship.	7.00	1.25
A multifamily therapy group gives family members a chance to see current patterns of interaction and learn to practice more positive ways of interacting.	6.75	1.13
A multifamily therapy group is appropriate because ADHD affects the entire family.	6.75	1.25
A multifamily therapy group is appropriate as an adjunct to family therapy.	6.83	0.75
The family focus of the program is a strength because it allows facilitators to observe how families interact together so that facilitators can educate participants and intervene in family interactions.	7.00	0.63
[A potential obstacle to a multifamily group is that] parental conflict may impede family growth.	6.17	0.58
[A potential obstacle to a multifamily group is that] parents having the disorder, resulting in conflicts with their spouse and a desire to talk about that which will need to be refocused to another setting.	6.50	0.56
Support		
This program provides support to participants as they navigate a challenging diagnosis.	6.75	1.25
A multifamily group provides peer support for parents.	7.00	0.25
Peer support for parents is a strength of this program.	7.00	1.13
A multifamily group provides peer support for children.	6.83	0.13
Parents benefit from the support of others parenting ADHD children, especially if education were provided to promote empathy and realistic expectations for their child's diagnosis.	7.00	0.13
A multifamily group offers families a shared experience.	7.00	0.13
A multifamily group offers support from other families.	7.00	0.63
This ADHD multifamily group provides families a shared experience, providing support while reducing the feeling of being alone in their struggles.	7.00	0.25
Normalization		
A multifamily group offers family members a chance to learn and reflect with each other.	6.83	0.75
This program could have a normalizing effect on families, reducing	7.00	0.63

isolation and increasing social support and education.		
An ADHD multifamily group normalizes kids' and families' experiences, reducing isolation - helping them understand that they are not alone.	7.00	0.00
Increasing Knowledge of ADHD		
A goal of increasing knowledge of ADHD and its effect on family interactions is important in an ADHD multifamily group.	7.00	0.13
Including the whole family helps facilitators observe and intervene with how the family is responding to and managing symptoms of the disorder.	7.00	0.13
An ADHD multifamily group provides strong support and education and a place to share interventions/solutions to parenting children with ADHD.	7.00	0.63
Strategies to reduce ADHD symptoms		
A goal of learning strategies to reduce ADHD symptoms is important in an ADHD multifamily group.	7.00	0.00
Specific skills should be taught in an ADHD multifamily group for kids and families to help manage ADHD symptoms and their effects.	7.00	0.00
Family structuring should be taught in an ADHD multifamily group –promoting family structure, time management, responsiveness, empathy, positive limit setting and setting realistic expectations.	7.00	0.25
Communication skills are important to include in an ADHD multifamily group curriculum.	7.00	0.25
Family Patterns of Interaction		
A goal of learning new and more satisfying ways of interacting with family members is important for an ADHD multifamily group.	6.75	1.13
A multifamily group provides family members a chance to see current patterns of interaction.	6.50	1.13
A multifamily group provides family members an opportunity to learn and practice more satisfying ways of interacting.	6.75	1.13
A multifamily group offers families a chance for positive interactions.	6.75	1.13
Safety and Group Process – Psychoeducation and Experiential techniques		
Before the group begins, screening assessments should be used to determine if parental skills and abilities are sufficient and children are stable enough to participate in group.	7.00	0.00
Punctuality and consistent attendance need to be addressed so that expectations are known.	7.00	0.63
It is important for facilitators to create an environment safe enough for participants to be authentic and self-disclose.	7.00	0.00
Separating children and parents in the first three sessions allows subgroups to bond and feel comfortable with each other –creating	6.75	1.25

safety for later sessions when participants are sharing personal details with one another and giving feedback.		
Separating children and parents for portions of the first three sessions is a good way to join and build group cohesion with the whole group and within the subsystems, allowing for group norms to be established.	6.83	0.75
A discussion following each subsystem session would help children and parents share what they learned with each other.	6.75	1.13
10-12 is an appropriate target age for this program because children are beginning to push for independence which can cause conflict with parents, yet they are vulnerable socially and need the support of their families.	6.25	1.42
An experiential component offers an opportunity for participants' strengths to shine when they are often feeling nothing is going well.	6.38	1.06
The process oriented activities are a strength of the program.	6.75	1.25
The program needs to have a structured plan to help children manage their ADHD symptoms (hyperactivity, overstimulation, lack of focus/concentration) in a therapeutic environment, i.e. managing transitions during program.	6.83	0.38
The program needs to be more active and interactive to meet the needs of ADHD child with limited attention spans: need to be more creative – find two or three activities to modify for group to include during each session.	6.70	0.33
The beneficial effects of ADHD medication on the children may be absent if the group is held late in day.	6.83	0.38
Group members may monopolize sessions.	6.75	0.63

Chapter Five: Discussion

This study aimed to reach expert consensus on the evaluation of a proposed curriculum for a multifamily therapy group for ADHD children and their families. It was hoped that in doing so, current research on ADHD and multifamily groups would be expanded upon. In this chapter, the findings of the study will be discussed and examined, as well as compared to existing literature on ADHD and multiple family groups. This chapter will also discuss limitations to the study, clinical implications and suggestions for future research.

Summary of Findings

Multiple common themes emerged that gave insight into how experts viewed the curriculum, including goals, theoretical framework, therapeutic processes and modality. Themes that arose included: systemic family approach; increasing knowledge of ADHD; strategies to reduce symptoms; support and normalization; family patterns of interaction; safety; and group process, including psychoeducation and experiential techniques. To briefly recap, panelists supported a systemic approach for ADHD treatment, acknowledging that ADHD symptoms spill into family dynamics, affecting the entire family. A multifamily group was endorsed as it may provide normalization and peer support. Numerous ADHD treatment goals were also agreed upon, in particular increasing knowledge of the disorder and learning strategies to reduce symptoms. Although panelists strongly concurred with the utilization of a psychoeducational component in the proposed curriculum as well as separating children and parents in the earlier sessions to ensure safety, the panel recommended added safety measures to be implemented as well. Furthermore, although numerous goals for ADHD treatment did meet agreement, panelists did not concur about all of the recommended therapeutic techniques, specifically the fishbowl – family members serving as reflective teams for each other.

Multifamily Therapy Group, A Systemic Family Approach

This study proposed a multifamily therapy group as an appropriate treatment modality for children with ADHD and panelists agreed. This concurs with Barkley et al. (1992) who reported that an ADHD child is at greater risk for experiencing family conflict, especially with parents who themselves may be susceptible to greater parental stress, marital discord and psychopathology. The experts further supported the modality concurring that ADHD affects the entire family and the family focus of the program is a strength as it allows facilitators an opportunity to observe how families interact. Research supports using multifamily groups as families work side by side, learning from each other (Asen, 2002).

Although experts agreed that using a multifamily group is appropriate, experts also agreed that a potential obstacle to a multifamily group may be parental conflict, as one parent may also suffer from the disorder. This comports with Griggs and Mikami (2011) who noted that confounding the familial component is the genetic predisposition of ADHD, as it is a heritable disorder; there is a high likelihood that children with ADHD may have one parent who also suffers from symptoms of the disorder. Chronis-Tuscano et al. (2011) reported that mothers with significant ADHD symptoms may have difficulty using skills taught in behavioral skills training, due to their inability to inhibit negative reactions to their ADHD child's behavior, and this may explain the diminished reduction in child behavior problems following treatment. Experts in this study raised a similar concern, not parents impeding post treatment adherence of treatment recommendations, but rather one parent's ADHD symptoms potentially impeding the group itself. Experts agreed that one parent having ADHD may lead to parental conflict in group or distractions caused by an ADHD symptomatic parent disrupting group injecting off topic extraneous comments.

Support. Support was a theme that was repeated by experts throughout this study. Interestingly, the proposed goal of increasing peer support and fostering peer interactions did not meet expert consensus. In fact, when asked to rate goals for the proposed program, six of seven experts ranked increasing peer support and fostering peer interactions as least important or second least important. This is puzzling as panelists reached consensus on numerous statements surrounding support and peer support. This is not consistent with Asen (2002) who reports that peer support and peer criticism are known to be powerful dynamics that can promote change.

However, panelists concurred with the curriculum agreeing that a multifamily group provides support to participants as they navigate a challenging diagnosis. Panelists associate multifamily groups as providing peer support for parents and that this support is a strength of the proposed program. Panelists also agreed that parents benefit from the support of others parenting ADHD children, especially if education were provided to promote empathy and realistic expectations for their child's diagnosis. Finally, panelists concur that a multifamily group provides peer support for children too. This is consistent with Coughlin and Wimberger (1968) who report that peers are a powerful support and influence in multifamily therapy. Providing peer support for ADHD children in a multifamily group may provide them with more positive peer experiences, as previous research has reported that ADHD children frequently lag behind their peers (Mrug, 2001).

Panelists agreed that a multifamily group offers families a shared experience and support from other families, while reducing the feeling of being alone in their struggles. This is consistent with Thorngren et al. (1996) who reported that multiple family groups offer participants a support system within the group as these families frequently feel socially isolated. Furthermore, Yalom (2005) suggested that multiple family groups increase the opportunity to

build a sense of community and social support. Panelists agreed that a multiple family group offers family members a chance to learn and reflect with each other, offering support from other families as well.

Normalization. Normalization was another theme that emerged suggesting that multiple family groups normalize the experience of living with ADHD. Therefore, normalization was added for the final analysis as well. Experts agreed that the proposed program could have a normalizing effect on families, reducing isolation and increasing social support and education. In fact, the panelists collectively agreed that an ADHD multifamily group normalizes kids' and families' experiences, reducing isolation, while helping them understand that they are not alone. This is in keeping with the recommendation that focusing on normalization is an important component of a multifamily group (Fristad et al., 1998; McDonell & Dyck, 2004).

Goals

Increasing knowledge of ADHD. Another strong finding of the study was the experts' support of several of the proposed goals of the program. Experts agreed that increasing knowledge of ADHD and its effect on family interactions is an important goal in an ADHD multifamily group. This is in keeping with Thorngren et al. (1998) recommendation that a multifamily group fosters common themes of increased awareness about the disorder for children and their family members. Experts also concurred that an ADHD multifamily group provides education and a place to share interventions and solutions to parenting children with ADHD. These findings are consistent with Fristad et al. (2003) study of a multifamily group for children with mood disorders aged 8-11 and their parents, which found that parents reported increased parental knowledge about the childhood disorder as well as increased positive family interactions.

Learning strategies to reduce ADHD symptoms. Panelists strongly recommended learning strategies to reduce ADHD symptoms as an important goal in an ADHD multifamily group. Experts emphasized the importance of teaching specific skills to help families manage ADHD symptoms and their effects. Experts specifically condoned teaching family structuring in a multifamily group to promote family structure, including time management responsiveness, positive limit setting and setting realistic expectations. This is supported by earlier research. McKay et al. (1995) identified rules, consequences, rewards, roles, communication and family relationships as key principles taught in a multifamily therapy group. This also comports with this study's findings as the experts identified the importance of including communication skills in the curriculum. Emphasizing communication and problem solving skills has been strongly endorsed by earlier multifamily group research (Thorngren et al., 1998; Stone et al., 1996).

Family patterns of interaction. Experts emphasized the importance of a goal of learning new and more satisfying ways of interacting with family members in the multifamily group. Thorngren and Kleist (2002) suggested that a multifamily group offers participants the opportunity to explore individual behaviors in the context of familial relationships. Panelists concurred that the proposed multifamily group provides family members a chance to see current patterns of interaction and an opportunity to learn to practice more satisfying ways of relating to family members. This consideration is consistent with a study by Schaefer (2008) who reported that multifamily groups help participants change dysfunctional family patterns. Experts also concurred that the proposed multiple family group offer families a chance for positive interactions. Schaefer (2008) suggested this link too as participants in this study reported an ability to integrate communication skills into more positive interactions with family members.

Furthermore, participants in Schaefer's study also reported more closeness to family members who attended therapy.

Safety and group process – psychoeducation and experiential techniques. Experts were in agreement regarding many aspects of the proposed curriculum, strongly endorsing the psychoeducational portion, children and parents meeting separately during part of the initial sessions, which was proposed to create safe subsystems within the larger group. The panel recommended additional steps to ensure group safety, which also met group consensus and have been added to the final profile. However, the experts did not concur on many of the proposed parameters of the program including length of sessions and length of program. Although experts concurred that the process oriented activities are a strength of the program, many of the experiential techniques were not supported. Experts also agreed that there are many potential obstacles one might expect to encounter running a multifamily group for ADHD children and their families, particularly issues surrounding the child's ADHD symptoms. Furthermore, although six of seven panelists answered affirmatively in Q1 that the proposed program is a good fit for treating ADHD children in a social service setting, this statement was included in Q2 for the experts to rank, and the experts did not meet consensus - therefore this statement was not included in the final profile.

Experts recommended pre-session safety measures. First, panelists emphasized the importance of screening assessments to determine if parental skills and abilities are sufficient and children are stable enough to participate in the group. Also recommended was a discussion with families about punctuality and consistent attendance so that expectations are known. Experts concurred that 10-12 is an appropriate target age for this program because children are beginning to push for independence which can cause conflict with parents, yet they are

vulnerable socially and need the support of their families. Five of seven experts recommended the proposed format as most efficacious for a multifamily group – first half of initial three sessions meeting in subgroups of parents and children, followed by a break and second hour meeting as one group with all participants meeting together in the remaining sessions. Experts agreed that it is important for facilitators to create an environment safe enough for participants to be authentic and self-disclose.

Meeting separately at first was proposed as a mechanism to create safety within the therapeutic setting. Experts supported separating children and parents for portions of the first three sessions, agreeing that this allowed subgroups to bond and feel comfortable with each other – creating safety for later sessions when participants would be sharing personal details with one another and giving feedback. This was keeping with the recommendation of Keiley (2002) that the initial sessions of group are intended to assist group members with socializing to group work and developing a sense of safety. Furthermore, experts concurred that separating children and parents for portions of the first three sessions was a good way to join and build group cohesion with the whole group and within the subsystems, allowing for group norms to be established. These considerations are consistent with a study of a multifamily group by Coughlin and Wimberger (1996) which created separate sessions for children and parents for the first hour of group in an effort to provide peer identification and support before the parent-child relationship was explored in later group sessions. A discussion following each subsystem session was recommended by experts suggesting it would help children and parents share what they learned with each other.

As mentioned earlier when discussing specific goals, psychoeducational components of the program were supported by experts, focusing on normalizing the experience of living with ADHD and providing education about symptoms (Fristad et al., 1998; McDonell & Dyck, 2004). Communication and problem-solving were topics that experts agreed should be emphasized in the program, and this is in keeping with recommendations by earlier research (Thorngren et al., 1998, Stone et al., 1996).

Process: experiential and narrative. Although systems theory was the overarching framework directing the development of this model, the proposed curriculum and process of delivery was based on Narrative Therapy and Experiential Therapy. A multifamily group setting, following the principles of experiential therapy, was proposed because of the emphasis on here-and-now experiences. Mrug et al., (2001) reported that ADHD children are less able to utilize situational cues and tend to behave in a similar manner regardless of the circumstance. Furthermore, Hoza et al. (2005) identified ADHD children having difficulty assessing their own behavior. Therefore it is important for ADHD children to become more aware of their own behavior and its consequences – using experiential process oriented activities was proposed as a means to this end. The process oriented activities were supported by the experts as a strength of the program. This is keeping with the recommendation of Barkley et al. (2004) that therapeutic settings be created to enable ADHD child performance, not simply to impart knowledge. Experts concurred that an experiential component offers an opportunity for participants' strengths to shine when they are often feeling nothing is going well.

Interestingly, the goal that was driven by narrative therapy - to create new stories for preferred ways of relating to themselves and their family members – did not achieve expert consensus. Nor did some narrative therapy techniques proposed in the curriculum. Specifically,

the fishbowl, a technique designed to utilize participants as a reflective team, did not receive support. Directing children to sit in an inner circle and hold a conversation while parents form a circle of chairs around the children first listening and observing and then reflecting back, the fishbowl technique was seen as intimidating by some of the experts as children would be interacting with adults of other families. There was a lot of variability in experts rating of this technique, indicating divergent expert opinions. The lack of support of this technique is not consistent with earlier research which recommended the fishbowl as a mechanism to create new contexts, allowing individual family members to be part of different subgroups and thus able to view themselves and be experienced differently (Steinglass et al., 2001; Asen & Scholz, 2010). Ostroff, Ross, Steinglass, Ronis-Tobin and Singh (2004) reported positive outcome evaluations of a one-day multifamily group for cancer survivors and their families, as families rated the program overwhelmingly positive and endorsed the group within group component.

Nor did the experts agree that an experiential component provides an opportunity for participants to become more comfortable while having a chance to be reflective and responsive to content. These results are not consistent with Benningfield (1978) who suggested that the group is a mirror in which the family is able to view themselves, challenging, supporting and reflecting so that individual families may learn to interact more positively. Furthermore, Leichter and Schulman (1974) advocated that viewing someone else's family's struggles first may, over the course of time help individuals connect to their own family's struggles, eventually enabling them to apply what they see in others to themselves.

Although role plays were not specifically supported or rejected by the panel, results were unclear surrounding the use of the technique. Proposed to be implemented in the middle sessions of the curriculum, the goal of role plays was twofold: first to highlight current patterns of

interaction; and then to experiment with new and more creative interactions and ways of communicating. Although experts concurred that a multifamily group gives family members a chance to see current patterns of interaction and learn to practice more positive ways of interacting, experts did not agree that an experiential format provides families an opportunity to interrupt negative cycles of interaction as they are occurring. This is not consistent with Asen and Scholz (2010) who endorsed working in vivo – in the moment – and suggested that role plays are intended to serve as the catalyst to new behaviors and increased positive family interactions. There is a lot of research supporting use of role plays in multifamily therapy. Role plays are an important component of Keiley's multifamily group for conduct disordered adolescents and intervention research on this study reported strong findings, reducing recidivism rates by 40% for incarcerated adolescents over an 8-month period (Keiley, 2007). Coughlin and Wimberger (1968) also report empirical support for utilizing role plays six months following a multiple family therapy group for adolescent boys having serious conflict with their families, with families reporting increased confidence with more open communication. Also role plays are an integral component of a multifamily group model developed for urban youth with oppositional behavioral difficulties. Numerous outcome studies supported the program, reporting higher retention rates for participants compared with individual therapy as well as reductions in ADHD and oppositional symptoms including conduct problems, impulsivity and hyperactivity (McKay et al., 1999; McKay et al., 2002; Stone et al., 1996). While we can't be certain that the role plays in these programs are what led to the findings, it is still important to note the positive outcomes of these programs that emphasize role plays.

The experts recommended incorporating a structured plan into the program to help the children manage their ADHD symptoms in a therapeutic environment, for instance managing

transitions during the program. This is not consistent with the proposed middle sessions of the curriculum or the recommendation of Asen and Schuff (2006) that sessions be less structured to allow facilitators to work in vivo, in the moment. It is possible that the experts did not concur on some of the experiential components of the curriculum due to the fact that they felt these activities did not provide enough structure for ADHD children. In fact, experts recommended that the program be more active and interactive to meet the needs of ADHD children, finding two or three activities to modify to include during each session. Furthermore, experts concurred that the beneficial effects of ADHD medication on the children may be absent if the group is held late in day and that group members may monopolize sessions. Although experts condoned the use of a multifamily therapy group for ADHD children and their families, experts also felt that there were numerous potential obstacles to implementing such a program. This may also explain divergent opinions presented by panelists on some of the parameters of the program, including length of session or number of sessions in the proposed multifamily group. Perhaps the experts may have concurred with more techniques if the program was proposed for older children, maybe 12-14 year olds. Maintaining a safe therapeutic environment was raised as a concern by some panelists and some suggested children may be intimidated by parents of other children in this group setting.

Theory. The use of Systems Theory as a guiding, overarching framework was supported by this study, aligning well with the ADHD literature indicating the spillover effects of ADHD into the family system, providing an opportunity to target ADHD as well as the related concerns within family relationships that stem from the disorder. Key tenets of systems theory are that elements within the system are inter-reliant, feedback loops guide behavior, and patterns and rules dictate the interactions across subsystem boundaries (Smith et al., 2009). Experts

concurred that providing an opportunity to see current patterns of interaction and learn new and more satisfying ways of relating to family members is of paramount importance. Including family members in treatment for an ADHD child is in keeping with the recommendation by Sperry and Duffy (2002) who stated that although the ADHD child may be the identified patient, the impact may be far reaching within family interactions.

Experiential Family Therapy working in the moment was supported in research (Asen & Schuff, 2006; Cooklin et al., 1983). Although the experts supported an experiential component and concurred that the process oriented activities are a strength of the program, experts did not agree on certain therapeutic techniques. In fact, the process oriented segments of the program, guided by Narrative Therapy were the least supported. The fishbowl technique was seen as some experts as unsafe for children therapeutically. Role plays, as mentioned above, supported in empirical studies, was absent in the expert comments. Lastly, creating new stories for preferred ways of relating to themselves and their family members was not seen as an important goal for an ADHD multifamily group.

Revisions to Curriculum

Based both on the findings and prior literature, there are certain revisions I propose to the curriculum. Following the panel's recommendation, screening assessments should be incorporated into the module. Through a semi-structured intake interview, families would be screened for safety concerns; families presenting with current child abuse/neglect or active suicide ideation would be excluded (McKay et al., 1995; Stone et al., 1996). Included in the interview would be questions to assess whether or not the child's ADHD symptoms could be managed to allow him or her to cooperate and not distract other children in a two hour program. Safety was a repeated theme raised by experts and heeding that advice seems appropriate.

Also based on the findings there are additional changes that would be important to incorporate into the curriculum, in particular several that are in response to comments made about fitting the curriculum to meet the unique needs of ADHD children. Instead of providing free time and snacks immediately prior to the onset of each session, a 15 minute break could be incorporated into the middle of each group session, allowing for the children and parents to socialize, have some refreshments and move around. After the break, a brief discussion should be added to the schedule to provide each subsystem group a chance to share what they learned in the first hour. Furthermore, to keep children and parents focused in session, a variety of more physical activities are recommended to supplement weeks 4 -11 scheduled program. Most of the proposed therapeutic activities would involve families working together and others would have the parent and child subsystems together to increase peer interaction. For families, possibilities include maneuvering through an obstacle course, building a family island on paper, creating their dream house, building life circles or holding a cast party (Asen & Scholz, 2010; Thorngren & Kleist,2002). These activities would be processed in the large group following the activity. Subsystem activities would be more action oriented for the children – a chance to expel some excess energy while practicing positive peer interactions.

Interestingly, although numerous studies pointed to peer difficulties of ADHD children, supporting the case for using a multifamily group for ADHD children, the panelists were generally silent on the topic, except supporting peer support as a potential benefit of the program. Hoza et al. (2005) and Pelham et al. (2005) both report the mechanisms that drive peer deficiencies a mystery and traditional social skills treatment as ineffectual. Therefore, further research is needed to explore the complexity of peer interactions for ADHD children and how to address this issue in treatment.

The panelists did not support the narrative techniques proposed for the curriculum, in particular the fishbowl reflective team concept. In the literature, this technique was recommended for use in hospital programs working with families of psychotic patients or families battling cancer (Ostroff et al., 2004; Steinglass et al., 2001). This technique is also strongly endorsed by Asen and Scholz (2010), documenting its use at the Marlborough Center. However, panelists commented that the children may be too young to benefit from this technique and it may not feel safe for a child to be surrounded by adults from other families. Although this could be monitored by facilitators, it seems prudent to heed the advice of the experts and remove this technique from the curriculum.

However, the reflecting team concept is one that is supported in literature for use with children (de Oliveira, 2008; Fredman, Christie & Bear, 2007; Lax, 1989). Yet, there is a dearth of empirical studies on reflecting teams (Pender & Stinchfield, 2012). Instead of using the reflecting teams with the fishbowl for general discussion and increasing participant perspectives, having participants reflect on role plays while sitting with their families will remain as a component of the curriculum. Although the role plays were not specifically recommended by the panelists, as mentioned above, there is support in the field to include role plays in a curriculum. In response to the comments about limited attention span of ADHD children, I would now recommend having the earlier session role plays be either role-reversals (children playing parents and vice versa) or facilitators acting out scenes for the family members to watch. This would add a layer a safety to the techniques allowing more time for the group to join while modeling and practicing appropriate reflecting comments.

Furthermore, there are numerous variations to enacting role plays that participants may find more engaging. For instance, participants may rotate in and out of a scene, creating more

interest while offering more perspectives to the participants. In essence, this is creating more safety embedded into the curriculum, hopefully reducing the vulnerability of participants.

In vivo interactions, although recommended by Asen and Scholz (2010) also did not receive specific support. Further research should explore this topic as well as using the fishbowl technique with children.

Study Limitations

There are inherent limitations in Delphi studies. One such limitation is that the validity of the study is reliant on the selection of the expert panel (Dawson & Brucker, 2001). This study was limited in the diversity and size of the sample. Although the researcher attempted to secure 8-10 experts holding different licenses to practice therapy, only seven of the thirty potential panelists met the criteria, had sufficient time to donate to the study, or chose to participate. Furthermore, although eleven of the potential panelists held PsyD or PhD licenses, none actually participated. Therefore, although there was diversity represented in the background of experts, four LCSW, two LMFT and one LPC, the results of the questionnaires are not representative of all people who are experts in this area. Furthermore, although the panel of experts reported extensive experience working with ADHD children in family therapy, and most expressed extensive experience facilitating groups, some experts did not report substantial experience facilitating family groups. In fact, three panelists did not have any experience facilitating family groups. Therefore, a narrow perspective may have been given as this study represents the opinions of these particular experts. A different panel may have generated different findings (Sori & Sprenkle, 2004).

There is considerable diversity on criteria for inclusion in multifamily group membership (O'Shea & Phelps, 1985). Age of children included as participants varies from study to study. Meezan and Okeefe (1998) indicated families had to have one child 2 to 11, while Cooklin at al.

(1983) reported children 5 to 15 and Tolan and McKay (1996) 7 to 13. In fact, the model from Stone et al. (1996) used role plays and included a modal age of ten with sibling participants from 4 to 16 years of age. One expert in this study wondered whether using an experiential intervention for children aged 10 to 12 was age or symptom appropriate and another commented that the fishbowl activity may be intimidating for children. Although the panelists concurred with the proposed program's target age 10-12, a limit of this study is that no consensus was reached on appropriate age for specific interventions.

Another limitation of the study is that there were questions that remained unanswered after the two rounds of the study. Following recommendations of earlier researchers to reduce the risk of panelist fatigue leading to attrition by limiting the Delphi study to two rounds, the researcher was not able to clarify panelists' remarks or address discrepancies in the data following the second round (Sori & Sprenkle, 2004). For instance, it may have been helpful for the researcher to obtain participants' views regarding the specific narrative techniques to clarify their positions and recommendations.

Clinical Implications

The results of this study have a number of implications for therapists as they work with ADHD children. First, experts agreed that measures have to be taken to assure emotional safety before beginning multifamily work. This advice may be applicable across the spectrum of modality and is applicable whether or not a therapist is working with one child, the entire family, a group of children, or a multifamily group. Repeatedly, experts raised concerns and recommendations to ensure the therapeutic environment is appropriate for an ADHD child.

Another clinical implication which arose from the results of this study is the consideration that one or both parents may display ADHD symptoms due to the apparent

heritability of ADHD. Experts agreed that parental conflict may be evident and in fact impede family growth. Therefore, therapists may find that ADHD childhood treatment adherence is at risk due to lack of follow-through and consistent parenting (Barkley et al., 1992). Helping find the family support and normalizing the ADHD experience is recommended.

Treating an ADHD child within the context of his or her family was strongly supported by the panel of experts, specifically in a multifamily group. However, whether treating the child individually or with the family, increasing knowledge of ADHD and its effect on family interactions, learning strategies to reduce symptoms and learning new and more satisfying ways of interacting within the family are appropriate therapeutic goals.

Last, if working with children in groups, either multifamily or peers, a therapist is tasked with balancing the need for structure of the ADHD child and the need for movement. Experts agreed that programs need to be designed keeping a child's ADHD symptoms in mind.

Future Research

This Delphi study provided expert consensus on utilizing a multifamily group to treat ADHD children and their families. Due to the exploratory nature of the Delphi method, there are many issues which remain unsolved. Therefore, there is a need for continued research to gain deeper understanding of this topic. If conducting another Delphi study, further research should expand on the sample size to include experts who are licensed PhD or PsyD. Furthermore, it would be beneficial to gain expert consensus on specific techniques recommended other than psychoeducational for inclusion within a multifamily group. It would also be helpful to gather expert consensus on how to balance a multifamily group format providing enough structure for an ADHD child, yet allowing enough flexibility and movement for ADHD symptoms.

Although there is a plethora of research on ADHD treatment, there is a dearth of studies on multifamily therapy as a modality. Findings from this study indicated through expert agreement that the modality is appropriate for ADHD children and their families. Therefore, a study measuring the effects of a multifamily group is recommended. Pre and post treatment assessments and interviews would glean valuable insight into the effectiveness of utilizing a multifamily therapy group and guide direction for further research.

Conclusion

ADHD children suffer from primary symptoms of inattention, impulsivity and hyperactivity, and also from secondary negative impacts including poor peer relationships, and increased conflict within family interactions. This study queried experts to obtain consensus view on the proposed ADHD multifamily group curriculum developed for implementation in a social service agency setting. Experts agreed that a multifamily therapy group for ADHD children and their families is an appropriate treatment modality as ADHD impacts the dynamics of the entire family and often strains relationships between parents and children. Furthermore, experts concurred that a multifamily group offers family members a chance to see current patterns of interaction and learn to practice more positive ways of interacting. The proposed 12-week pilot curriculum developed for implementation in a social service agency was supported in part. Experts identified numerous strengths in the program, concurring that the program would provide support and normalization to the ADHD child and parents. Specifically, family focus and peer support for parents were identified as strengths, as were the process oriented segments of the program. Experts highlighted the importance of two goals, learning strategies to reduce ADHD symptoms and increasing knowledge of ADHD and its impact on family interactions. Experts in this study offered valuable insight into the importance of implementing measures to ensure safety in the therapeutic setting. The psychoeducational component of the curriculum was

lauded, as panelists supported the creation of parent and child subsystems early in the treatment - to provide support, normalization and safety.

Although experts supported the process portions of the curriculum, agreement was not reached on certain techniques, in particular the use of participants as reflecting teams. Experts also concurred that a goal of learning new and more satisfying ways of interacting with family members is important for an ADHD multifamily group; yet how to achieve that goal was not determined. Further research is warranted to obtain consensus view on program parameters and therapeutic techniques, including use of children in a multifamily reflecting team, role plays and therapists working in vivo. Furthermore, a challenge moving forward is how to balance managing a child's ADHD symptoms while attempting to affect change in a multifamily group setting. In other words, it will be important to determine how to develop a program that provides enough structure for safety yet allows for enough movement and variety to keep ADHD children invested and interested in the group.

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Appendix A

CURRICULUM FOR MULTIFAMILY GROUP FOR ADHD CHILDREN AND THEIR FAMILIES

Beginning Sessions – Weeks ONE - THREE

WEEK ONE

I. Welcome to group by facilitators.

II. Introductions:

1. Ourselves and others: Everyone creates own name tag. Then, introduce other members of your family to the group. Children, introduce parents who are present and share with group one thing about each. Parents each introduce child and share one thing with group about child. [facilitators provide example by introducing each other]

2. Purpose of multifamily group: To provide support and to increase understanding about how ADHD impacts your families and to learn strategies to reduce ADHD symptoms, learning new and more satisfying ways of interacting with family members. In particular, to help all of us learn to support each other in order to think about how to get along differently; to interrupt old and unhelpful patterns of interacting and to explore new and more satisfying patterns – ultimately to create new stories for preferred ways of relating to yourselves and your family members.

3. Examples:

   a. When dinner is ready, Mary (ADHD child) is not at the table after mom has repeatedly called her. Mary has been sitting in her room with her headphones on listening to music. Mom yells for dad but no one answers and she goes to Mary's room, yells at Mary who yells back but stomps into dinner. Dad comes to table 5 minutes later, notices that no one is speaking, asks Mary how her day was and she mumbles 'no one understands me' and she rolls her eyes at mom. Mom yells at Mary for disrespecting her and Dad yells at Mom to ease up on Mary. The rest of the meal is spent in stony silence as each family member continues to feel angry and misunderstood, then quickly separate rooms of the house.

   b. Mom was angry because she spent time on dinner and no one arrived on time even though she tried to ask Dad and Mary calmly. Then she felt Mary was acting disrespectfully and that Dad undermined her authority as mother. At the end of the day she felt lonely and unloved. Mary was angry because she felt

no one understood her as she was trying to do her homework as mom told her to do and the only way she could focus was with headphones on.

c. At end of day, Mom, Dad and Mary each felt tired and lonely and that other family members didn't understand where they were coming from. In fact, each was searching for validation and connection.

4. Method: We have a 12 week program that has been developed so that families may engage and support each other, observe and challenge patterns of interaction, share strategies and encourage change, while exploring new behaviors. Structured exercises will be included to increase the intensity and interaction level of participants (Keiley, 2002).

5. Business of Group:

   a. Develop the rules of the group.

   b. Our sessions will last two hours and we will meet at the same time and place each week for 12 weeks. Snacks will be provided and the group room will be available for thirty minutes prior to each session allowing ADHD children, peers and families to socialize and exchange ideas, developing support allowing for informal intra and inter-family conversations.

   c. From week four onwards, we will have an experiential component along with a discussion about the activity. For the next three weeks the session will be split, one hour spent with one facilitator meeting with the children and one with the parents; the remaining hour we will convene together, parents and children.

6. Activity: Family goal/group goal

   a. Brainstorm within your family. Working together as a family come up with one positive aspect of ADHD and one area you'd like to work on in group. For instance, is there one area of interaction within your family that you would like to see improved, as it relates to ADHD as a part of your family?

   b. Families share the positive as well as area for growth and facilitators process the exercise. Facilitators begin to notice family patterns of interactions. Facilitator records list of growth/strengths .

   c. Facilitator led discussion of strengths and growth areas – group discussion of goals; hearing from family members about what would like to work on, expectations for group.

7. Break into groups – children with one facilitator, parents with another. Children are asked to come up with group ritual to end each session. Parents have informal

discussion about any concerns they have about group – chance for parents to ask facilitators questions.

8. Group reconvenes and children present ritual to entire group. Group ends with ritual.

WEEK TWO

I. Opening, Welcome, Check-in

II. Break into groups

1. Child/parent and sibling groups meet separately to socialize the participants to group interactions and to develop a sense of safety (Keiley, 2002).

    a. Children's group(s)

        1. Ice breaker (ball toss to get to know group member names)

        2. Pscyhoeducation - ADHD and how it affects people. Three major components of ADHD symptoms: Inattention, impulsivity, and hyperactivity

        3. Review of last week's discussion of lists of attributes of ADHD children and list of areas of growth. Play matching game with children and list. What area of ADHD matches with area of growth from list?

        4. Discussion with children about times when they may have noticed any of three symptoms and examples they would share with group members.

    b. Parent group

        1. Discussion of parents' hopes and fears surrounding ADHD kids.

        2. Psychoeducation – ADHD and how it affects people. Three major components of ADHD symptoms: Inattention, impulsivity, and hyperactivity.

        3. Review of last week's lists of attributes of ADHD children and list of areas of growth followed by discussion of how items on growth list match with one of three main symptoms of ADHD.

        4. Opportunity for parents to express frustrations about children's behaviors and feelings of isolation and to receive support from other families (Asen, 2002).

III. Back together - Discussion about how ADHD is a part of a child and that it does not define the child. Thinking of ADHD part in a more constructive, educated way can be helpful in the way we relate in our families.

1. Using the specific area of growth each family identified week I, brainstorm within the family and decide as a family a way to refer to the ADHD part using new language, in essence externalizing the part.

    a. For instance, if hyperactivity is the symptom as Martha has trouble staying in her seat during a movie, she and her family may name her fidgeting as her 'engine revving'.

    b. The goal is to change the way the family speaks surrounding the ADHD symptom and to help recognize that the ADHD child is not a problem, the ADHD symptom is the issue. [Facilitators move between families to assist in conversations, and to observe patterns of interaction].

2. Group led discussion about new language; chance for group as whole to join and to hear stories and support each other. How do families feel about using new language? Anyone willing to try this week?

3. Ritual & ending. Facilitators ask families to meet once during the week and discuss new language – perhaps practice or discuss feelings around idea.

WEEK THREE

I. Opening, Welcome, Check-In

II. Distractions – Break into Groups

1. Children's group – discussion of distractions and losing focus. What happens when you are at your computer doing your homework and look up and realize it's time to go to soccer practice but you're staring at a blank screen? You haven't finished any of your homework and aren't really sure where the time went. Mom is calling from the car and you're late. You run downstairs and into the car knowing Mom is going to ask about homework and not let you go to friend's house after practice if it isn't done. What are you feeling? What will you do?

    a. Children discuss feelings and then strategies that may help them. Facilitator passes out plastic fidgets which may be used as squeeze object to assist with fidgeting.

2. Parent's group – discussion of distractions and losing focus. Same scenario as above. Zachary runs into the car for baseball practice and doesn't answer when you ask if his homework is completed. You promised Zachary he could go to his

friend's house after practice if the homework was done but think's Zachary silence is your answer. What are you feeling? What will you do?

a. Parents discuss feelings and then strategies that may help them cope with feelings or aid children with distractions and losing focus.

b. Parental discussion of what strategies work and opportunity for parents to provide support for each other, normalizing their experiences (Fristad et al., 1998; McDonell & Dyck, 2004).

III. Back together – Role Play – Facilitators role play the scenario then lead discussion about how it felt to watch? What did participants feel as they watched mom? Zachary? Any ideas about how mom and Zachary were feeling? What might make it better? How could the interaction be more positive or less negative? [Input from group – maybe less yelling, either person listening, showing respect, using new language for ADHD part]. If this was your family, how would you like the scenario to be different? What is one way you could suggest that might help? List suggestions on board –specific ideas for each person. [Activity introduces role plays with group feedback – facilitators as actors enacting first role play to introduce concept and safely begin to process].

IV. Role Play – Facilitators again enact role play, this time utilizing suggestions from discussion for how the situation might be more successful for each family member.

V. Process role play. Again, what do you think Zachary was feeling during role play? Mom? How did you feel watching this role play? What made you know that Mom was angry? Sad? How could you tell Zachary shifted and appeared engaged and was listening? What signals did Mom show that she was feeling differently?

VI. Ritual & ending: This week, try and be an observer within your own family. Do you notice any interactions that looked like the scene enacted tonight? Are you an observer or participant in these interactions? How does it feel for you either watching the scene or being in it?

Middle Sessions – WEEKS FOUR – NINE

WEEK FOUR

I. Opening, Welcome, Check-in

II. Perspectives: Children Versus Parents about ADHD child – Fishbowl Group within a group (Steinglass) Purpose is to allow family members to gain appreciation of different viewpoints and emotions generated by ADHD child in family.

1. Group Convenes. First, in 'normal seats' [where family members sit by choice] one facilitator directs conversation with parents about impact of ADHD on their families. Next, chairs are moved so that the children are sitting in the center forming a circle with parents seated as observers on periphery looking towards center, creating a fishbowl effect: children as goldfish, parents as cats looking in. Facilitator directs children to have conversation amongst themselves about the effect they think that ADHD has had on their lives and their families. Facilitator reminds observers to maintain observer stance and not comment.

2. Next the observers (parents) move their chairs to form a circle as it is now the parent's group turn to converse, while the children's group chairs open and becomes the listening group. The parents will talk between themselves without input from the children as the facilitator focuses on drawing connections between the feelings and thoughts of various members of the parents group about what they have heard as observers. Next the facilitator directs the parents in essence to switch from their observer role to discuss how ADHD affects their family. In other words, focusing on the family as a whole, how family members interact with one another surrounding the child's ADHD. During step 2, children are observing parents first commenting as observers themselves, and then children are observing their parents discussion of the parental perspective of ADHD in the family.

3. Next, step 2 is repeated in reverse. The children move back to form a circle so they may have a discussion amongst themselves as they respond to their parents' discussion of the parental perspective of ADHD in the family. Parents open up their chairs so that they may again sit in the observer role.

4. Group reconvenes and everyone sits in one circle. The conversation is opened up to the group as a whole. Facilitators may emphasize connections of perspectives or emerging themes from children or parents. Hopefully seeing perspectives of other family members may open up new appreciation that different attitudes and feelings are neither right nor wrong, they are merely different perspectives shared across families.

III. Ritual and ending: In group, you heard and may have spoken about how ADHD affects your family. This week, select a time to meet with your family members to discuss the impact of ADHD on your family. Feel free to ask each other questions and notice how your perspective may or may not be the same as your parents or your children.

WEEK FIVE

I. Opening, Welcome, Check-in

II. Introduction of Family Activity – Family Scribble – Family Play Activity (Gil, 1994)

1. Purpose of activity is for family members to participate in a non-goal activity and to begin to process family interactions in group. Parents and children work together to identify family processes. The activity is a vehicle to observe habitual patterns (Asen & Scholz, 2010)

2. Families will take turns either participating in the activity or observing. Create reflecting team of group members who are observers. Metaphor of multifamily group as a Greek chorus - allows observers to see things in perspective and from different perspectives, two goals of multifamily therapy. (Asen, 2002)

3. First, ½ families are instructed to be in middle of room at tables with one piece of construction paper and one marker per family member. Each family member is directed to make a scribble drawing on the paper with their marker. Once the scribbles are drawn, the facilitator directs the family to decide as a family how they will make their family scribble and to grow it into the right picture for everyone here in their family group.

4. Observing family members are asked to sit silently around perimeter of the room but to be observant so that they may provide feedback afterwards.

5. Once the families have completed their drawings, first those family members are asked by the facilitator about the process. What was the experience like for them?

6. Facilitator leads discussion about how to be an observer and then how to provide feedback without judgment. Validation, reflection and empathy will be discussed. Utilizing listening skills and use of nonthreatening language when providing feedback is emphasized. Phrases are written on the board to aid participants with appropriate, thoughtful comments.

    a. I noticed that …….
    b. It made me think …….
    c. I wonder ……

7. Switch – families who participated in the exercise become observers and observers become participants. Process following exercise.

III. Ending, ritual. This week, meet and plan a family 'fun' activity – a time to be together without an agenda. Flip chart paper will be distributed if families want to do another scribble drawing or art activity at home.

WEEK SIX

I. Opening, Welcome, Check-In

II. Meet in family units - Families are tasked with reaching a consensus about a family scenario they would like to enact during group. Family is encouraged to discuss times when their family struggled to resolve a conflict (preferably surrounding ADHD child). The only directive is that the scenario should be something that each family member feels comfortable sharing with other group members. Facilitators walk around room providing support in this process [step 1 of Asen & Scholz (2010) five-step model: observing and punctuating problematic observations and communications).

III. Role play – Facilitators inform group that this role play is a chance for a family to get assistance in working on this struggle. After the role play, other group members will have an opportunity to provide comments about their observations. Facilitators ask for one family to volunteer to have their scenario represented in the role play, acting as themselves while the rest of the group observes.* Observers are reminded about their roles to be silent and thoughtful during role play. Chairs are moved to periphery of room and observers sit around family enacting role play. The family role plays while the rest of the group observes silently.

IV. Processing Role Play – [Following Asen & Scholz's (2010) five step model]

a. First, facilitators check in with family members to see if enactment was representative of what happens at home. Each family member will be asked individually: "Is this a good representation of what happens at home?" [Step 2: checking perceptions]. If yes, facilitators will begin to make observations with presumptive wording: I wonder if…Did I get that right? If not, facilitator asks for clarification.

b. Next, once family members agree that this is an accurate portrayal of scenario, facilitator invites evaluation [Step 3].

Evaluation is heightened as observers become in a sense 'outsider witness groups' (White). The process allows a family's story to be deepened by sharing an experience from someone else's lives. One family's story may resonate with other families so that what is being told is heard, processed from a different perspective and placed within that family's context, perhaps with a change in focus as nuances are gradually introduced. In this way, multifamily group generates multiple new perspectives and meanings, opening up new possibilities and curiosities (Asen, 2002).

Observers are directed that they may provide feedback on what they noticed and what they saw, being mindful of constructive feedback (as discussed earlier in session & Week 5, II 6). Reminders of appropriate ways to begin commenting are displayed on board: 1) I noticed that. 2) I wonder if. 3) It made me think that. "What did you notice and what did you see?" Facilitators also provide feedback, noticing boundaries, alliances, wondering about power and silence within the family.

c. Once observations are complete, facilitator redirects focus back to family enacting role play. “Is this how you see your family? I wonder if we got this right?” [Going back to Step 2, checking perceptions. If perceptions are correct, facilitator can move to Step 4] “Are you happy that it is this way, or does this bother you?”[Step 4 – determining the wish to change] Question is again posed to each participating family member. As different family members have different perspectives, each person is asked each question. Follow-up question: So, if you do not want things to continue this way, how would you like it to be? How might you envision this scenario going differently? What may it look like? –[Step 5] At this point, facilitators receive permission from participating family to break up into smaller groups to allow feedback and discussion to continue. Suggestions are to help family members answer the question “What would you have to say or do now to make it the way you want it to be? What would be the first step?”

d. Parents and children meet separately each with a facilitator and a flip chart. Each group brainstorms ideas from observers providing suggestions. Each group discusses only the participant from the family that is in their discussion; for instance, the parents will provide feedback for the parents in the role play and the children will provide feedback for the child. Suggestions are recorded on a flip chart for each family to take home. Again, observing family members are reminded of appropriate language for comments. Suggestion: “I think it would be helpful if…..”

e. Group reconvenes - Process for family who participated in role play. “How did that feel? What did you think about suggestions? Do you have suggestion of your own? Discussion of suggestions from each subgroup are presented and processed.

V. *In Vivo processing: This is a chance for in vivo processing by group facilitators. Beginning in the middle sessions (weeks 4 – 9) facilitators may interrupt families as they are struggling during group. For instance, when the facilitator asks for family volunteers, if mom raises her hand to volunteer without consulting other family members, it may prompt son’s face to redden in embarrassment as he hides his head in his hands, which in turn prompts dad to turn to son and roll his eyes towards mom. Facilitator follows Asen & Scholz (2010) five step model and processes interaction in the moment.

In vivo processing may also be used if family enters group continuing argument they were having in car, or if facilitator observes a child having difficulty focusing in group and is receiving different signals from mom than from dad (i.e. son refuses to put away phone, mom attempts to grab out of son’s hand and dad attempts humor to diffuse situation).

VI. Ritual and ending: Some thoughts you may want to consider during the week:

1. For those who participated in the role play. What did you notice in yourself or hear from group members that may help make your interactions with your family members more of how you envision them?

2. For observers – Based on the role play you watched, what did you notice about yourself as you observed? Are there any similarities/differences between how things work in this family compared to yours? Is there anything you noticed that might help you think differently about your own family interactions?

WEEKS SEVEN, EIGHT & NINE

I. Opening, Welcome, Check-in

II. Role play – First hour of Week 7, 8 and 9 - remaining families enact role play in front of entire group. WEEK 6 outline is followed [If there are more than 4 families in group, week 7 includes 2 family role plays].

III. Second hour of WEEKS 7, 8 and 9 allow for increased facilitator flexibility. Below are some choices. Goal is for facilitation role to decrease as families become greater forms of support for each other. Encourage families to become more active in facilitation and provide support as needed.

1. Alternative Role Play - Role Reversal & Trading Places.

   a) In this role play, we have parents playing ADHD children and children playing parents. However, no one who is related role plays together. First we ask the participants to come up with a topic for the role play, act the role play ineffectively. Then, the role players are coached by their observers with suggestions to be implemented for another role play. How could the role play be more functional?

   b) Participants enact the role play again, this time utilizing suggestions from group. However, role play will be interrupted from time to time as group members change places. Facilitator will stop the role play and ask observing group for volunteer to take place of one participant, once again keeping in mind that family members will not be participating at same time. Once role play has completed, facilitators process role play asking participants and observers about their experiences? What were they feeling? How did it feel when you changed from a participant to an observer? What were your thoughts when you entered the role play? Were there different solutions proposed?

c) Group reconvenes. Discussion led by facilitators. How may group members take what they learned today home with them. How could they use ideas they heard in the coming week.

2. Fishbowl discussion – Parents first and then children sit in fishbowl and discuss strategies they would like to employ to improve family interactions -When Things Aren't Going According to Plan. Discuss strategies you might use when interacting with your child/parent. Observers (first children) respond to their parents about their reactions to the strategies and then children discuss their own strategies they would like to employ with parents as observers.

3. Obstacle course – alternative activity for entire family(way to observe family process/dynamics). Plastic garbage cans, plastic cones and books may be brought into group to set up obstacle course for family. First the child sets up course and then directs blindfolded parent through course to end (one at a time). Then, parents direct blindfolded child through course. Other group members sit in periphery of room and then provide observations at conclusion as activity is processed [follow process of Week 5 Scribble Activity]

4. Split into groups – parents in one/children in another and discuss 'When Emotions Run High' – 1) how to evaluate if emotions are running high 2) strategies to employ to prevent emotions from escalating; and 3) plan if strategies did not work and emotions (either child or parent) are out of control. Then, reconvene in large group and continue discussion.

IV. Ritual & Ending – [Ending thought for weeks 7 – 9 align with specific activity chosen from above list or thought may be repeated from week 6 as stated below]

1) For those who participated in the role play. What did you notice in yourself or hear from group members that may help make your interactions with your family members more of how you envision them?

2) For observers – Based on the role play you watched, what did you notice about yourself as you observed? Are there any similarities/differences between how things work in this family compared to yours? Is there anything you noticed that might help you think differently about your own family interactions?

Closing Sessions – WEEKS TEN – TWELVE

WEEK TEN

I. Opening, Welcome, Check-in

II. Role play – Group divides into subgroups of two families each. Within sub-group, one family enacts role play of scenario they would like to improve upon regarding ADHD and its impact on their family. Each family member plays themselves. Other family facilitates role play entirely, first silently watching, then acting as reflecting team and finally as facilitators to assist family enacting role play with suggestions. Participating family responds and comments. Then, family reenacts role play inserting strategies they feel will make scenario a more positive experience. Group facilitators move from family dyad to family dyad to help facilitate process but not to provide reflections. Group has moved towards families acting as experts for each other, increasing their sense of self-efficacy and confidence as well as support.

III. Ritual and Ending: During the week, meet as a family and discuss strategies you came up with in group or ones you would like to use to improve family interactions regarding ADHD. Some items you may want to discuss:

1) How does it feel to use your new ideas/strategies?
2) As a family, have any of your interactions changed? If so, how?

WEEK ELEVEN

I. Opening, Welcome, Check-in

II. Role play – Group divides into same subgroups of two families each as WEEK TEN. Within sub-group, the family that enacted the role play previous week becomes the facilitators and the family that facilitated becomes the enactors. Similar to last week, the family enacts a role play of scenario which represents an area they would like to improve upon regarding ADHD and its impact on their family. Each family member plays themselves. Other family facilitates role play entirely, first silently watching, then acting as reflecting team and finally as facilitators to assist family enacting role play with suggestions. Participating family responds and comments. Then, family reenacts role play inserting strategies they feel will make scenario a more positive experience . Group facilitators move from family dyad to family dyad to help facilitate process but not to provide reflections. Group has moved towards families acting as experts for each other, increasing their sense of self-efficacy and confidence as well as support.

III. Ritual & Ending: During the week, meet as a family and discuss an interaction that occurred regarding ADHD. Some things that you may want to discuss:

1. Were you able to use any of your new strategies?
2. How did it feel in the moment and now as you discuss?
3. What might you do differently next time?

WEEK TWELVE

ADHD MULTIFAMILY THERAPY GROUP

I. Opening, Welcome, Check-in

II. Overview of Program

III. Concluding Activity – Creating Family Poster. We provide materials and parents and children work together to create a family poster which represents what they feel they have learned in the previous 9 weeks. After families complete posters, they are presented to group.

IV. Post-treatment questionnaires completed.

V. Celebration of group learnings. Completion Certificates are presented to each family.

VI. Party – refreshments and a time for families to interact informally.

Appendix B

Email Letter 1

For my master's degree in Human Development at Virginia Tech, I am conducting a study for my thesis to evaluate a curriculum for a multifamily group for ADHD children and their families for use in a social service agency setting. A pilot curriculum has been developed for evaluation and this study aims to collect data from expert reviewers in an effort to reach consensus on critical aspects of the constructed treatment manual including the modality, program, goals and interventions. Due to the exploratory nature of the program, the Delphi Method is being used to gather consensus on any proposed changes.

I would like to invite you to participate as an expert for the study. To qualify as an expert evaluator, you must meet the following criteria:

1) Have at least five year's clinical experience treating children diagnosed with ADHD
2) Be a licensed clinician, holding an LMFT, LPC, LCSW, PhD or PsyD, and
3) Must meet one criteria from the following list:
    a. at least 5 years facilitating family therapy groups;
    b. at least 5 years clinical experience counseling children in family therapy;
    c. at least 5 years facilitating therapy groups; or
    d. published 2 articles on ADHD clinical research.

If you meet the above criteria and are interested in serving on the expert panel, please read the attached consent form. After reading the consent form, please read the attached pilot curriculum. Then, click on this link: https://survey.vt.edu/survey/entry.jsp?id=1371833893278 or copy the link to your web browser and the survey will appear. By completing the questionnaire, your consent to participate will be implied.

The study will require you to complete two questionnaires. The first questionnaire should take about an hour to complete; I would need the completed questionnaire by _____. After I receive the first round of questionnaires, I will develop a second questionnaire based on your feedback and will send the second questionnaire for you to complete within one week. It should take about 30 minutes to complete.

Your involvement in the study is completely voluntary and you may withdraw from the study at any time without facing adverse consequences. Your ID number is __ . You will be asked to enter this number in both questionnaires. All data will be anonymous, meaning that I will not link your name to your responses. The ID number will allow me to group responses from both questionnaires together appropriately for data analysis.

There is minimal risk to participate in the study; you may experience weariness from completing the surveys. Participants will receive a copy of the final analysis.

Thank you.

Martha Fischer
Master's Student
Virginia Tech
Human Development

Appendix C

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Informed Consent for Participants in Research Projects Involving Human Subjects

Title of Project: Multifamily Therapy Group for ADHD Children and Their Families:

A Delphi Study

Principle Investigator: Andrea K. Wittenborn

I. Purpose of Research

The purpose of this study is to evaluate a curriculum for a multifamily group for ADHD children and their families for use in a social service agency setting. We are interested in learning about what you think about the efficacy of utilizing a multifamily group for ADHD children ages 10 - 12. We are also interested in learning your thoughts about the program and its session structure, goals and interventions.

II. Procedures

You will be asked to read the curriculum and complete a questionnaire which should take about an hour to complete. You will not put your name on the questionnaires in order to keep them confidential. After you complete the first questionnaire, you will be asked to complete a second questionnaire. The second questionnaire will also take about 30 minutes to complete. Your participation in this study is completely voluntary. If you wish to discontinue your participation in this study at any time, you may do so without facing any adverse consequences.

III. Risks

Risks of participating in this study are minimal. As a result of participating in this study, you may become fatigued and not wish to continue.

IV. Benefits

As a participant in the study, you will receive a description of the findings.

V. Extent of Anonymity and Confidentiality

Strict confidentiality of information will be preserved. This means that we won't tell anyone what you say in the questionnaires. You will be assigned an identification number that will be kept separate from any identifying information, and your questionnaires will contain only this identification number. Names will not be used on any reports or publications that are developed from the results of this study.

VI. Compensation

There is no compensation for participating in this survey.

VII. Freedom to Withdraw

You do not have to participate in this research study. If you agree to participate, you can withdraw your participation at any time without penalty.

VIII. Participant's Responsibilities

I voluntarily agree to participate in this study. I have the following responsibility:

1. I will complete two questionnaires to the best of my ability.

IX. Participant's Permission

I have read the Consent Form and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent.

I understand that continuing on and completing the questionnaires gives my consent to allow my answers to be used in the research.

If you have any questions about this research study or its conduct, and research subjects' rights, and whom to contact in the event of a research-related injury to the subject, I may contact:

Martha F. Fischer	703-867-8135/marthafischer@vt.edu
Investigator	Telephone/e-mail
Andrea Wittenborn, Ph.D.	703-538-3787/andreawittenborn@vt.edu
Investigator	Telephone/e-mail
David M. Moore	540-231-4991/moored@vt.edu
Chair, Virginia Tech Institutional Review Board for the Protection of Human Subjects Office of Research Compliance	Telephone/e-mail

Appendix D

Q1

Multifamily Therapy Group Curriculum Questionnaire

ID Number (enter the ID number provided to you in the initial email you received)

What is your gender?

- Male
- Female

What is your age?

How many years have you been a licensed therapist?

How many years have you been treating children with ADHD as a licensed therapist?

What is your current license to practice?

- LMFT
- LPC
- LCSW
- PhD
- PsyD

How many years of experience do you have facilitating therapy groups?

How many years of experience do you have facilitating *family* therapy groups?

How many years of clinical experience do you have counseling children in family therapy?

How many articles have you published on ADHD clinical research?

In your clinical practice, what percentage of time do you spend treating children?

- 0-25%
- 25-50%
- 50-75%
- 75-100%

In your clinical practice, what percentage of time do you spend treating*ADHD* children?

- 0-25%
- 25-50%
- 50-75%
- 75-100%

Of the time you spend treating ADHD children, what percentage do you provide individual therapy to the child?

- 0-25%
- 25-50%
- 50-75%
- 75-100%

Of the time you spend treating ADHD children, what percentage do you provide family therapy?

- 0-25%
- 25-50%
- 50-75%
- 75-100%

Of the time you spend treating ADHD children, what percentage do you provide group therapy for children?

- 0-25%
- 25-50%
- 50-75%
- 75-100%

Of the time you spend treating ADHD children, what percentage do you provide *family* group therapy?

- 0-25%
- 25-50%
- 50-75%
- 75-100%

The following questions pertain specifically to the curriculum for a multifamily group for ADHD children and their families.

Please describe your reaction to the program module.

Do you feel this module is a good fit for treating children with ADHD in a social service setting?

- Yes
- No

Do you think a multifamily therapy group is an appropriate modality for children with ADHD? If not, what modality do you support and why?

Which of the following goals do you feel would effect change in families of ADHD children? Please rank in order of importance. Goals should be ranked from 1-5 with 1 being the most important to 5 being the least important.

To increase knowledge of ADHD and its effect on family interactions.

Rank 1-5

To learn strategies to reduce ADHD symptoms

Rank 1-5

To increase peer support and foster peer interactions.

Rank 1-5

To learn new and more satisfying ways of interacting with family members.

Rank 1-5

To create new stories for preferred ways of relating to themselves and their family members.

Rank 1-5

Are there additional goals you recommend as promoting change above and beyond the goals listed in the previous question?

What do you see as strengths of the curriculum?

This program is designed for ADHD children aged 10-12 and their families. Do you feel this is an appropriate target age? Please explain.

This is a 12 week program with 2 hour sessions each week. Do you feel this is an appropriate length of program and duration for sessions? Please explain.

This program is designed to be experiential, consisting of group participation through role plays, initially processed by group facilitators, at times utilizing group members as participants in enactments whereas other times group members observe role plays, in a sense serving on reflective panels. As the group progresses, the intent is for participants to become increasingly more active in the facilitation of feedback for other group members, thus reducing the role of formal group facilitators. Do you think this format for the group will be helpful to these families? Why or why not? Please explain.

This module is designed to have parents and children separate for parts of the first three sessions to enable the group to join and to create safe subsystems of children and parents. Beginning in the fourth week, all participants will be together for the duration of the program so that systemic intervention may occur. What is your reaction to this? Is there another format you think may be more efficacious? If so, please describe.

What obstacles might you expect to encounter in running such a program?

Please provide any other information you feel may be valuable to finalizing the development of a multifamily group therapy program for ADHD children and their families.

Appendix E

VirginiaTech

Office of Research Compliance
Institutational Review Board
North End Center, Suite 4120, Virginia Tech
300 Turner Street NW
Blacksburg, Virginia 24061
540/231-4606 Fax 540/231-0959
email irb@vt.edu
website http://www.irb.vt.edu

MEMORANDUM

DATE: June 24, 2013

TO: Andrea K Wittenborn, Martha Francis Fischer

FROM: Virginia Tech Institutional Review Board (FWA00000572, expires April 25, 2018)

PROTOCOL TITLE: Multifamily Therapy Group for ADHD Children and Their Families: A Delphi Study

IRB NUMBER: **13-575**

Effective June 21, 2013, the Virginia Tech Institution Review Board (IRB) Chair, David M Moore, approved the New Application request for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report within 5 business days to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

All investigators (listed above) are required to comply with the researcher requirements outlined at:

http://www.irb.vt.edu/pages/responsibilities.htm

(Please review responsibilities before the commencement of your research.)

PROTOCOL INFORMATION:

Approved As:	**Expedited, under 45 CFR 46.110 category(ies) 7**
Protocol Approval Date:	**June 21, 2013**
Protocol Expiration Date:	**June 20, 2014**
Continuing Review Due Date*:	**June 6, 2014**

*Date a Continuing Review application is due to the IRB office if human subject activities covered under this protocol, including data analysis, are to continue beyond the Protocol Expiration Date.

FEDERALLY FUNDED RESEARCH REQUIREMENTS:

Per federal regulations, 45 CFR 46.103(f), the IRB is required to compare all federally funded grant proposals/work statements to the IRB protocol(s) which cover the human research activities included in the proposal / work statement before funds are released. Note that this requirement does not apply to Exempt and Interim IRB protocols, or grants for which VT is not the primary awardee.

The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.

APPENDIX F
Q2

Multifamily Therapy Group Curriculum
Questionnaire #2

ID number (enter the ID number provided to you in your email).

I. A Systemic Family Approach
The following statements relate to utilizing a multifamily therapy group as a modality for treating ADHD children.
Please rate the following comments on a scale from 1 to 7, with 1 representing 'strongly disagree' to 7 representing 'strongly agree.'
1 - Strongly disagree | 2 - Disagree | 3 - Somewhat disagree | 4 - Neither agree nor disagree | 5 - Somewhat agree | 6 - Agree | 7 - Strongly agree

A multifamily therapy group is an appropriate modality for children with ADHD as ADHD impacts the dynamics of the whole family and strains the parent/child relationship.
rate 1-7

A multifamily therapy group gives family members a chance to see current patterns of interaction and learn to practice more positive ways of interacting.
rate 1-7

A multifamily therapy group is appropriate because ADHD affects the entire family.
rate 1-7

A multifamily therapy group is appropriate as an adjunct to family therapy.
rate 1-7

II. Goals
Listed below are goals which may effect change in families of ADHD children. Following each goal are statements relating to that specific goal.
Please rate the following goals and comments on a scale from 1 to 7, with 1 representing 'strongly disagree' to 7 representing 'strongly agree.' **1 - Strongly disagree | 2 - Disagree | 3 - Somewhat disagree | 4 - Neither agree nor disagree | 5 - Somewhat agree | 6 - Agree | 7 - Strongly agree**

A goal of increasing knowledge of ADHD and its effect on family interactions is important in

an ADHD multifamily group.

rate 1-7

Including the whole family helps facilitators observe and intervene with how the family is responding to and managing symptoms of the disorder.

rate 1-7

An ADHD multifamily group provides strong support and education and a place to share interventions/solutions to parenting children with ADHD.

rate 1-7

An ADHD multifamily group normalizes kids' and families' experiences, reducing isolation - helping them understand that they are not alone.

rate 1-7

1 - Strongly disagree | 2 - Disagree | 3 - Somewhat disagree | 4 - Neither agree nor disagree | 5 - Somewhat agree | 6 - Agree | 7 - Strongly agree

A goal of learning strategies to reduce ADHD symptoms is important in an ADHD multifamily group.

rate 1-7

Specific skills should be taught in an ADHD multifamily group for kids and families to help manage ADHD symptoms and their effects.

rate 1-7

Family structuring should be taught in an ADHD multifamily group – promoting family structure, time management, responsiveness, empathy, positive limit setting and setting realistic expectations.

rate 1-7

Communication skills are important to include in an ADHD multifamily group curriculum.

rate 1-7

A goal of increasing peer support and fostering peer interactions is important in an ADHD multifamily group.

rate 1-7

A multifamily group provides peer support for parents.

rate 1-7

A multifamily group provides peer support for children.

rate 1-7

Parents benefit from the support of others parenting ADHD children, especially if education were provided to promote empathy and realistic expectations for their child's diagnosis.

rate 1-7

A multifamily group offers families a shared experience.

rate 1-7

A multifamily group offers support from other families.

rate 1-7

A multifamily group offers family members a chance to learn and reflect with each other.

rate 1-7

1 - Strongly disagree | 2 - Disagree | 3 - Somewhat disagree | 4 - Neither agree nor disagree | 5 - Somewhat agree | 6 - Agree | 7 - Strongly agree

A goal of learning new and more satisfying ways of interacting with family members is important for an ADHD multifamily group.

rate 1-7

A multifamily group provides family members a chance to see current patterns of interaction.

rate 1-7

A multifamily group provides family members an opportunity to learn and practice more satisfying ways of interacting.

rate 1-7

A multifamily group offers families a chance for positive interactions.

rate 1 -7

A goal of creating new stories for preferred ways of relating to themselves and their family members is important for an ADHD multifamily group.

rate 1-7

III. Strengths of Curriculum

Following are statements discussing strengths of the proposed program.

Please rate the statements on a scale from 1 to 7, with 1 representing 'strongly disagree' to 7 representing 'strongly agree.'
1 - Strongly disagree | 2 - Disagree | 3 - Somewhat disagree | 4 - Neither agree nor disagree | 5 - Somewhat agree | 6 - Agree | 7 - Strongly agree

This program is a good fit for treating children with ADHD in a social service setting.

rate 1-7

This program provides support to participants as they navigate a challenging diagnosis.

rate 1-7

Peer support for parents is a strength of this program.

rate 1-7

This program could have a normalizing effect on families, reducing isolation and increasing social support and education.

rate 1-7

The process oriented activities are a strength of the program.

rate 1-7

The family focus of the program is a strength because it allows facilitators to observe how families interact together so that facilitators can educate participants and intervene in family interactions.

rate 1-7

This ADHD multifamily group provides families a shared experience, providing support while reducing the feeling of being alone in their struggles.

rate 1-7

IV. Target Age for Program
The following statements comment on age appropriateness of the program module.
Please rate the following comments on a scale from 1 to 7, with 1 representing 'strongly disagree' to 7 representing 'strongly agree.'
1 - Strongly disagree | 2 - Disagree | 3 - Somewhat disagree | 4 - Neither agree nor disagree | 5 - Somewhat agree | 6 - Agree | 7 - Strongly agree

10-12 is an appropriate target age for this program because children are beginning to push for independence which can cause conflict with parents, yet they are vulnerable socially and need the support of their families.

rate 1-7

The program is appropriate for children aged 10-12 only if their ADHD symptoms are

controlled enough for them to benefit from the experiential format.

rate 1-7

Because a portion of the program separates children from parents, and because the program includes ADHD children interacting with parents of other children, the module is more appropriate for children older than 12.

rate 1-7

V. Length of Session and Duration of Program

The following statements comment on the length of program session and duration of the program.

Please rate the following comments on a scale from 1 to 7, with 1 representing 'strongly disagree' to 7 representing 'strongly agree.'

1 - Strongly disagree | 2 - Disagree | 3 - Somewhat disagree | 4 - Neither agree nor disagree | 5 - Somewhat agree | 6 - Agree | 7 - Strongly agree

2 hour sessions are preferred over 90 minute sessions, as long as there is a break.

rate 1-7

90 minute sessions are preferred over 2 hour sessions due to the nature of ADHD symptoms, in particular keeping child focused.

rate 1-7

An assessment should be made to see if the ADHD child can control impulses and is verbally expressive enough to participate in a 2 hour group.

rate 1-7

Families are unlikely to commit to a 12 week program.

rate 1-7

12 week format is preferable as it provides time for the group to become cohesive.

rate 1-7

A program that is less than 12 weeks is preferable.

rate 1-7

VI. Experiential Format

The following statements discuss the experiential format of the proposed curriculum: group participation in role plays, enactments and fishbowl – at times group members participating and at times observing, serving as reflective panels.

Please rate the following comments on a scale from 1 to 7, with 1 representing 'strongly disagree' to 7 representing 'strongly agree.'

1 - Strongly disagree | 2 - Disagree | 3 - Somewhat disagree | 4 - Neither agree nor disagree |

5 - Somewhat agree | 6 - Agree | 7 - Strongly agree

The experiential component provides an opportunity for participants to become more comfortable while having a chance to be reflective and responsive to content.

rate 1-7 ☐

An experiential format provides families an opportunity to interrupt negative cycles of interaction as they are occurring.

rate 1-7 ☐

An experiential format puts family members into expert roles and helps them boost their confidence.

rate 1-7 ☐

It is important for participants to have ample time to process what is true for them/their experience and also give others feedback on what they have felt is helpful or worked.

rate 1-7 ☐

An experiential component offers an opportunity for participants' strengths to shine when they are often feeling like nothing is going well.

rate 1-7 ☐

The fishbowl activity, where children sit in an inner circle and parents form a circle of chairs around the children - listening, observing and reflecting back - may be intimidating for children because they would be interacting with adults of other families.

1-7 ☐

An experiential format is appropriate for the target age and symptoms of this program.

rate 1-7 ☐

An experiential format would not be helpful because of the attention span of ADHD children – if children are not active in the process, they will lose attention quickly.

rate 1-7 ☐

VII. Process and safety of group

Creating safe subsystems - psychoeducational component leading to systemic process oriented sessions. The following statements surround safety and the process of the group – meeting separately for parts of the first three sessions to enable the group to join and to create subsystems of children and parents before moving towards experiential systemic interventions.

Please rate the following comments on a scale from 1 to 7, with 1 representing 'strongly disagree' to 7 representing 'strongly agree.'

1 - Strongly disagree | 2 - Disagree | 3 - Somewhat disagree | 4 - Neither agree nor disagree | 5 - Somewhat agree | 6 - Agree | 7 - Strongly agree

Before the group begins, screening assessments should be used to determine if parental skills and abilities are sufficient and children are stable enough to participate in group.

rate 1-7 ☐

Punctuality and consistent attendance need to be addressed so that expectations are known.

rate 1-7 ☐

Separating parents and children in the first three sessions facilitates joining and enhances safety.

rate 1-7 ☐

It is important for facilitators to create an environment safe enough for participants to be authentic and self-disclose.

rate 1-7 ☐

Separating children and parents in the first three sessions allows subgroups to bond and feel comfortable with each other -creating safety for later sessions when participants are sharing personal details with one another and giving feedback.

rate 1-7 ☐

Separating children and parents for portions of the first three sessions is a good way to join and build group cohesion with the whole group and within the subsystems, allowing for group norms to be established.

rate 1-7 ☐

A discussion following each subsystem session would help children and parents share what they learned with each other.

rate 1-7 ☐

Listed below are four possible formats for the proposed multifamily therapy group.
Which of the following formats do you feel would be most efficacious for a multifamily group for ADHD children and their families?

Please rank in order of importance. Formats should be ranked from 1-4 with 1 being the most recommended to 4 being the least recommended.

First three sessions split 1/2 and 1/2 - first hour in subgroups of parents and children, followed by a break and second hour meet as one group. Sessions 4-12 meet all together [as proposed in curriculum]

Rank 1-4 ☐

ADHD MULTIFAMILY THERAPY GROUP

First *six* sessions split 1/2 and 1/2 - first hour in subgroups of parents and children, followed by a break and second hour meet as one group. Sessions 7-12 meet all together

rank 1-4

All 12 sessions split 1/2 and 1/2 - first hour in subgroups of parents and children, followed by a break and second hour meet as one group.

Rank 1-4

All 12 sessions all together - no subgroups; break between hours.

Rank 1-4

VIII. Potential Obstacles

The following statements reflect obstacles one might expect to encounter in running such a program.

Please rate the following comments on a scale from 1 to 7, with 1 representing 'strongly disagree' to seven representing 'strongly agree.'

1 - Strongly disagree | 2 - Disagree | 3 - Somewhat disagree | 4 - Neither agree nor disagree | 5 - Somewhat agree | 6 - Agree | 7 - Strongly agree

Obstacles one may encounter due to ADHD

The beneficial effects of ADHD medication on the children may be absent if the group is held late in day.

rate 1-7

The program needs to have a structured plan to help children manage their ADHD symptoms (hyperactivity, overstimulation, lack of focus/concentration) in a therapeutic environment, i.e. managing transitions during program.

rate 1-7

The program needs to be more active and interactive to meet the needs of ADHD child with limited attention spans: need to be more creative – find two or three activities to modify for group to include during each session.

rate 1-7

Parents having the disorder, resulting in conflicts with their spouse and a desire to talk about that which will need to be refocused to another setting.

rate 1-7

Obstacles not associated with child's ADHD

Facilitators may face resistance from group members to trying new things.

rate 1-7

Parental conflict may impede family growth.

rate 1-7

Parents may balk at a process oriented modality, demanding more concrete structure.

rate 1-7

The negativity of one family may bring down group cohesion.

rate 1-7

Group members may monopolize sessions.

rate 1-7

This concludes the second questionnaire. If you have any additional comments, please add below. Thank you so much for serving on the expert panel. I will email you the analysis.

Thank you very much for participating as an expert in this study!

Appendix G

Email Letter 2

Thank you very much for participating as an expert in my study for my thesis evaluating a curriculum for a multifamily group for ADHD children and their families for use in a social service agency setting. Based on feedback from you and the other expert reviewers, a second questionnaire has been developed. This questionnaire asks you to rate the importance of items pertaining to an initial question from the first questionnaire, in an effort to reach consensus on critical aspects of the constructed treatment manual including the modality, program, goals and interventions.

To complete the second questionnaire, click on this link: https://survey.vt.edu/survey/entry.jsp?id=1372626700981 or copy the link to your web browser and the survey will appear. I would need the completed questionnaire by___ and it should take about 30 minutes to complete.

Your involvement in the study is completely voluntary and you may withdraw from the study at any time without facing adverse consequences. Your ID number is__ and you will be asked to enter this number in the questionnaire. All data will be anonymous, meaning that I will not link your name to your responses. The ID number will allow me to group responses from both questionnaires together appropriately for data analysis.

There is minimal risk to participate in the study; you may experience weariness from completing the surveys. Participants will receive a copy of the final analysis.

Thank you!

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