

***Doctorate in Professional Educational,
Child and Adolescent Psychology***



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**Doctorate in Professional Educational, Child and Adolescent
Psychology**

**Multi-Family Group Therapy in Primary Schools:
Effectiveness, Processes and Challenges**

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ABSTRACT

Background: There is a growing recognition of need for adequate mental health provision for children and young people (CYP) in the UK and an acknowledgement that schools play a large part in providing early intervention. It is important that interventions that are to be used with CYP have an evidence base that can be applied to the UK school context. Much of the literature on the effectiveness of multi-family group therapy (MFGT) to date looks at its use in a clinical setting rather than in a school setting. Furthermore, much of the previous research has used quantitative self-report measures which give little insight into the experiences of group members and the processes involved in change.

Aims: To evaluate the use of MFGT within a primary school context, to gather the views of the children, parents, school-based partners (SBP) and educational psychologists (EP) who have experienced the intervention and to investigate processes of change.

Method: MFGT was run within four schools in an inner-London borough. 30 children and 29 parents were involved in the intervention. Target monitoring and evaluation (TME) data was collected for all 30 children. Pre- and post-intervention strengths and difficulties questionnaire (SDQ) data was collected from two schools. Focus groups and interviews were conducted with a subsample of children, parents, EPs and SBPs.

Results: On average, children made nearly three points of progress towards their targets, based on TME data. Progress towards targets was also reported across all participant groups in the focus groups and interviews. Pre- and post-intervention SDQ data provided mixed results, with some schools reporting more positive outcomes than others. From the qualitative data, six themes relating to processes of change emerged: collaborative target setting; motivation; parental engagement; facilitators; content of sessions; and shared

learning. Poor parental attendance and systematic issues, such as the amount of time allocated to the SBP, were reported to be barriers to the success of the intervention.

Conclusion: Results indicate that MFGT can support children make progress towards targets in a school context.

Declaration

I, Penelope Whittles confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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IMPACT STATEMENT

Within the UK, there has been a six-fold increase in the prevalence of mental health conditions in children and young people (CYP) over the last 20 years (Pitchforth, Fahy, Ford, Wolpert, Viner & Hargreaves, 2019). Schools are considered to be key partners in supporting the mental health of CYP and are well-placed to intervene early to prevent problems escalating. The government has invested in increasing school's capacity to offer this provision. Within schools, there are a number of universal and targeted interventions that can be applied. One targeted intervention that is available in some parts of the UK is multi-family group therapy (MFGT).

MFGT has been running in schools in the UK for over 30 years, yet there is little research that has evaluated its effectiveness within the school context. The majority of research has looked at MFGT that has taken place within a clinical setting and used as part of the treatment process for various mental health disorders, such as anorexia (Gelin et al., 2016), depression (Lemmens et al, 2009), and schizophrenia (McFarlane, 2016). The research that does look at MFGT within the UK school system has been mainly quantitative in its approach, for example using self-report questionnaires, and does not explain the processes involved in achieving positive outcomes, gather the voice of the participants or the professionals involved in running the groups, or explore the implications for EP practice.

The findings of this study suggest that MFGT can support children to make progress towards their targets. Targets can be set based on the needs of the child and can focus on a range of different areas, such as improving emotional outcomes. Pre- and post-SDQ data provided mixed results, with some schools seeing more success, in relation to positive outcomes, than others. This highlighted the possibility that contextual factors within the schools may contribute towards the success of the intervention. Contextual factors included: SBP's time allocation; parental attendance; organisation of the school; status of SBP; and having school leader who values the intervention. Anticipating these and making adaptations in order to prevent these factors becoming barriers are key implications for the role of the facilitator and for the future use of MFGT in a school context.

The study also found that six themes relating to processes of change emerged from the qualitative data, these were: collaborative target setting; motivation; parental engagement; facilitators; content of sessions; and shared learning. Considering these factors and trying to incorporate them when planning the intervention is a further implication for the role of the facilitator and for the future use of MFGT in a school context.

The research also highlighted implications for EP practice, for example, having already-established facilitator-school relationships led to better outcomes, suggesting that EPs are best placed to run MFGT within the school context. Another implication based on the research findings is that it is important to insist that schools ensure the attendance of both teacher and parent in consultations as this can help to support the home-school connection.

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ACRONYMS

ABFT – Attachment-based family therapy

AEP – Association of Educational Psychologists

ADHD - Attention deficit hyperactivity disorder

BPS – British Psychological Society

BSFT - Brief strategic family therapy

CAMHS - Child and Adolescent Mental Health Service

CBT – Cognitive behavioural therapy

CYP – Children and young people

DfE - Department for Education

EAL - English as an additional language

EP – Educational Psychologists

FAST - Families and School Together programme

GAS - Goal attainment scaling

HCPC - Health and Care Professions Council

IP - Individual psychotherapy

LA1 – Local Authority 1

MDFT – Multi-dimensional family therapy

MFG – Multi-family group

MFGT - Multi-family group therapy

MFES - Marlborough Family Education Service

MFS - Marlborough Family Service

NHS – National Health Service

RQ – Research question

SBP – School-based partner

SEN – Special educational needs

SENCO - Special educational needs coordinators

SEND – Special educational needs and disabilities

SDQ - Strengths and Difficulties Questionnaire

TME – Target monitoring and evaluation

UCL – University College London

UK – United Kingdom

US – United States

Chapter 1: Introduction

1.1 Research Context

This research was undertaken as part of the Professional Educational Child and Adolescent Psychology doctoral programme. The purpose of the research was to evaluate the use of multi-family group therapy (MFGT), an intervention that brings together families experiencing similar challenges, with the aim of finding new solutions within a primary school context. As a Trainee Educational Psychologist completing my work placement in an inner-London Local Authority (LA1), this topic was in line with my professional interests and also contributed directly to LA1, as well as the local Child and Adolescent Mental Health Service (CAMHS) alliance, who were funding the intervention by evaluating an intervention that was already taking place in multiple schools. Therefore, the study had a practical and real-world purpose, which was to critically consider the value of the intervention in terms of its impact on children and families and to inform its future use.

1.2 National and legislative context

The rise in the prevalence of mental health problems in children and young people (CYP) in the United Kingdom (UK) has been well documented. In 1995, 0.8% of CYP in England reported a long-standing mental health condition. By 2014 this had increased to 4.8%, a six-fold increase (Pitchforth, Fahy, Ford, Wolpert, Viner & Hargreaves, 2019).

The 2017 green paper, entitled 'transforming children and young people's mental health provision' stated that one in ten children and young people has some form of clinically diagnosable mental health disorder (Department of Health and Social Care and Department of Education, 2017). The green paper built upon the Department of Health's 'Future in Mind' document, which outlined their five-year plan to improve the mental health and wellbeing of CYP (Department of Health and Social Care and Department of Education, 2017). Both of these documents highlighted the important role that schools play in promoting mental health and well-being in children. The green paper emphasised the importance of early intervention as a way of preventing the escalation mental health

problems. Within the document, schools are put at the heart of efforts to intervene early and to prevent escalation.

Another relevant national issue is the number of school exclusions. In 2017/18 the number of permanent exclusions from schools in England increased by 3% and reached the highest point in nearly a decade (Department for Education (DFE), 2019). In 2018, the Secretary of State commissioned the Timpson Review (DfE, 2019) to review school exclusions. The review concluded that there were certain groups of CYP who were more likely to be excluded: children with special educational needs (SEN); children supported by social care; children from particular ethnic groups; and children eligible for free school meals. They also found that, across the country, there were inconsistencies in the application of exclusions in both primary and secondary schools, and that there were instances where exclusions should not have happened.

The outcomes for children who are excluded can be worrying. Based on 2014/15 exam results, only 7% of children who were permanently excluded achieved a C grade or above in English and maths GCSEs (DfE, 2019) compared with 53.8% of all children (DfE, 2016). Gill, Quilter-Pinner and Swift (2017) found that CYP who are excluded are more likely to develop serious mental health problems, be unemployed or go to prison.

The Timpson report made recommendations for the government, many of which highlighted the importance of early intervention and support programmes. One example of early intervention was to involve the family at the earliest opportunity. The literature review (DfE, 2019) that informed the Timpson report also cited research that evaluated Multi-Family Group Therapy (MFGT) as an intervention to reduce school exclusions (Smith, Jackson & Comber, 2013).

1.3 Local context and the background to the intervention

In 2015, within the area in which the study is based, a CAMHS alliance was set-up in order to 'develop more integrated care pathways that reach children and young people in families, schools and the wider community' (NHS, 2016, p.4). The alliance's aims were aligned with those set out in the 'Future in Mind' document (NHS, 2016).

The alliance consulted with local children and young people, families, local voluntary sector organisations and local statutory sector services to identify key issues and priorities for mental health services. Based on this consultation, the alliance produced a 'transformation plan' to address the priorities identified. Within the local area some of the key issues identified were: a higher than national average level of school exclusion; 79% (estimated) higher level of need for CAMH services, compared with the national average level of need; and a higher number of 'hard to reach' groups.

As part of the transformation plan, organisations working with CYP and operating in the local area could bid for funding from CAMHS in order to provide a service or intervention aligned with the issues and priorities that had been identified by the alliance. The Educational Psychology Service (EPS) in LA1 were successful in securing funding to pilot MFGT in two schools in the LA1 in 2017. Educational Psychologists (EP) within the EPS undertook training at the Anna Freud centre in order to be able to run the intervention. After running the pilot intervention, further funding enabled four more schools in LA1 to run MFGT. The current study is evaluating the MFGT intervention that was run in those four schools.

1.4 Professional context

The role of EPs is varied, and EPs have been defined by Fallon, Woods and Rooney (2010) as 'scientist-practitioners who utilise, for the benefit of children and young people (CYP), psychological skills, knowledge and understanding through the functions of consultation, assessment, intervention, research and training, at organisational, group or individual level across educational, community and care settings, with a variety of role partners' pp.4. Increasingly, EPs are working therapeutically with CYP to deliver evidence-based psychological therapies (Dunsmuir & Hardy, 2016).

Under the Special Educational Needs and Disabilities (SEND) Code of Practice (2015) EPs have a role in identifying CYP who may have mental health difficulties, provide advice on how to support positive mental health and work as a multidisciplinary team to provide individual interventions (DfE, 2015).

The Health and Care Professions Council (HCPC), the statutory regulator of the EP profession, states that EPs 'need to be able to develop and apply effective interventions to promote psychological wellbeing, social, emotional and behavioural development and to raise educational standards' (HCPC, 2015). MFGT, an intervention designed to bring together families experiencing similar challenges in order to find new solutions, could be considered an intervention that promotes all of the elements outlined by the HCPC.

Farrell, Woods, Lewis, Rooney, Squires & O'Connor (2006) reviewed the function and contribution of EPs in England and Wales and found that participants (nearly 1000 stakeholders, including EPs, special educational needs coordinators (SENCO), parents, social workers etc.) regularly referred to EPs' academic background and training in psychology as being the factors that enabled them to offer a distinctive contribution. Findings also suggested that EPs make a unique contribution towards bridging the gap between school and community as they are regarded as having in-depth knowledge of both educational and community contexts and of the different demands that are present in both contexts (Farrell et al. 2006). As MFGT is an intervention that brings both school and the community together, it would make sense the EPs are involved in its facilitation.

1.5 Research Rationale

MFGT has been running in schools in the UK for over 30 years, yet there is little research that has evaluated its effectiveness within the school context (Dawson & McHugh, 1994). Cook-Darzens, Gelin and Hendrick (2018) reviewed literature on MFGT and its use with non-psychiatric conditions. They found that there was low research activity on MFGT outside of a clinical setting. The majority of research has looked at MFGT that has taken place within a clinical setting, and used as part of the treatment process for various mental health disorders, such as anorexia (Gelin, Cook-Darzens, Simon & Hendrick, 2016), depression (Lemmens, Eisler, Dierick, Lietaer & Demyttenaere, 2009), and schizophrenia (McFarlane, 2016). The research that does look at MFGT within the UK school system has been mainly quantitative in its approach, for example using self-report questionnaires, and does not explain the processes involved in achieving positive outcomes, gather the voice of the participants or the professionals involved in running the groups, or explore the implications for EP practice.

Cook-Darzens et al. (2018) concludes that it may be more valid to evaluate MFGT in a non-psychiatric setting, compared with a psychiatric setting, as MFGT in a non-psychiatric setting tends to be a 'stand-alone' intervention which is less likely to be paired with other forms of treatment. Participants in psychiatric research have often received additional treatment either before, during or after MFGT intervention which makes it difficult to isolate the effects of MFGT. Cook-Darzens et al. (2018) recommend that there should be a stronger commitment to the evaluation of MFGT and suggest that uncontrolled designs, using pre-post measures of effectiveness could be one of the ways in which they are evaluated.

Research by Morris, Le Huray, Skagerberg, Gomes and Ninteman (2014) suggests that future research should focus on eliciting the views of those involved in the intervention in order to gain a richer understanding of the mechanisms of change.

Chapter 2: Literature review

2.1 Approach to Literature Review

A computerised literature search was conducted in January 2019. Google Scholar and the University College London (UCL) Library's electronic databases were used to find relevant articles in the field. The historical background of family therapy and its evidence base when used with CYP was the first area of literature to be reviewed. An initial search on Google Scholar, using the term "family therapy" yielded 820,000 results. Given the vast amount of literature, it was decided to focus on a few key textbooks that gave an overview of the history of family therapy, in order to get an outline of the development of the field and to set the scene for the current context in which family therapy is applied.

In terms of reviewing the literature on the effectiveness of family therapy and its use with CYP, the search terms were "family therapy", "children", and "adolescents". These terms led to 231,000 results on Google Scholar. The search terms were narrowed to only include literature published since 2010. The words "family therapy" and "children" featured in the title of 297 results on the UCL library database. The words "family therapy" and

“adolescents” featured in the title of 209 results on the UCL library database. Research conducted in a non-western country was discounted. This geographical focus was guided by the idea that cultural differences may impact upon the success of the intervention. Deuze (2002) writes that there are similarities between The Netherlands, Germany, Great Britain, Australia, and the United States, in terms of democracy and values. Tang and Cousins (2005) found differences in the family structure, for example family roles performed by fathers were different in the East of Europe, compared with the West. Daatland, Herlofson and Lima (2011) found differences in parental responsibility when comparing East and West Europe.

For literature on multi-family therapy, the initial search on Google Scholar used the terms “multi-family group” and led to 1,970 articles. The same search using the UCL library resources led to 857 results, including articles, theses, dissertations, etc. The term “multi-family group therapy” led to 428 articles on Google Scholar and 188 articles in the UCL library databases. “Multi-family therapy” led to 661 articles on Google Scholar and 215 in the UCL databases. The majority of the results were articles looking at the use of MFG within a clinical context, for example in the treatment of depression and eating disorders.

The term “multi-family therapy” and “school” led to 399 results on Google Scholar and 144 results from the UCL database.

The reduction in the number of articles when adding “school” into the search indicated that this is an area that has yet to be fully explored. It was therefore decided to retain research within a clinical setting as long as the participants were children or adolescents, and the research had taken place in a ‘Western’ country (i.e. UK, United States (US), Australia, and New Zealand) and/or Western Europe, in order to focus on contexts which are comparable to the UK.

For researching the processes involved in change, the terms were much more difficult to refine. The terms “processes of change” and “therapy” were used on Google Scholar and 19100 results were found, on the UCL database there were 558 results. To narrow this search, the term “mechanism” was also included. The term “mechanisms of change” are increasingly referred to in literature aiming to understand how interventions might be

effective, for example Morris et al. (2014) used the term when suggesting areas for further research and Petrik and Cronin (2014) write of the importance of defining the mechanisms that are at play in psychological therapies.

2.2 History of Family Therapy

MFGT has evolved from traditional family therapy (Broderick & Schrader, 1991). Law and Martin (2020) define family therapy as “a form of psychotherapy based on the belief that psychological problems are the products of abnormalities in communication between family members. All family members are therefore seen together, when possible, in order to clarify and modify the ways they relate together” pp. 193 (Law and Martin, 2020). Varghese, Kirpekar and Loganathan (2020) define family therapy as a “structured form of psychotherapy that seeks to reduce distress and conflict by improving the systems of interactions between family members” pp. 139.

Family therapy emerged as a new paradigm and method of treatment in the mid-twentieth century (Simmons, 2010). Many mental health providers, such as psychoanalysts and psychiatrists had become dissatisfied with methods of therapy that were based on traditional therapist-patient interactions (Dallos & Draper, 2010). The effectiveness of treating only the individual was low when working with severe mental health issues, such as schizophrenia (Nichols & Schwartz, 2012). Clinicians began to expand their focus and look at the wider systems in which a patient was situated, with the family system being the most important. This widened perspective birthed new theories and approaches to clinical work, with families being at the centre (Nichols and Schwartz, 2012).

The founders of family therapy stepped away from many ‘within person’ models and frameworks that were popular within the mental health field at the time, which assume that a patient’s problems are internal to the patient (Dallos & Draper, 2010). One of the first papers published in the field of family therapy was by Ackerman in 1937. Within this paper, Ackerman emphasised the influence of family as a ‘psychosocial unit’ when treating patients with severe mental health disorders. Family therapy is reported to have started in many different parts of the US, within similar time frames, by independent-minded

practitioners. By the end of the 1950s, many of these practitioners had formed a connected movement and shared their practice (Broderick & Schrader, 1991).

In the 1950s, Gregory Bateson, who is considered 'one of the most influential theoreticians in marriage and family therapy' (Mental Research Institute, 2008, p.25), became one of the first to apply cybernetics to human behaviour (Becvar & Becvar, 2013). Cybernetics was originally aimed at studying information processing in inanimate systems and machines. It was later applied to human systems to try and understand communication, behaviour and organisation. Guttman (1991) described cybernetics as recognising that:

“many different phenomena (both biological and non-biological) share the attributes of a system – that is, a unified whole that consists of interrelated parts, such that the whole can be identified as being different from the sum of its parts and any change in one part affects the rest of the system” (Guttman, 1991, p. 41).

Conversely, individual therapy treats a patient in isolation, without considering that person as part of its wider family system. Bateson, who was working with patients with schizophrenia, noticed that inpatient's conditions would improve, only to relapse when they returned home. They hypothesised that there were patterns of communication within the family system that were preventing the change being applied outside of the hospital context. Bateson's work with families was focused on interactional problems between people deemed schizophrenic and members of their family (Becvar & Becvar, 2013).

Simultaneously, Murray Bowen was also studying schizophrenia within the context of families (Nichols and Schwartz, 2012). His focus was on mother-child relationships, rather than Bateson's focus on interaction and communication. Bowen concentrated on the transmissions of anxiety from parents to their children and from previous generations to the parent (Nichols and Schwartz, 2012). He developed Bowen Theory which applies systems thinking. It takes the view that a family is an emotional unit with members who are intensely connected. This connectedness makes the family members interdependent. A change in one person within the unit is likely to cause changes in the other members, for instance if a family member is anxious, the feelings of anxiety will affect other family members' feelings

of anxiety. It assumes that the interdependence is present, to some degree, in all families (Kerr, 2000).

From the 1960s, a number of distinct schools of family therapy had emerged. These included those that were influenced by cybernetics, systems theory and the work of Bateson, such as Salvador Minuchin's 'Structural Family therapy'. Minuchin developed his approach when working with 'troubled youths' in the US (Minuchin 1972). He realised that many of the problems that the children were experiencing were not within-child but came from within the family unit. Therefore, in order to support the child, the therapist must help to change the dynamics of the family unit. Minuchin focussed on family structures and hierarchy, the sub-systems within the family and family boundaries. Structural family therapy would involve the therapist as an active member of the treatment group, who would get involved in the dynamics to promote change (Colapinto, 2019).

Other schools included intergenerational approaches, such as the work by Bowen, which focused on intergenerational transmission of disorders, and psychodynamic approaches which focus on the unconscious in the context of current relationships. Therapy in this area was influenced by Bowlby's work on attachment. MFGT emerged at this point as an alternative form of intervention, one that differed from others in the field in that it took some of the blame away from the family. Instead, families learned directly and indirectly from others without the need for their problems to be explicitly explored, thus avoiding conflict and blame (Fadul, 2014).

In the 1970s and 80s, there became less of a distinction between the different schools of family therapy and, in general, practitioners tended to favour a more eclectic approach (Nichols & Schwartz, 2012). Although there were still practitioners that preferred to stick rigidly to the theoretical position of certain schools, other therapists were more willing to work in clinical partnership with other agencies (Fadul, 2014).

From the 1980s to the present day, there is a growing movement towards a single, more general family therapy that incorporates the collective knowledge of the field and can be generalised to many contexts (Fadul, 2014). Theory and practice from family therapy have been particularly influential in the field of psychotherapy. Cook, Biyanova, Elhai, Schnurr

and Coyne (2010) surveyed 2200 psychotherapists in the US and found that the second most common theoretical orientation, after cognitive behavioural therapy (CBT), was a family systems approach.

2.3 Family Therapy Evidence Base

The efficacy of family therapy has been investigated in a number of studies. Shpigel, Diamond and Diamond (2012), researched the use of attachment-based family therapy (ABFT) with depressive and suicidal adolescents in the US. A total of 18 families (mother and child) received 12 weeks of attachment-based family therapy. Self-report questionnaires were administered, and videotape therapy sessions were coded. They concluded that ABFT led to increases in maternal autonomy, decreases in anxiety and a reduction in depressive symptoms. The study did not use a control group; therefore, it is difficult to conclude that ABFT was associated with the positive change, or whether any form of therapy may have elicited similar results.

Diamond et al. (2010) conducted similar research into ABFT as a treatment for suicidal adolescents. This study included a control group receiving enhanced usual care in the form of a facilitated referral to other providers. They found that patients who received ABFT showed significantly greater rates of change in self-reported suicidal ideation, compared with the control group. More ABFT patients met criteria for clinical recovery, compared with the control group. However, there was a low retention rate in the control group, meaning that the treatment dose was different in the two groups. The difference in outcome could therefore have been a result of treatment dose, rather than treatment type.

Robbins et al. (2011) used randomised control trials to compare brief strategic family therapy (BSFT) as a treatment for substance misuse in adolescents with 'treatment as usual', which was a community-based outpatient drugs programme in the US. While they found no difference in the self-reported drug use between the two groups, BSFT was found to be more effective in engaging and retaining family members in treatment and improving family functioning, as reported by the parents. A limitation of the research was that it relied upon self-reported drug use. Many of the participants were being monitored by the justice system at the time and may not have felt able to report their drug use honestly.

Rigter et al. (2013) used randomised control trials to compare multi-dimensional family therapy (MDFT) with individual psychotherapy (IP) as a treatment for cannabis dependency in adolescents. The research took place across Belgium, Germany, Switzerland, France and the Netherlands. Positive outcomes were found in both groups. There was a higher retention rate and a greater reduction in the number of cannabis consumption days in the MDFT group compared with the IP group. This research had a large sample size of nearly 500 participants across five countries, increasing its generalisability.

Farrington and Welsh (2003) conducted a meta-analysis on family-based interventions for preventing delinquency. They found that family-based interventions, including family therapy, had desirable effects in reducing delinquency and antisocial child behaviour. They concluded that the prevalence of offending could be reduced by 10-15% as a result of such interventions.

Research looking specifically at the use of family therapy with children and adolescents with Attention Deficit Hyperactivity Disorder (ADHD) did not show family therapy to have any advantage over 'treatment as usual' (Bjornstad and Montgomery, 2005), suggesting that family therapy is a not suitable treatment for ADHD.

Overall, these studies show that family therapy has positive outcomes when used with adolescents for a variety of mental health disorders, such as depression, substance misuse and delinquency. It appears to be less successful when used as a treatment for ADHD in children and adolescents. There appears to be a gap in the literature around the use of family therapy with pre-adolescents. Korner and Brown (1990) found that only 31% of family therapists reported involving children in more than 25% of their practice, which could explain why little research has been done in this area.

2.4 What is Multi-Family Group Therapy?

MFGT involves working with a collection of families in a group setting. Asen and Scholz (2010) define MFGT as: "therapeutic work carried out with a group of families and their individual members, all experiencing similar difficulties, in a setting that permits mutual sharing, understanding and transparency" pp.1. Within the group setting, children and parents engage in various tasks, collaboratively setting targets and reviewing progress on a

weekly basis, and where they are “required to examine not only their own, but also the interactions and communications of other families and their individual members – which often mirror their own difficulties” (Morris et al. 2014, p.618). MFGT allows for a person to be exposed to multiple perspectives, something that would not happen in individual therapy, and is associated with change (Morris et al, 2014). MFGT, as a method of treatment, has since been used by many different professionals to treat mental health concerns in a variety of settings. Because of this wide use, the term MFGT has been used to refer to any treatment intervention that involves groups containing multiple families.

Treating multiple families together began more than five decades ago with the work of Laqueur and his co-workers in New York (Laqueur, LaBurt & Morong, 1964). Families of patients with schizophrenia were invited into the hospital in which their relative was being treated and were put together in groups. Laqueur found that families learnt directly and indirectly from each other and that the therapists themselves felt less inhibited, compared to working with just one family. Lacquer’s early work inspired many clinicians and MFGT has been used as a treatment for many psychiatric conditions (Asen and Scholz, 2010).

2.5 The Marlborough Model of MFGT

The Marlborough Model of MFGT emerged from the Marlborough Hospital in London in 1970’s. Within the hospital, psychiatrist Alan Cooklin and his team developed the ‘Family Day Unit’ as part of their work in the Marlborough Family Service (MFS). The day unit was created in response to a need for a specialised service for multi-problem and multi-agency families who were deemed to be ‘impossible to help’ (Asen, Stein, Stevens, McHugh, Greenwood and Cooklin, 1982). The MFS had a multidisciplinary team so that agencies could work collaboratively to support the families, taking a more systemic approach (Asen and Scholz, 2010). One of the key interventions for these families was MFGT (Asen, 2002). In the early days the Marlborough Model saw up to 10 families attending MFGT for 5 days a week for 8 hours a day, often for a period of many months.

Asen and Scholz (2010) describe some of the principles of the Marlborough Model of MFGT. One principle is the removal of the demarcations that separate those who receive help and those who give help, which are common in individual and traditional family

therapy. Instead, MFGT encourages families to take on a therapeutic role and offer support to other families, while the therapist moves away from the central expert role (Asen and Scholz, 2010). Within MFGT, the therapist's role tends to evolve over time, changing from being 'hands-on' at the beginning to taking more of a 'back seat' when the group has become established and families feel safe to take on a therapeutic role (Asen 2006). A further principle is encouraging the sharing of problems or difficulties. Sharing experiences can help to reduce stigma and social isolation. When families realise that others are experiencing the same challenges as them, they become less defensive which can lead to greater openness and capacity to change (Asen and Scholz, 2010). The sharing of experiences enables the voices of group members to be heard. This can also help children to develop their voices and to feel as though they have more control within the family context (Asen, Dawson and McHugh, 2001). A third principle is the encouragement of families to voice their opinions on the strengths and weaknesses of other family's management of specific issues. These criticisms are often received better when they made by other families, compared with if they had come from the therapist (Asen 2002).

The model has been adapted to suit different client groups and different contexts, such as: a treatment for depression (Lemmens et al. 2009); substance misuse (Kaufman & Kaufman, 1979) and eating disorders (Salaminiou, Campbell, Simic, Kuipers & Eisler, 2017). The Marlborough model has also been proved to be a useful approach for the treatment and management of CYP in a school context (Asen & Scholz, 2010) and has been championed in various government documents, for example Every Child Matters (2003):

"The Marlborough Family Service runs a programme to tackle barriers to learning by focusing on repeating cycles of disruptive behaviour. Each child has measurable behavioural targets on areas such as anger and stress management, which are rated every day by parents, class teachers and pupils themselves."

(DfES, 2003).

It is also used in Aiming High for Children: Supporting Families:

"The Marlborough Family Service (MFS) is an organisation run by the NHS, which offers a range of outpatient services for children, adolescents, adults, couples and

families with personal or behavioural problems. The MFS makes intensive use of multi-family groups, in which six to nine families work together to find solutions to their problems. The process of family-to-family consultancy, under the guidance and supervision of professionals offers a powerful alternative to the downward spiral of social exclusion. It helps to develop a small community and breaks the isolation which many families with problems experience.

Furthermore, this approach is cost-efficient as one professional can 'treat' several families at a time. Multi-family groups are appropriate to tackle a wide variety of issues and can be used alongside individual support sessions for family members or other types of approaches."

(HM Treasury, 2007)

MFGT is increasingly offered in educational settings outside of the MFS and is based upon an adapted version of the Marlborough Model. This adaptation was created by the Marlborough Family Service to intervene with 'problem pupils' by involving pupils, their families and the school system. This first took place within the MFS own 'Family School' which was an educational provision with the MFS and then later adapted to be used within mainstream schools (Asen & Scholz, 2010). This later adaptation for use in mainstream schools is the model used in the current research. One of the main adaptations made to the model when it is used within the school system is the use of targets. This enabled MFT to become an educational intervention as well as a therapeutic one (Asen & Scholz, 2010).

The targets are:

"clearly defined behavioural targets, both for school and the home setting, and are rated on a daily basis (weekly when used in mainstream school) by teachers and parents." pp. 111, Asen and Scholz (2010).

It could be argued that this adaptation, focusing on both educational and therapeutic outcomes, could lead to contradictory aims. Dreher and Sandler (1996) write that conflicting aims, or differing agendas can undermine the therapeutic process. It may be the school's agenda is to change a pupil's behaviour. This could lead to greater focus being put upon the behaviour-based targets, rather than the therapeutic process. However, based upon current literature (see chapter 2.9) positive outcomes have been found across many areas,

other than behaviour, suggesting that this conflict of aims may not impact upon the therapeutic process.

The Anna Freud National Centre for Children and Families offers training to educational and clinical psychologists in order for them to be able to facilitate the Marlborough model of MFGT in schools. This training was attended by the EP facilitators in the current research. The centre's website describes the MFGT model as an intervention to give psychological and therapeutic help to children who are at risk of exclusion by working with them and their families in a non-stigmatising environment. Some of the aims of the model include: addressing behaviour; developing social and emotional skills; strengthening parent-child and parent-school relationships; exchanging skills and knowledge; developing mini-communities capable of sustaining improvement; improving achievement and attendance; and improving parenting competencies.

Currently, MFGT is offered to schools in a handful of London boroughs and is most often facilitated by a Clinical Psychologist following the Marlborough model of MFGT. The current study follows the Marlborough model of MFGT with facilitators having completed their training at the Anna Freud Centre.

2.6 Theoretical Underpinning of Multi-Family Group Therapy

There are a variety of theoretical perspectives that acknowledge the role of family in personal dysfunction and problem-solving. Asen (2002) writes that MFGT has been based upon "a peculiar blend of group therapy and family therapy, psychodynamic practices and attachment theory" (p. 4). Saayman, Saayman and Wiens (2006) describe MFGT as having "roots in psychodynamic and systems theory" (p. 406). The three main influences that appear to underpin MFGT are influences from family therapy, attachment theory and systems theory.

2.6.1 Influences from Family Therapy

MFGT evolved from traditional family therapy, therefore much of the theory and research can be applied to MFGT. Some of the most relevant ideas are now discussed. Laqueur's model of MFGT incorporated Bateson's idea of 'double description' (Bateson, 1973).

Bateson used the idea of binocular vision to explain his theory of 'double description', in that each eye sees a different image and that these images come together to provide new information, such as the distance of an object. Each family within an MFG provides a viewpoint and when these different viewpoints come together, they can create new understanding and new approaches to thinking. Bringing viewpoints together was also deemed important for communication and solving interactional problems (Bateson, 1973).

Anderson (1983), an American therapist, also saw the importance of communication in family therapy and used this as a basis for her model of MFGT. She believed that dialogue and communication between group members aid their understanding and improve the patterns of functional communication.

Sullivan (1938) also saw the importance of communication and interaction and theorised that interpersonal relationships influence personality development. A person's perception of themselves is shaped by the personal interactions that they have with those they are close to, such as their family members. Therefore, involving the family in therapy could help to improve interactions.

From a psychodynamic family therapy perspective, intrapsychic (occurring within the mind) and interpersonal (between people) conflicts are believed to begin with, and be maintained by, relationships within a family. Change occurs when 'unacknowledged expectations' of each other are explored (Goldenberg & Goldenberg, 2000).

Most of the influences from family therapy centre around interaction and communication between family members and that change occurs when these interactions are investigated and improved.

2.6.2: Attachment Theory

Attachment theory is an approach to development which was originally proposed by John Bowlby (1969; 1980). Bowlby theorised that all people have an innate need to bond with a caregiver from an early age. This bond is important for survival. The function of attachment is to provide security when the environment is frightening. Learning to feel secure and protected serves to promote independence and autonomy in later life. Others have described the purpose of attachment as the process by which a child learns to regulate

their emotional arousal. A parent responding appropriately to their infant's emotional arousal will help to stabilise the infant's emotional state (Fonagy, Target & Gergely, 2000).

All children develop attachments to their caregivers, but the quality of these attachments may differ, depending on circumstances. These relationships provide a set of expectations about how to interpret other people and how to respond to them. They are key to the development of relationships outside of the caregiver-child relationship.

Bowlby suggests that the way in which a caregiver responds to a child is important, as it can create a set of expectations of what the child is to anticipate from others. Supportive and reliable parenting creates a 'secure base' for the child, providing feelings of security at difficult times. This will lead to the development and internalisation of the expectation that others are supportive and can be relied upon. The absence of supportive and reliable parenting could lead to the development and internalisation of the expectation that others cannot be relied upon for support. It is proposed that these internalisations are stable cognitive structures that continue to hold influence across a person's life.

Ainsworth (1969; 1985) developed experimental procedures to observe attachment behaviours in small children. This enabled behaviours to be categorised and attachment 'types' were developed. Ainsworth (1969; 1985) proposed three attachment types: secure; anxious resistant; and anxious avoidant. A fourth, disorganised attachment, was added more recently (Crittenden, 1988).

There are many positive developmental outcomes that have been linked to secure attachment, such as; improved emotional regulation, higher academic attainment, and better social skills (Bretherton, 1985; Richters & Waters, 1991). In contrast, Carlson & Sroufe (1993) write that insecure attachment has been linked to poor emotional regulation, behavioural problems and lower social skills. Disorganised attachment has been found to have a relationship with psychopathology in later life (Lyons-Ruth & Jacobvitz, 1999).

Byng-Hall (1995, 1998) wrote of the application of attachment theory in family therapy. He highlighted the importance of the family as a secure base and how therapy could repair it when it was damaged. Kobak and Sreery (1988) argue that family therapy can support the

fostering of trustworthy, healthy, reliable, and emotionally sensitive parent–child relationships. Shpigel, Diamond, and Diamond (2012) found that family therapy improved adolescents' attachments to their parents.

MFGT has its roots in family therapy, and both have been greatly influenced by attachment theory (Lui et al, 2015). Research has found that MFGT can aid family cohesion and motivation to change and can strengthen the attachment between family members (Dickerson & Crase, 2005).

2.6.3: Systems Theory

Systems theories acknowledge the interactions between different systems, such as the individual and their family. Bronfenbrenner's ecological systems theory (1979) proposed that children constantly change, grow and engage within multiple systems, and are active participants in their development as a result of a reciprocal interaction between individual characteristics and their environments, which consist of the following interacting systems:

- The 'Microsystem', comprises the child's immediate environments. It refers to the environments that the child actually experiences. Swick and Williams (2006) write that the family is the child's earliest microsystem for learning how to live. Caring relationships within the microsystem can help to build a healthy personality.
- The 'Mesosystem', comprises of connections between immediate environments (for example, the relationships that those involved directly with the child have, such as the way that their school communicates with their parents). Mesosystems with particular characteristics can promote positive development. These characteristics include: rich, positive, and diverse connections between the microsystems; and the sharing and promotion of common values and goals (Garbarino, 1982). Within a school, an example of this might be when parents have multiple, positive and reciprocal interactions with the school staff, such as the teacher, and that all involved share a common goal, for instance promoting the child's academic growth (Bouchard & Smith, 2016).
- The 'Exosystem', comprises of external environmental settings which affect the child indirectly for example, school management or local authority policy.

- The 'Macrosystem', refers to the wider cultural context in which a child lives, and includes beliefs and cultural values, such as what comprises a 'good' education.

Szapocznik and Prado (2007) acknowledged these reciprocal reactions and their impact upon therapeutic interventions. They write of the importance of involving different systems in an intervention in order to have long term success. They explain that when an individual is changed by an intervention, their family may not receive any support to adapt to this change and the family could be negatively affected. The family may attempt to achieve a state of homeostasis which could undo the changes that were achieved by the intervention.

Bronfenbrenner and Neville (1994) highlighted the importance of creating strong links between the systems in order for effective child-rearing. They wrote:

"Effective child-rearing processes in the family and in other settings requires establishing ongoing patterns of exchange of information, two-way communication, mutual accommodation, and mutual trust between the principal settings in which children and their families live." Bronfenbrenner and Neville (1994) p.17

MFGT is a way of building trust and communication between home and school, as both systems are brought together on a weekly basis.

Bronfenbrenner (1995) further developed his theory and renamed it 'bioecological theory'. The updated model acknowledged the relevance of biological and genetic aspects of a person. The 'chronosystem' was also added to the model in order to acknowledge the influence of process, person, context and time factors (PPCT) on individual development.

Process – reciprocal interactions between individuals and environment. Person – acknowledging the personal characteristics that an individual brings to a social situation. Context – acknowledging that people operate in multiple microsystems and that these systems can influence each other and that events in an exosystem can have an impact on the microsystem. Time – this is broken down into micro-time (occurring during a specific activity), meso-time (consistency of the activities, for example are they daily?) and macro-time (time in history, for instance if a child is born to a single parent they may view their family situation very differently than if they were born 60 years ago, due to social changes).

Bronfenbrenner's theories are relevant to MFGT, as the groups will include three interacting systems: the child; their family; and the school. It is also important to acknowledge the personal characteristics that are being brought to the group, the interactions between the individual and the group environment, as well as the influence of micro-, meso- and macro-time.

2.7 Use of Multi Family Group Therapy in a Clinical and Social Care

Context

Much of the research into MFGT has taken place in a clinical setting, with the aim of improving the outcomes for patients with mental health disorders. For example, Salamiou et al. (2017) researched MFGT undertaken with families of adolescents with a clinical diagnosis of Anorexia Nervosa in two London hospitals and found that after six months, two-thirds of the participants had gained enough weight to be considered in the 'normal' weight range. There were also significant improvements in self-esteem and mood. It is important to note that this intervention involved four consecutive days of treatment, followed by between five and seven whole-day follow-ups, as well as individual therapy if deemed necessary. These positive outcomes may, at least in part, be due to intense involvement of professionals, rather than being part of the MFGT itself.

Dickerson and Crase (2005) researched the use of MFGT with adolescents in a residential substance abuse clinic in the US. They found that parent and adolescents reported improved communication and increased closeness.

Similar findings were made by Voriadaki, Simic, Espie and Eisler (2015) who conducted research in a London hospital with adolescents diagnosed with anorexia. Based on daily journals and rating scales, they found that patients' insight into their illness increased, four out of five patients reported enhanced motivation for recovery, and 7 out of 10 parents reported improved self-efficacy. Again, the MFG involved an intensive 4-day block of multi-family intervention, rather than short weekly sessions and the participants were aged 15-16 years old. Also, the research consisted of six families who were all members of the same MFG. This makes the findings difficult to generalise, as the themes may have been unique to the interactions between this particular group of families and the facilitators.

A much larger study was conducted in California by Marzola et al. (2015). 74 adolescents with eating disorders underwent MFGT and it was found that 87% of participants achieved either full or partial remission. 87% of participants also reported MFGT to be helpful, compared with 60% of participants that had received individual family therapy. However, a number of participants didn't take part in the follow-up assessment as they were unable to be contacted, and this missing data could have influenced the overall results.

Gopalam et al. (2015) measured outcomes of clinic-referred US children with disruptive behaviour who had taken part in MFGT. Using various parent-report measures (IOWA Connors Rating Scale, Social Skills Rating System, and Impairment Rating Scale) they found that at a 6-month follow-up, parents reported significant improvements in the children's behaviour, peer-relationships and the impact of the child's difficulties on their family. There are similarities between Gopalam et al.'s research and the current study, in that they used children of primary school age, and that the intervention took place on a weekly basis.

Fristad, Goldberg-Arnold and Gavazzi (2003) found positive outcomes when researching the use of MFGT with families of children diagnosed with a mood disorder in the US. After six-months, participants reported that their knowledge around mood disorders had increased, there were increases in positive family interactions, families felt more confident to use services, and children felt more supported by their parents. However, these conclusions are based upon self-reports from one family member, therefore may not fully reflect the true outcomes of being part of a MFG.

Not all research has demonstrated the efficacy of MFGT, however. Contradictory evidence has been reported by Colahan and Robinson (2002) who ran a MFG for adolescents with eating disorders in a London hospital. They found that only two out of the four families reported improvements and that one family actually reported their situation to have declined. However, it is difficult to make generalisations due to the very small sample size in this study.

Together, these findings suggest that MFGT may be effective in a clinical environment. However, as the current study is looking at MFGT as a method of early intervention, the

participants do not have difficulties that would meet the clinical threshold for diagnosis or treatment, therefore the findings from a clinical population might not be applicable to the current study's sample. Gaps in the literature suggest that further research should focus on the qualitative experiences of MFGT participants and to investigate the processes involved in MFGT.

2.8 Use of Multi Family Group Therapy in a Criminal Justice Context

There has been a body of research that has looked at the effectiveness of the use of MFGT to support people who have engaged in offending behaviours. Caldwell, Horne, Davidson and Quinn (2007) ran MFGT with the families of juvenile offenders and found that involvement in the group reduced parental stress and improved communications between the young people and their parents. The MFGT sessions ran on a weekly basis for 10 weeks which, of all of the research already reported, is the most similar model to the model being followed in this research.

Keiley, Zaremba-Morgan, Datubo-Brown, Pyle and Cox (2015) used MFGT with incarcerated sexually offending adolescents and their families and confirmed significant improvements in problem behaviours as a result of MFGT participation, which were maintained at the one-year follow-up and were predicted by significant decreases in maladaptive emotion regulation. In addition, rates of post-release recidivism were extremely low compared to national rates.

Meezan and O'Keefe (1998) studied the 'Family-to-Family' programme (an MFGT program developed in California) which was used as an intervention with 42 families who had been referred by social services due to child maltreatment (abuse and/or neglect, families with a history of sexual abuse weren't eligible). There was also a control group who received individual family therapy. Six to eight families met for two and a half hours a week for 34 weeks. After the intervention, caregivers in the MFGT group reported improvements in parent-child interactions, while the control group reported these interactions to be unchanged. Children in the MFGT condition were reported to have become more assertive, less submissive, and displayed fewer behavioural problems. The control group's scores showed a slight deterioration in these areas. All of the measures used in this research were

self-report measures, therefore could be susceptible to demand characteristics and social desirability.

Together, these findings suggest that MFGT may be effective at improving behaviour and reducing reoffending. Similarly, to the clinical research, the measures of effectiveness are mostly self-report questionnaires with little focus on participants experiences or the processes of change.

2.9 Use of Multi Family Group Therapy in an Educational Context

Although the largest body of research into MFGT has focussed on its use in a clinical context, there is literature that has evaluated its use in non-clinical settings and some that has specifically focused on an educational context. Cook-Darzens, Gelin and Hendrick (2018) reviewed research that looked at the use of MFGT in non-psychiatric conditions. They were able to identify four studies that had evaluated MFGT within an educational context. Only one of those studies, by Morris, Huray, Skagerberg, Gomes and Ninteman (2014) was conducted in the UK. The current researcher has been unable to find any further school-based research from the UK or from further afield. The four studies reviewed by Cook-Darzens, Gelin and Hendrick (2018) are the same studies found by the researcher and are summarised in this section.

Morris et al. (2014) researched whether MFGT being run both in a specialist education centre and in a school led to positive outcomes. MFGT was compared with a control group and they found that the children in the MFG had improved functioning on the Strengths and Difficulties Questionnaire (SDQ) and improved their academic ability. The parents that took part had higher well-being scores compared with the parents in the control group. It is important to note, however, that participants weren't randomly assigned to the control group, therefore it cannot be assumed that the differences between the groups were due to the MFG intervention.

Kratochwill, McDonald, Levin, Bear-Tibbetts and Demaray (2004) used random controlled trials to research the outcomes of Native American children who took part in the Families and School Together (FAST) programme, which has similar principles to MFG's. They found that, one year on from programme graduation, children were less socially withdrawn

and had increased academic competence, compared with the control group. However, 20% of the families didn't complete the programme, therefore their data wasn't included in the one-year follow-up. This missing data may have biased the overall results. Kratochwill, McDonald, Levin, Scalia and Coover (2009) conducted similar research using a larger sample that consisted of families from a diverse range of cultural and ethnic backgrounds. They found that that FAST parents reported statistically significant reductions in children's aggressive behaviours, compared to the control group and that this change was maintained at the one year follow up.

McDonald et al. (2006) randomly assigned Latino parents to either an after-school FAST group (based on the principles of MFGT) or to receive parenting pamphlets. 180 parents were involved in the FAST programme and data from a two-year follow up was collected from 130 parents. They found that there were statistically significant improvements in academic performance and classroom behaviours (reduction in aggression and improvement in social skills) in the FAST group, compared with the control group.

Together, these findings suggest that MFGT may be effective in a school context. However, three of the four studies were conducted in the US, using a different MFGT model, therefore the findings may not be generalisable to population of the current study. As with the clinical and criminal justice system research, the effectiveness was explored using self-report measures. Participant experiences and change processes were not explored. From all of the literature reviewed in this chapter the study by Morris et al. (2014) has the most similarities with the current research, as the intervention took place within a UK primary school context and the outcomes were measured using the SDQ.

2.10 Processes involved in Multi Family Group Therapy

Heatherington, Friedlander and Greenberg (2005) write that therapeutic changes can take place both during a therapy session and outside of it. Changes can also take place within a person as well as among a group. The aims of therapeutic change processes are to contribute towards measurable improvements in a client's condition.

Research has investigated these change processes in order to understand what it is that contributes to the changes in children and families when involved in treatment or intervention. Understanding what brings about positive change can help guide professional leading therapy and interventions to deliver a programme that incorporates the processes/mechanisms.

Some research suggests that it is the therapists or facilitators behaviour that brings about change (Patterson and Forgatch, 1985). Individual cognitions have been reported to influence change (Treadwell and Kendall, 1996) as well as parenting behaviour (Stoolmiller, Duncan, Bank and Patterson, 1993).

Lemmens, Eisler, Heireman, Houdenhove and Sabbe (2005) explored processes involved in MFGT that was offered to patients with chronic fatigue and chronic pain. Content analysis showed that group cohesion, insight and hope, learning through observation, and communality and support were regarded by the patients as the most helpful processes.

Communality was also a factor that Colahan and Robinson (2002) picked out as being important for change. They suggest that the families feel a sense of 'safety in numbers' when receiving therapy with others and that multi-family group approach allows them to explore their issues without feeling judged. They also believed that families were more open to receiving advice from other stricken families than from professionals.

Huey, Henggeler, Brondino and Pickrel (2000) researched the mechanisms involved in multi-systemic therapy (MST). MST is similar to MFGT, in that it involves young people and their families and is based upon the principals of family therapy. The main differences between MST and MFGT are the client group and the intensity of the therapy. MST has solely been developed and used with 'juvenile offenders' and involves more members of a young person's 'whole world' than MFGT. MST aims to make positive changes in a number of different social systems, such as the home, a school, or a peer group. MST is also more intensive than MFGT as the therapists are involved for three to five months and during this time will be on call for families, 24 hours a day. Huey et al. (2000) found that an improvement in family functioning (quality of functioning, cohesion and increased parent

monitoring) led to a decrease in the amount of problem behaviours reported by both home and school.

Hellemans, De Mol, Buysse, Eisler, Demyttenaere, and Lemmens (2011) explored the underlying processes involved in MFGT. They gave patients with depression, and their partners, a questionnaire to explore therapeutic factors. They found that there were eight themes, or factors, reported by the participants (patients and partners) that they felt had an impact upon the intervention. The factors were: guidance from the therapist; cohesion and understanding; presence of others; openness; observational experiences; insights; self-disclosure; and discussion. Lemmens et al. (2009) used questionnaires with patients with depression and their partners, following each MFG session. They found that factors, such as guidance and modelling from the therapist, were related to improvements in depressive symptoms.

McFarlane (1983) used MFGT within a psychiatric hospital and believed the following processes to be important in achieving positive change: resocialisation; stigma reversal; modulated disenmeshment (helping family members to see themselves as individuals); communication normalisation; and crisis management. McFarlane believed that families did not necessarily need to develop 'insight' into their problems, but that they could learn by seeing parts of their dysfunction in other group members, without their issues being explicitly addressed.

Taken together, the literature to date suggests that the key processes or mechanisms of change in MFGTs are: facilitators' behaviour; parenting behaviour; group cohesion; learning through observation; stigma reversal; improved family functioning; self-disclosure and discussions; modelling from therapist; communication resocialisation; and modulated disenmeshment.

2.11 Summary of Current Literature

From reviewing the literature in the area of MFGT, MFGT has been shown to produce positive outcomes, such as weight gain and improved mood in a clinical setting, particularly with adolescents with eating disorders. However, the clinical research in chapter 2.7 relied

on quantitative measures, such as self-report questionnaires, to assess effectiveness and did not explore the reasons or processes underpinning positive outcomes.

Within an educational setting, MFGT has also been shown to produce positive outcomes, such as improved academic ability and improved social skills. However, the research in this area and reviewed in chapter 2.9 relied on quantitative measures (e.g. self-report questionnaires) to assess effectiveness. The existing literature does not explore the experiences of those involved.

Research exploring the processes involved in MFGT to date has mostly been conducted in a clinical environment with adults or adolescents. There are a wide variety of factors that have been attributed to the effectiveness of the intervention, such as group cohesion, improved family functioning, presence of others, resocialisation, among other things. As yet no research has been identified that explores the change processes involved in MFGT within the school context.

The gaps in the existing literature have helped to guide the research questions.

2.12 Research Questions

RQ1: Does being part of primary school based multi-family group therapy lead to positive emotional, social and behavioural outcomes?

RQ2: How does primary school based multi-family group therapy bring about change?

RQ3: What factors contribute to the primary school based multi-family group being successful?

RQ4: What factors act as barriers to primary school based multi-family group being successful?

Chapter 3: Methodology

3.1 Overview

This chapter explains the approach that underpinned the mixed methods research design and describes the methodology, including measures, participants, procedures and ethical considerations.

- The intervention evaluated in this study involved 12 group sessions, delivered weekly by an Educational Psychologist (EP) and School-Based partner (SBP).
- The intervention took place in four different schools, with each school having one group of 7-8 children and their parents.
- The EPs and SBPs running the groups had received training in MFGT.
- The study sample involved 30 children who received the intervention. TME data was collected for all 30 children.
- Pre- and post-SDQ teacher data was collected for 13 children across two different schools.
- Pre- and post-SDQ parent data was collected for 8 children at one school.
- Focus groups with children were run in three of the schools, with a total of 20 children taking part.
- 29 parents were involved in the intervention. Qualitative data was collected from three parents.
- Four SBP were involved in running the intervention. Qualitative data was collected using interviews with two SBPs.
- Three EPs were involved in running the intervention. Qualitative data was collected using a focus group, in which all three EPs participated.

3.2 The Multi Family Group Therapy Intervention

The intervention was run in 4 primary schools in a London Borough. Each MFG consisted of 7-8 families, an Educational Psychologist who had attended a five-day training course run by the Anna Freud National Centre for Children and Families, and a 'School-Based Partner' (SBP) who worked within the pastoral team within the school. The SBPs attended a two-day training course.

The MFG met on a weekly basis, during term time, for 12 sessions. The MFGT followed the Marlborough Model. Each weekly session followed a similar routine and started with

reviewing the Target Monitoring and Evaluation (TME) targets that had been set the previous week, setting new targets and a joint activity or game. Although there was a structure to the sessions, each session was unique, as the parents were invited to plan the games and activities that would happen in the next session. See Appendix 1 for an example of the structure and timings of a typical MFGT session.

3.3 Research paradigm

Guba and Lincoln (1994) define a paradigm as the “basic belief system or worldview that guides the investigation, not only in choices of method but in ontologically and epistemologically fundamental ways” (p. 105). Morgan (2007) similarly describes research paradigms as “the set of beliefs and practices that guide a field”.

A mixed methods design was used in this study. The reason for this was to enable rich data to be collected on the same or similar issue (Creswell and Plano Clark, 2011). A pragmatic position is viewed as being the most appropriate for this approach (Creswell, 2003). As noted by Robson (2011), pragmatism assumes a moderate and common-sense style in which research methods are chosen based on how well they address the research questions. Robson (2011) went on to describe pragmatism as being a ‘middle ground’ between subjectivity and objectivity, which recognises that knowledge is both constructed and also based on real experiences of the world. This approach can also be seen as a taking a ‘middle ground’ between positivists and social constructivists as it values the importance of subjective interpretation in the construction of experience, while at the same time acknowledges an acceptance of an external reality of shared perspectives.

Pragmatism fits well with the practice of the EP. Burnham (2013) interviewed EP’s regarding epistemological and ontological positions and found that “although participants did not reference a clear epistemological framework when describing their own practice, it can be argued that the views they expressed are characteristic of the philosophical position of pragmatism” (p. 28). In relation to the current study for example, in order for an outcome to be considered positive it would be assumed that some ‘real’ change has happened and that that change is not entirely a construction on the part of the recipient.

3.4 Researcher's Position and Reflexivity

Reflexivity is important in qualitative research. Being reflexive enables a researcher to consider the ways in which they may influence the research or the ways in which the research may influence them (King & Horrocks, 2010).

A key part of the role of an EP and trainee EP is bringing about positive change for children and young people by listening to their views and their parents' views and ensuring provision meets their needs. One way of ensuring that provision will meet the needs of children is by selecting practices and interventions that have an evidence base. Therefore, the researcher approached the research with the aim of evaluating an intervention that is already in use in schools, adding to its evidence base and exploring the experiences of those who have participated in MFGT. The researcher's role within the current study was to collate data that had already been collected by the schools and the EP facilitators (TME data and SDQ data) and to collect data from MFGT participants (children, parents, EPs and SBPs) through interviews and focus groups. The researcher was not involved with the planning, running or facilitation of MFGT. Although the researcher did not have any direct experience of running MFGT, either personally or professionally, they had read through the literature in the field and were aware of its success within the clinical field. This knowledge may have influenced the researcher's expectations of the research and could have had an impact upon various aspects of the process, for example the questions in the interview schedule or the responses to the participants.

The researcher was able to observe two MFGT sessions in order to gain a better understanding of the way in which the groups were run. This experience may have influenced the researcher's perceptions regarding recruiting participants for interviews e.g. the group members were friendly and welcoming, therefore it was assumed that recruitment would not be too difficult.

The researcher had no prior relationship with any of the schools that participated in the research and was therefore unaware of the distinct context that each school had and how that would impact upon data collection. Although this lack of knowledge meant that the

researcher had no preconceived ideas about the schools, their prior experiences with other schools may have influenced their expectations.

3.5 Design

This research is of a mixed methods design, which incorporates data using both quantitative and qualitative methods. Mixed methods research could be described as being the 'third research paradigm' as it sits in between quantitative and qualitative methods.

Johnson and Onwuegbuzie (2004) defined it as:

"The class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts or language into a single study" (p.120).

Johnson and Christensen (2004) write that mixed method designs combine the strengths of both quantitative and qualitative research processes, and Weber (1949) advocated the importance of both "rational or objective" (as in quantitative research) and "empathic or subjective" (as in qualitative research) dimensions for understanding human phenomena.

Further strengths of the qualitative aspect of mixed methods were noted by Willig (2001) who stated that "qualitative research allows the researcher to tap into the perspectives and interpretations of participants" (p.150).

Greene, Kreider and Mayer (2005) write that: "the early roots of mixed-method social inquiry are found partly in the construct of triangulation, which involves the use of multiple methods — each representing a different perspective or lens - to assess a given phenomenon in order to enhance confidence in the validity of the findings" (p. 274). They also argue that mixed methods research helps to develop a more complete portrait of our social world as data is collected from multiple perspectives. Finally, the use of different methods can allow for different stances or positions to be explored.

Greene, Caracelli and Graham (1989) reviewed 57 mixed method studies and found five potential purposes and advantages of using mixed methods: (1) Initiation, which enables the discovery of new perspectives through contractions; (2) Triangulation, which helps to assure validity as the same findings may be seen across methods; (3) Complementarity,

which allows for elaboration, enrichment, illustration and clarification of results.; (4) Development, which involves using the data and results from one method to inform the design of another method; and (5) Expansion, to increase the scope and/or breadth of the research. The current research uses mixed methods for each of these purposes, as identified by Greene et al. (1989). Firstly, Triangulation – this is particularly relevant to RQ1 as data relating to positive outcomes will be collected using quantitative SDQ and TME data as well as qualitative data from focus groups and interviews. Secondly, Complementarity to measure overlapping but also different aspects of phenomenon, for example what changes have come about, but also how change has come about. This differs from Triangulation as the different methods aren't necessarily measuring the same conceptual phenomenon. Thirdly, Development – the findings from the quantitative aspect of the research will inform the questions that are posed to the focus group and in the interviews. Fourthly, Initiation – the majority of research in the field has not sought the voices of the group members, therefore fresh perspectives will emerge. Finally, Expansion, which enables the exploration of the processes involved in MFGT.

The study used research methods that most effectively answered each of the RQs:

- RQ1: Does being part of a primary school based multi-family group therapy lead to positive emotional, social and behavioural outcomes?

RQ1 was explored both quantitatively and qualitatively. Quantitative data was collected before the intervention began, using both TME and SDQ. TME data was collected on a weekly basis and an overall rating of progress towards the targets was given when the intervention had finished. SDQ data was collected from parents and teachers before the first MFGT and again after the intervention had finished. Questions relating to positive outcomes were asked during the focus groups and interviews.

- RQ2: How does primary school based multi-family group therapy bring about change?
- RQ3: What factors contribute to the primary school based multi-family group being successful?

- RQ4: What factors act as barriers to the primary school based multi-family group being successful?

RQ2, RQ3 and RQ4 were explored qualitatively to gather information about why the intervention was having the impact shown. A semi-structured technique was adopted in both focus groups and interviews, as it allowed for RQ2-4 to be addressed without inhibiting the participants from sharing additional information and ideas about their experiences.

3.6 Research design constraints

The data from the SDQ and TME was collected by the SBPs with the support of the EP.

This data was then shared with the researcher, with the consent of the parents involved in the intervention.

Obtaining the data from the SBP proved to be difficult, as the SBP who held the data was not always easy to reach. In one particular school, contact with the SBP had not been possible, therefore SDQ data was not able to be obtained. In another school, there had been difficulties obtaining post-intervention data, therefore no pre- and post-intervention comparison could be made. It may have been beneficial for the researcher to administer the pre- and post-SDQs to ensure that a full data set was collected.

Further constraints came from recruiting parent participants to take part in the focus groups. Focus groups were planned at three of the four schools. The first group to run only saw two parents participate. It is unknown as to why the other parents did not attend the focus group, as they had indicated to the SBP that they were available. Focus groups in the other two schools were rescheduled a total of seven times, due to parents becoming unavailable at short notice. The number of parents confirming availability at these two schools decreased after each rescheduling. It was decided to offer interviews as an alternative, so that all parents did not have to be available at the same time. Only one parent consented to an interview. All focus groups and interviews with parents were arranged via the SBP. It may have been beneficial for the researcher to have been in direct contact with the participants in order to schedule focus groups and interviews.

3.7 Measures

3.7.1 Target Monitoring and Evaluation (TME)

Target Monitoring and Evaluation (TME) was inspired by Goal Attainment Scaling (GAS), which was devised by Kiresuk and Sherman (1968) as a method of evaluating the outcomes of mental health interventions. A review of GAS found that most users of GAS reported difficulties with the criteria, for example they were time consuming and there was a difficulty with defining the levels for each target, so it was modified (Cytrynbaum, Ginath, Birdwell, and Brandt 1979).

Dunsmuir, Brown, Iyadurai and Monsen (2009) modified GAS, in order to iron out some of the difficulties reported by the users of the GAS. The new evaluation system, TME, involves setting clearer baselines and requires specific and measurable outcomes to be clearly defined so that the progress of the individual, the group or the agency is easily reflected.

The TME scale provides interval-level measurement (Dunsmuir, Brown, Iyadurai and Monsen, 2009). When the target is set, it is given a baseline score (on a scale of 1 to 10) and then the expected progress and time frame is agreed upon. When the target is reviewed, the progress is scored against the baseline. When analysing the TME data for the current research, the change in score from baseline to the end of intervention was recorded. For example, a target might be set to support a child who finds it difficult to not call out in class. On a TME scale, 1 may represent 'Child A never puts their hand up to answer a question' and 10 may represent 'Child A puts their hand up every time they want to answer a question'. When taking a baseline measure, Child A may be rated as a 3. At the end of the intervention, they may have achieved a 7. This would be recorded as a 4-point increase towards their target (see Appendix 2 for an example).

The use of TME could be considered to be reductionist, as it focuses only on measurable outcomes (Turner, Randall and Mohammed, 2010). Although this offers an important insight into the impact of MFGT, it is only a small part. This is why further measures have been used, in order to explore MFGT impact.

3.7.2 Strengths and Difficulties Questionnaire (SDQ)

The Strengths and Difficulties Questionnaire (Goodman, 1997) is a 25-item questionnaire used to assess five different areas of a child's behaviour (see Appendix 3). The five areas are: conduct problems; emotional symptoms; hyperactivity and inattention; peer relationship problems; and prosocial behaviour. A 'total difficulties' score is generated by combining all of the scores, except for prosocial behaviour. The prosocial score is not included in the total difficulties score as this measures positive social behaviours, such as being kind to others and sharing.

Each of the 25 items on the questionnaire are in the form of a statement about the child, for example 'generally liked by other children' and 'steals from home, school or elsewhere'. The person completing the questionnaire is asked to use a three-point scale to rate the truth of the statement, in relation to the child they are filling it out about. The response options are: 'Not True'; 'Somewhat True'; and 'Certainly True'.

The original SDQ was aimed for use with children aged between 4-16 years old but has now been adapted and is suitable for children from the age of three. Goodman (1997) demonstrated that the SDQ demonstrates both concurrent and predictive validity and describes the SDQ as "a useful brief measure of the adjustment and psychopathology of children and adolescents" (p.1). The SDQ has been shown to correlate highly with the Child Behaviour Checklist (CBCL) which has been evidenced as having good validity and reliability (Goodman, 1999).

Becker et al. (2015) conducted a 6-year longitudinal analysis of the SDQ and found that there was a high test-retest validity, with the children's and adolescent's scores remaining relatively consistent over a 6-year period.

In the present study, SDQ's were completed by parents and teachers before the MFG intervention began and then again after the 12 sessions. Teachers were chosen to complete the questionnaire as they have a good knowledge of each child in an education context, whilst parents were chosen because of their knowledge of the home context. Teachers were not part of MFGT and did not attend any of the sessions. The parent that completed the SDQ was the parent that attended MFGT.

There is a self-report version of the SDQ, which is suitable for children aged 11-16, therefore it was not deemed appropriate for use with the participants as the majority of the child participants were under the age of 11 at the date that the pre-intervention data was collected.

3.7.3 Focus Groups

Focus groups are open-ended group discussions, guided by a researcher. These groups enable rich data about the beliefs and experiences of the participants to be generated. (Robson, 2011). Focus groups provide a non-threatening space in which feelings, perceptions and attitudes can be explored through the interactions of participants. (Morgan, 1998). Morgan (1998) identified three main strengths of focus groups: context and depth; interpretation; and exploration and discovery.

Research suggests that, due to the interpersonal and interactive nature of focus groups, information that may not be obtained from individual interviews can be produced (Kidd & Parshall, 2000; Greenbaum, (2003).

Guest, Namey, Taylor, Eley and McKenna (2017) systematically compared focus groups and interviews and found that personal and sensitive disclosures occurred more frequently in focus groups and that some sensitive themes were unique to the focus group setting. However, they did note that interviews were more effective at generating a broader range of topics and themes.

Meeting the members of each MFG together would provide a good insight into the dynamics of each group and the relationships that may have formed over the 12 sessions. Meeting participants in groups would also be an efficient way of gaining the voice of all those involved with the MFG process.

As the focus groups for children involved young people as participants it was important for facilitation methods to take into consideration the age of participants as well as cognitive level and interests (Kirby, 2001).

A limitation of running focus groups, rather than doing individual interviews, is that some participants may not feel confident to share their views in the presence of others. (Krueger,

1994). However, the focus group took place after the MFG had been together for 12 sessions, therefore the participants were familiar with each other and it was hoped that they would feel more relaxed as they were in the company of people they are used to being in a group with. Also, the MFGs have ground rules that are enforced by the EP facilitator, one of which is linked to respecting other's opinions and treating each other equally. These rules enabled participants to feel safe voicing their opinions to the group.

In order to include everyone in the children's groups and to capture each voice, brainstorming activities took place (see Appendix 16). The children were each given an activity which involved them having to draw themselves or write about their life before the intervention and then again after the intervention. The aim of this was to elicit changes that may have happened since attending MFGT. These were then discussed as a group and additional questions were asked based on the interview schedule (Appendix 14).

The initial aim was to run four focus groups, one at each of the four schools in order to capture the voice of as many children as possible. However, it was only possible to run focus groups in three of the schools. Research suggests that data collected from three focus groups would gather a sufficient amount of data. Guest, Namey and McKenna (2017) ran 40 focus groups on the same topic and found that more than 80% of all themes were discoverable within two to three focus groups, and 90% were discoverable within three to six focus groups. They concluded that three focus groups were enough to identify all of the most prevalent themes within a data set.

3.7.4 Semi-Structured Interviews

Lofland & Lofland (1995) give a definition of research interviews as a "guided conversation whose goal is to elicit from the interviewees rich, detailed material which can be used in data analysis." (p.18).

Semi-structured interviews were chosen as a method of data collection as they allow the interviewee to talk readily about a topic, the interviewer can ask for clarification on points made by the interviewee and themes can be probed further (Howitt & Cramer, 2007).

Cohen, Manion and Morrison (2007) note that semi-structured interviews allow for a fluid and dynamic guided conversation that allows further exploration of topics of interest.

In comparison to structured interviews, which are much more prescriptive in nature, semi-structured interviews fit well with research into MFG as they allow for the researcher to ask open questions, respond, and be led by the answers of the interviewees while remaining exploratory.

All of the interviews and focus groups were conducted by one interviewer so that the approach was consistent.

The semi-structured interview questions also helped the discussion centre upon the research questions (Brinkmann, 2014) and were developed after the focus groups. Themes that come up during the focus groups were explored in more depth during the individual interviews.

Interview questions were written from a pragmatic research perspective in order to gather responses which would be likely to address the research questions. It was important for these questions to remain open to allow for a range of responses. The interview schedules included optional prompts that were used depending on the participants' responses; not all participants were asked exactly the same questions in the same order. Both interview schedules were shown to EP colleagues prior to their use in order to assess their suitability and minor changes were made.

3.8 Ethical Considerations

Ethical approval was sought from the Ethics Board at UCL Institute of Education prior to the commencement of this study, in line with the British Psychological Society's ethical guidelines (BPS, 2014). The following was considered:

Respect

The dignity and worth of all participants was valued equally, in line with the Code of Ethics and Conduct. All members of the intervention were given an equal opportunity to participate in the research. The timing of focus groups and interviews was flexible to ensure that there were no barriers preventing someone from participating e.g. work or childcare commitments.

Risk

The research involved some participants that were under the age of 16, therefore considered to be a vulnerable group. Fully informed consent was granted from both parents and the school. Focus group tasks and questions were shared with EP colleagues prior to the intervention in order to check their suitability and ensure that they would be unlikely to cause harm. There was the potential for sensitive topics to arise, which may have induced psychological stress or anxiety. Participants were made aware that they were not obliged to answer any questions and that they could withdraw at any time. It was felt that all participants left the focus group or interview in the same psychological state in which they arrived and that no harm had been caused. SBPs within the schools were signposted to agencies, including the EPS, that would support participants should they experience stress or anxiety after participation. Participants were made aware that the SBP would be available to offer support if participation in the research altered their psychological state.

Consent

Fully informed written consent was sought from the following: the parents and school of each child taking part in the focus groups and whose SDQ and TME data was analysed; each child who took part in the focus group; each EP who took part in the EP focus group; and each parent and SBP who was interviewed. Each participant and their parent or guardian (where relevant) had access to an information sheet that clearly stated: the aims; types of data to be collected; method of data collection; conditions of confidentiality and anonymity; compliance with the Data Protection Act; the right to decline and withdraw; contact details of researcher; any planned debriefing; and how the results will be made available to participants (see Appendix 4-13 for consent forms and information sheets).

Confidentiality

All quantitative data has been anonymised. Data collected from focus groups and interviews is pseudonymised. Any identifying information regarding an individual participant, an EP or school has not been reported in any direct quotes.

Giving Advice

SBP were signposted towards agencies that could support the parent and child participants if they felt that taking part in the research had altered their psychological state. Parent and child participants were informed that the SBP was available if they needed additional support. SBPs were able to contact the researcher or their school EP for additional support if required. EPs were able to seek supervision from their EP supervisors if anything arose from participating in the research. It is believed that no participants used the support that was offered.

Deception

All participants were informed about the nature of the research, therefore there they were not deceived in any way.

Debriefing

Although the participants were fully informed and no deception was involved, there was still the possibility of the research having a harmful effect on them. Post-research support was offered to all participants. See above point for further information.

3.9 Data Protection

In accordance with the Data Protection Act 2018, the audio recordings from interviews and the focus groups are stored using an encrypted password protected computer file. Hard copies of data such as the completed SDQs, TMEs and transcripts from focus groups and interviews were anonymised and stored in a locker. When the final thesis has been examined, all hard copies of data, as well as electronic data will be destroyed.

There were times in which the participant's responses included information that made them, the school or the LA identifiable. All identifying details have been anonymised or pseudonymised. Some quotes were removed from the transcripts based on identifiable features. Participants were made aware of this through the information sheet that was shared with them prior to signing the consent form. They were also made aware of the length of time in which their data will be kept and stored.

3.10 Participants

The population of schools considered for inclusion were the four schools that were receiving the MFGT intervention. All schools were state-funded primary schools within the same London borough. The headteachers of these schools had attended an information session about the intervention and had subsequently volunteered for the intervention to be run in their schools. The resulting sample comprised four schools – labelled School A, B, C and D.

The children selected to take part in the intervention were chosen by the schools. In most instances the school's lead for inclusion, the SENCo and pastoral team were involved in selecting target children that they felt would benefit from the intervention. The children were selected for either behavioural, social or emotional issues and schools were advised by the EP to have a range of needs within the group. Table 1 shows the final number of children and parents for each MFG, as well as the number of participants for interviews and focus groups. In School C, one parent had two children taking part in the intervention, therefore there were 8 children and 7 parents in that particular MFG. There was one EP who facilitated the MFG in two different schools, hence the total number of EPs involved in the focus group was 3. Situational factors prevented full SDQ data being collected from all schools. The number of interviews and focus groups is also lower than planned, due to situational factors.

Table 1: Number of participants

	School A	School B	School C	School D	Totals
Number of children in MFG	8	7	8	7	30
Mean age of children in MFG	9.2	8.7	7.2	8.9	8.5
Number of parents in MFG	8	7	7	7	29
Pre and Post Teacher SDQ	8	5	0	0	13
Pre and post Parent SDQ	8	0	0	0	8
Children participating in focus group	6	0	7	7	20
Parents participating in focus group/interviews	0	0	1	2	3
SBPs participating in interviews	1	0	1	0	2
EPs participating in focus group	1	1	1	1	3

Mean age of children in MFG	9.2	8.7	7.2	8.9	8.5
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3.10.1: School Contexts

School A is a larger-than-average-sized, state-funded primary school. Pupils from African and Turkish backgrounds make up the largest groups in the school. The proportion of children who have English as an additional language (EAL), who are eligible for free school meals and those with special educational needs (SEN) is significantly above average.

School B is a larger-than-average-sized, state-funded primary schools. The majority of pupils are from a minority ethnic background. The proportion of children who have EAL and children who are eligible for free school meals is well above average. The proportion of children who leave or join the school throughout the school year is above average. The proportion of children with SEN is below average.

School C is a larger-than-average-sized, state-funded primary school. It is in a federation with two other local primary schools. Pupils from an African background make up the largest group in the school. The proportion of children who have EAL, who are eligible for free school meals and those with SEN is significantly above average.

School D is a larger-than-average-sized, state-funded primary school. The school recently left a federation and changed its name. The majority of pupils are from a minority ethnic background with the largest groups being from Black, Black British and other White backgrounds. The proportion of children who have EAL, who are eligible for free school meals and those with SEN is significantly above average.

3.11 Sampling

Opportunity sampling was used for all elements of the research. All members of the MFGs that were being run in the Local Authority were invited to take part in the research.

Typically, this type of sampling can affect the generalisability of the findings as the sample may be biased. However, in this case there were only four schools running the intervention, so it was deemed appropriate to use those schools.

There was an original aim to use a variety of different sampling methods to select participants for the interview stage of the research. However, the parent participants proved difficult to recruit, therefore opportunity sampling was used throughout.

Opportunity sampling was used to select the EP participants and the SBP. This is because there were only three EPs involved in running the MFGs in the LA1 and only one SBP per

primary school. There are some limitations to this approach. Firstly, as the EPs have shown an interest in MFGT, attended a comprehensive training course and chosen to run MFGs in schools, their opinions on the intervention may be biased and may not reflect the views of the wider EP population. Similarly, the schools have elected to sign up to have an MFG running in the school, therefore they may have a more favourable opinion of MFGT compared with schools that had not chosen to sign up.

All parents were invited to attend focus groups. It proved difficult to arrange these groups, with many dates and times being arranged and then postponed due to parents dropping out. One focus group ran with two parents. Parents were then offered individual interviews, rather than focus groups. One parent volunteered to take part in an interview.

There are potential limitations to the sampling method used to gain the parent interview participants. Volunteers may have different characteristics compared to non-volunteers. Rosnow & Rosenthal (1997) found that volunteers tend to be more educated, more sociable, more approval-motivated and less traditional.

3.12 Procedure

Table 2: Procedure of research

Procedure	Description
1. Collection of data from the pre-measures	<p>The EPs working with the groups collected the SDQ data from parents and teachers before the MFG began. The EPs had already obtained consent from the Local Authority to collect data as part of the EP services impact measurements. At this stage, consent hadn't been obtained from participants for their data to be used in this research.</p> <p>Gaining permission from the Local Authority involved working within the child's exosystem. At this stage, the child was indirectly involved. Consent from the Local</p>

	<p>Authority meant that the researcher had permission to be directly involved with the child (in their microsystem) during the focus group stage of the research.</p>
<p>2. Collection of TME data</p>	<p>Individual targets for each child were set at the beginning of the intervention and reviewed on a weekly basis by group members and recorded by the EP.</p> <p>The setting of targets created connections within the child's mesosystem as home and school came together to set targets.</p> <p>As the child attended these meetings, all people present were also part of the child's microsystem.</p>
<p>3. Consent obtained</p>	<p>The EPs running the groups introduced the research to group members and headteachers. Information sheets were given out, explaining the quantitative element of the research as well as the focus groups. Consent was given for the pre- and post-SDQ data and TME data to be shared with the researcher.</p> <p>Consent was given for children to take part in a focus group.</p> <p>This took place within the child's mesosystem. The giving of consent also had an impact upon the child's microsystem as they would then be part of the focus group with the researcher.</p>
<p>4. Collection of data from post-measures</p>	<p>The EPs collected the SDQ data from parents and teachers after the final session had taken place.</p>

<p>5. Parents invited to take part in focus groups</p>	<p>SBP contacted parents to arrange a time and date for a focus group. Uptake was low and groups were rescheduled multiple times with little success. One focus group consisting of 2 parents took place in one of the schools.</p> <p>This took place within the child's mesosystem.</p> <p>Reflections made within the interviews and focus groups may have had a direct impact upon the child e.g. being reminded of the child's progress may have encouraged the parent to continue with strategies they learnt within MFGT at home.</p>
<p>6. Focus groups with children</p>	<p>Consent forms were signed at the beginning of the focus group session by children. Audio from the focus groups was recorded.</p> <p>These focus groups took place within the child's microsystem as they were directly involved with the researcher.</p>
<p>7. Invite to interview</p>	<p>The SBP were invited to be interviewed. SBP invited parents to be interviewed, instead of attending a focus group.</p> <p>Similar to the parent interviews/focus groups, this took place within the child's mesosystem and may have had an indirect impact upon the child.</p>
<p>8. Interviews</p>	<p>Semi-structured individual interviews were conducted with two SBPs and one parent. Consent obtained before beginning the interview. Audio from the interviews was recorded.</p>

	Again, this took place within the mesosystem and may have indirectly impacted upon the child.
9. EPs invited to take part in focus groups	EPs were invited to take part in a focus group.
10. EP focus group	<p>Focus group was run with all three EPs. Consent was obtained before starting the group. Audio from the focus group was recorded.</p> <p>Although the EPs were part of the child's microsystem, this focus group was mainly concerned with the exosystem. Reflections that took place within the session may have impacted upon the future running of MFGT and how they are run within the child's school.</p>
11. Qualitative data transcribed	All interviews and focus groups were transcribed.
12. Analysis	<p>Thematic analysis carried out on qualitative data and statistical analysis conducted on quantitative data.</p> <p>Thematic analysis may impact upon the exosystem. Forming themes is subjective in nature. Focusing on particular themes may impact upon the future running of the intervention and how the intervention is run within the child's school.</p>

Table 3: Focus group and interview durations

Focus group/interview	Number of participants	Duration	Average age (of children, if present)
School A children's focus group	6	27 minutes	9.2 years

School C children's focus group	7	18 minutes	7.2 years
School D children's focus group	7	23 minutes	8.9 years
EP focus group	3	39 minutes	n/a
School A SBP interview	1	22 minutes	n/a
School C SBP interview	1	26 minutes	n/a
School D parent focus group	2	15 minutes	n/a
School C parent interview	1	18 minutes	n/a

3.13 Analysis

The first phase of the data analysis was to analyse the quantitative data gathered through the pre- and post-intervention SDQ questionnaires and the TME data. This was undertaken using paired samples t-tests on SPSS.

Thematic analysis was chosen to analyse the qualitative data as it allowed for patterns and themes to be identified from the data. Although considered to be a flexible approach, it still enables a rich picture to be created that reflects the experiences of the participants.

Potential disadvantages, such as difficulties around filtering out information that is irrelevant and the limited interpretative power beyond description, as described by Braun and Clarke (2006) can be minimised if a rigorous approach is taken. Braun and Clarke (2006) write that many of the disadvantages depend more on inappropriate research questions and analysis that does not stick to the thematic analysis phases than on the method itself. This highlights the importance of following the phases, as described below, and ensuring the research questions are appropriate.

The thematic analysis was conducted based on the six phases recommended by Braun and Clarke (2006), outlined in the table below.

Table 4: Thematic Analysis Phases

Phase	Description
1. Familiarising yourself with the Data	All of the data was transcribed, verbatim. Time was spent reading and re-reading the data, with initial ideas being noted down. Initial ideas around themes were

	also noted after the running of each focus group and interview.
2. Generating Initial Codes	Notes relating to potential codes were initially noted in the margin of the transcripts. Codes represented 'units of meaningful text' (Braun & Clarke, 2006). The data was driving the codes. To ensure reflexivity, a paper trail was kept.
3. Searching for Themes	Codes were then arranged into themes. Data from the interviews and focus groups were analysed together. Themes and sub-themes were identified.
4. Reviewing Themes	Transcripts were re-read to ensure that no codes were missed. Themes became clear and identifiable.
5. Defining and naming Themes	Clear working definitions that capture the essence of each theme were developed.
6. Producing the Report	Findings were then reported.

There are disadvantages to thematic analysis which were taken into consideration when completing this part of the research. For example, the flexibility allowed by this approach could also be a weakness as it can lead to inconsistency and a lack of coherence when finding themes within the data. (Holloway & Todres, 2003). In an effort to address this risk, Nowell, Norris, White and Moules (2017) have devised an auditable decision trail that can be used when conducting thematic analysis in order to increase the trustworthiness and credibility of the analysis. Each phase of thematic analysis has suggested ways to establish trustworthiness, for example for Phase 1 (familiarising yourself with the data), they suggest that theoretical and reflective thoughts could be documented. During the analysis of the MFG data the means of establishing trustworthiness, as devised by Nowell et al (2017), was be used wherever possible in order to maximise the credibility of the data.

Chapter 4: Findings

Data from TME data, and parent and teacher SDQs was analysed to explore any potential positive outcomes following the MFGT intervention. Qualitative data from interviews and

focus groups with children, parents, SBPs and EPs was then analysed to further explore positive outcomes and to explore themes relating to processes of change and potential barriers to the success of the intervention.

4.1: Quantitative Findings

4.1.1: Findings from pre-intervention and post-intervention target data

'Target monitoring and evaluation' (TME) data was collected from all four schools who ran the intervention, for a total of 29 children. There are 50 targets as some of the children had separate targets for home and school. A paired samples t-test was carried out on the data.

Table 5: Pre and Post Intervention Target Ratings

	Mean score				Std Error Mean	95% confidence interval of the difference		<i>t</i>	<i>df</i>	Sig (2-tailed)
	Pre	Post	Mean change	SD		lower	upper			
Targets	4.26	7.24	2.98	1.76	0.25	-3.48	-2.48	-12.00	49	0.000

As can be seen from Table 4, there has been an increase in ratings for pupil targets. This increase suggests that attending the MFG intervention has enabled students to move closer to their targets on a rating scale. This difference reached statistical significance.

4.1.2: Aggregate findings from teacher pre- and post-SDQ ratings for 'School A' and 'School B'.

Only two of the four schools returned teacher SDQ data ('School A' and 'School B'). Paired samples t-tests were carried out on the combined teacher data for the two schools (see Table 5 in Appendix 17).

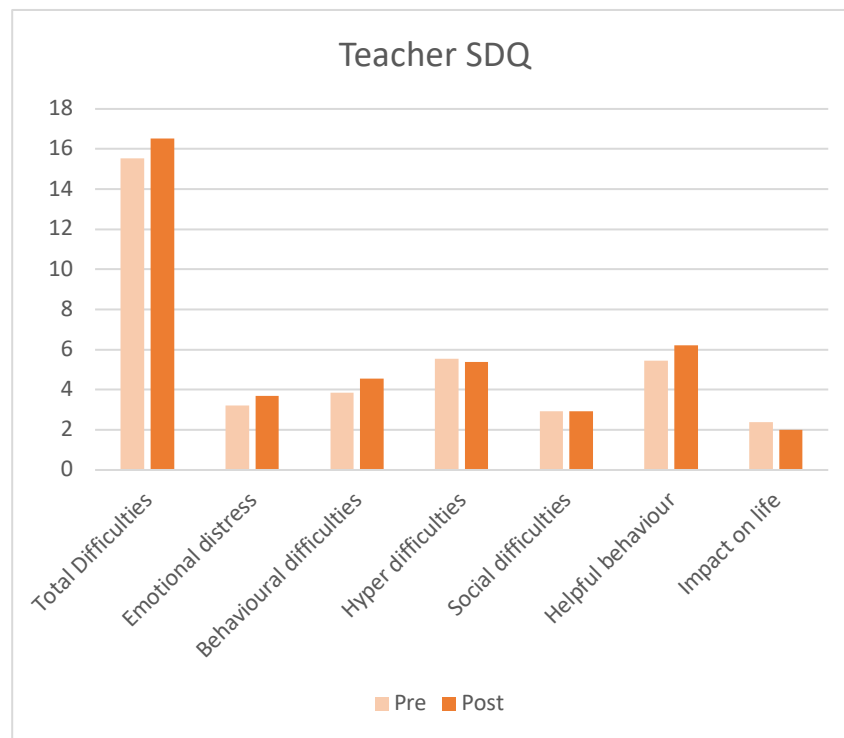


Figure 1: Graph Showing Pre and Post Teacher SDQ Ratings for 'School A' and 'School B'

As can be seen from Figure 1, results indicated slight increases in teachers' ratings of total difficulties, emotional distress, behavioural difficulties, hyperactivity and attention difficulties. Ratings were unchanged for teachers' ratings of social difficulties. Scores for helpful behaviour and impact on life suggested some improvement in these areas. None of the differences observed reached statistical significance.

4.1.3: Comparison of Changes in Teacher Pre- and Post-SDQ ratings between 'School A' and 'School B'

'School A' and 'School B' were then analysed separately. Paired samples t-tests were carried out on each data set (see Table 7 and Table 8 in Appendix 17). Figure 5 shows the differences between the two schools on the pre- and post-SDQ ratings.

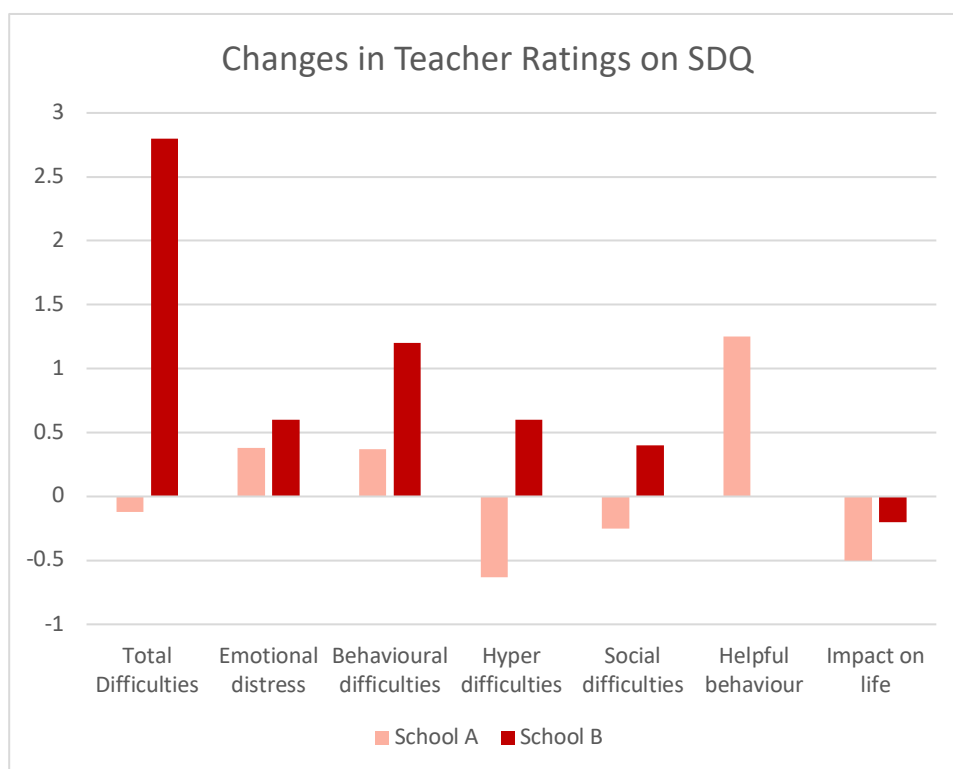


Figure 2: Graph Showing a Comparison of Changes in Teacher Pre and Post SDQ ratings between 'School A' and 'School B'

Inspection of the pattern of SDQ responses between schools suggested differences in perceived changes. Figure 5 indicates that 'School A' reported improvements (decrease in ratings) in the following: total difficulties; hyperactivity and attention difficulties; social difficulties; and helpful behaviour (increase in rating). They also reported that difficulties were having less of an impact upon the children's lives. 'School B' reported increases in total difficulties, emotional distress, behavioural difficulties, hyperactivity and attention difficulties and social difficulties. They also reported that difficulties were having less of an impact upon the children's lives. None of the differences observed reached statistical significance.

4.1.4: Parent pre- and post-SDQ ratings for 'School A'.

'School A' was the only school to return a complete parent SDQ data set. Paired samples t-tests were carried out on the data. As can be seen from Table 5 and Figure 3, results indicate decreases in parents' ratings of total difficulties, emotional distress, behavioural difficulties, social difficulties and the impact of difficulties on life, suggesting some improvement in these areas. Scores for helpful behaviour increased slightly, suggesting

improvement in this area. Scores for hyperactivity and attention difficulties did not change.

Only the difference between the pre (m=3.50) and post (m=2.13) scores for emotional distress reached statistical significance $t(7)= 2.43, p = 0.05$.

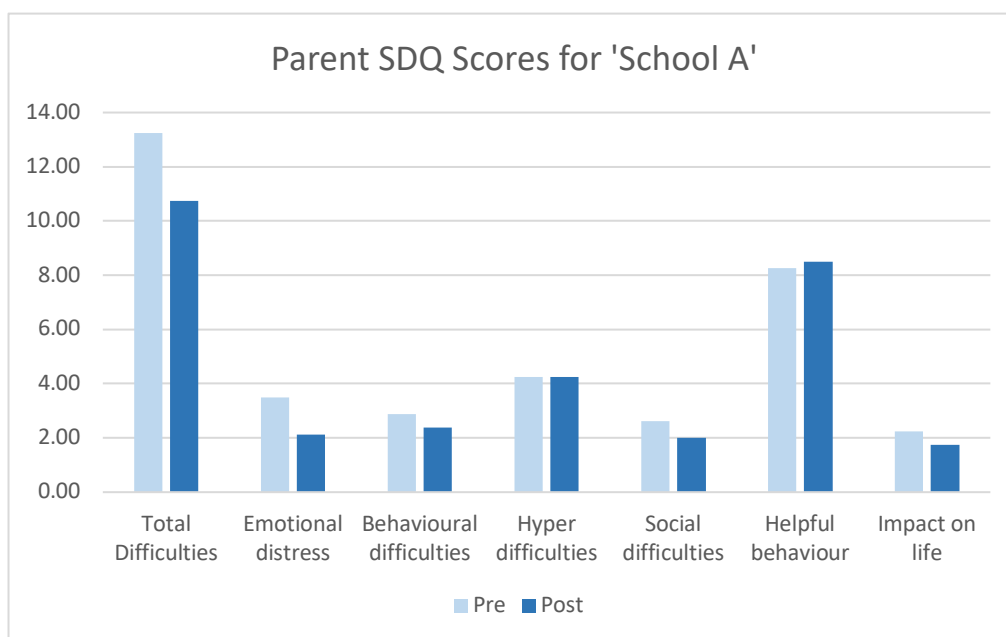


Figure 3: Graph Showing Pre and Post Parent SDQ ratings for 'School A'

Table 6: Pre and Post Parent SDQ ratings for 'School A'

Domain	Mean score				95% confidence interval of the difference					
	Pre	Post	Mean change	SD	Std Error Mean	lower	upper	t	df	Sig (2-tailed)
Total Difficulties	13.25	10.75	-2.50	3.74	1.32	-0.63	5.63	1.89	7	0.101
Emotional distress	3.50	2.13	-1.37	1.60	0.57	0.04	2.71	2.43	7	0.045
Behavioural difficulties	2.88	2.38	-0.50	1.51	0.54	-0.76	1.64	0.94	7	0.381
Hyper difficulties	4.25	4.25	0.00	0.54	0.19	-0.45	-0.45	0.00	7	1.000
Social difficulties	2.63	2.00	-0.63	1.60	0.57	-0.71	1.96	1.11	7	0.305
Helpful behaviour	8.25	8.50	0.25	1.39	0.49	-1.41	-0.91	-0.51	7	0.626
Impact on life	2.25	1.75	-0.50	2.73	0.96	-1.80	2.78	0.52	7	0.620

4.2 Qualitative Findings

Participant views were collected using both interviews and focus groups. A cross-analysis of all of the participant findings have been organised under five overarching themes.

Each overarching theme is presented in turn and is broken down into separate themes and sub-themes. Evidence of the analysis is provided with quotations, identified by a label (G = group, C = child, SBP = school-based partner, EP = Educational Psychologist).

4.2.1 Overarching Theme 1: Positive Change

All participants reported that there had been positives changes. During the intervention, targets were set and reviewed on a weekly basis. This regular and structured focus on progress may be the reason why all participants were able to report so many positive effects. The changes that were reported have been organised into three themes and five sub-themes. See Figure 6 for themes and sub-themes.

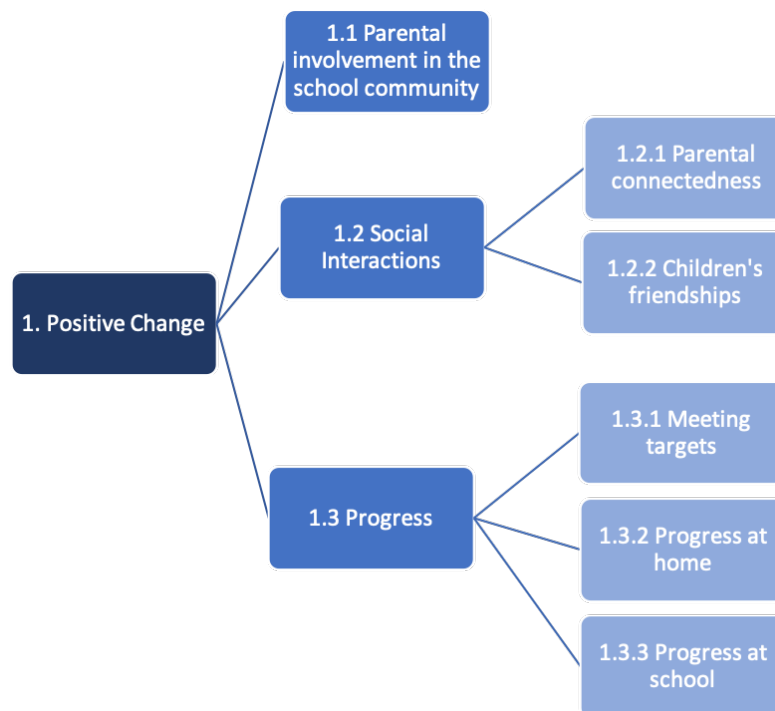


Figure 4: Overarching Theme 1: Positive Change

Theme 1.1: Parental involvement in the school community

This was a theme that emerged mostly from the adult participant's reports. The idea that being part of the MFG strengthened the link between home and school was shared by parents, EPs and school-based partners. Two school-based partners recognised that the

intervention had increased the presence of some of the parents around school, and that they were more willing and open to engage in conversations with staff.

“I think because we have such a tight community around school everyone is literally from the four borders of the school it’s nice to see parents coming because there is some parents we never see and family group let us see them and have that communication with them.” SBP2

“I’m at the gates every morning, so I ring the bell and even just like with me, they seem so much more like easier to talk to. Like normally they’re just like ‘morning, morning’ and drop the kids off, but now we stop, we chat, we used to talk about targets like ‘how’s it going on?’ and now it’s just like general conversations that we have.” SBP1

Theme 1.2: Social Interaction

Social interaction was a theme that came out in all interviews and focus groups. Being part of the MFG appears to have increased social interactions on a peer-to-peer level in both the parents and the children. The theme has been broken down into two sub-themes: ‘parental connectedness’ and ‘children’s friendships’.

Sub-theme 1.2.1: Parental Connectedness

Parental connectedness describes the bond between the adults in the group. This was reported by all of the adult participants. Being part of MFG seems to have created parent-to-parent friendships that had not existed before. Group chats via text-message were reported to have been set up by each group of parents to communicate lateness and other group related issues.

“The school-based partner did say that she could, from her office, see mums in the group that haven’t spoken before chatting at the school gate.” EP2

“By then [the end of the intervention] they had all exchanged numbers and had become really close to one another and they’ll text each other around saying, you know ‘how long are you going to be? We’re here, we’re waiting for you, come on.’ That did happen pretty much every week where if

someone is coming in, we'd say 'have you heard from x?' and they'd just call or text each other." SBP1

Sub-theme 1.2.1: Children's Friendships

This was a theme that emerged in every focus group with the children. Being in an MFG introduced children that may not have spoken before. Children reported that they had made new friends within the group and that these friendships had migrated from the group to the playground and classroom. Reports from the adults reinforced the idea that new friendships had been formed.

"We made friends because we were first lonely and we were shy and then we started getting comfortable and confident with everyone and trust them so you wanna be their friend. It's hard to ask them if you don't know them."

G1C3

"X has become my best friend in family groups and we play together in the playground." G2C2

"She's got a few friends from the group that she plays with on a regular basis. One that she is still very close to now." P3

Theme 1.3: Progress

As setting and reviewing targets was an integral part of the intervention, 'progress' was a theme that was present in all interviews and focus groups. Targets could be set for home, for school or for both settings, therefore sub-themes have been created to reflect the type of target. The sub-themes are: 'meeting targets'; 'progress at home'; and 'progress at school'.

Sub-theme 1.3.1: Meeting Targets

The meeting of targets was a common theme across all groups interviewed. The children, in particular, appeared to enjoy sharing their progress towards their targets. They tended to

know that they had made progress but seemed to struggle to name what the target was. The collective meeting of targets was a theme with the SBPs and EPs as they tended to describe progress in terms of the whole group, rather than individual progress.

“It was really worth taking Friday’s out of class. It was really fun and kinda helped me get better at my targets.” G3C3

“They did all make progress towards their targets in our group, quite well.”
EP1

Sub-theme 1.3.2: Progress at home

Progress at home tended to be a theme that emerged from the interviews with the parents, as they tended to be the problem-owners who raised the issues on which the home targets were based. EPs and SBPs comments on progress at home were mainly anecdotes that parents had shared with them. A few children mentioned specific home-based targets that they had made progress towards.

“There were some changes, I think that he did kind of change his attitude a little bit because we talked about it quite extensively.” P1

“One mum in particular, I remember her saying, she had two children in the group, and talked about the fact that she always dreading shopping because of their behaviour and now she could go shopping and it would go ok”. EP3

“My target was to leave my house at 8:20. I stopped turning my mum’s alarm off because if I turn it off then we would just be more late, so I stopped that and I tell my mum we need to go to school.” G1C2

“The parents were noting progress on the home-based ones [targets]. So, like self-regulation, emotional regulation.....they found that their children had made progress.” EP2

Subtheme 1.3.3: Progress at school

Progress at school seemed to be the most common sub-theme within the theme of 'progress'. All participants commented on making progress towards the school-based targets, emerging most frequently within the children's focus-groups.

"Mine [target] was to like pay more attention in the lessons and it worked. It's also brung me to, one day, we were on topic and I asked a question about the world. Like after my teacher said something, I would ask another question and it happened like seven times." G3C3

"It feels more better that I can concentrate." G1C1

"His teacher said that it did improve his concentration in the afternoons because one of his goals from the school was the concentration in the afternoons because he tended to doze off in the afternoons and lose concentration. The school did say that he did really well." P2

4.2.2 Overarching Theme 2: Processes of change

This theme links to RQ2: How does primary school based multi-family group therapy bring about change?

'Processes of change' describes factors to which change could be attributed. Many factors were mentioned across all participant groups and have been organised into themes and sub-themes. The main themes that arose were: 'collaborative target setting'; 'motivation'; 'parental engagement'; 'facilitators'; 'content of sessions'; and 'shared learning'. See Figure 7 for themes and sub-themes.

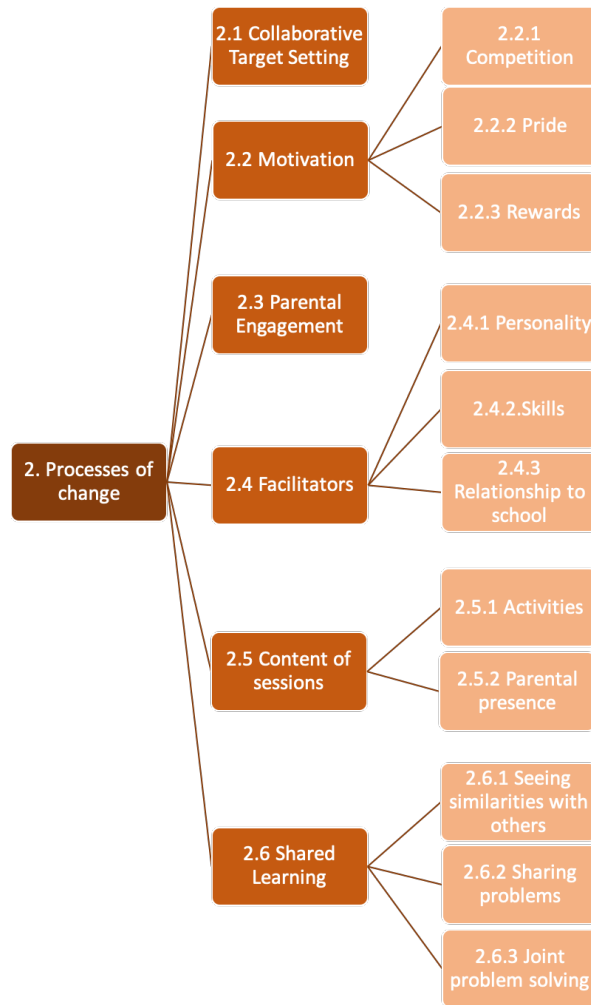


Figure 5: Overarching Theme 2: Processes of Change

Theme 2.1: Collaborative Target Setting

'Collaborative target setting' was a theme that featured across all participant groups.

Setting targets and reviewing progress on a weekly basis appears to have facilitated

change by creating a specific focus to work towards, a focus that was consistently

reviewed. As targets were set collaboratively, there were multiple people invested in the

progress being made. Having multiple people invested in the setting of targets meant that

children were regularly reminded of their progress.

"The group helped us do that because of our targets and we were saying which one we needed to do with our parents and then one of the teachers had to print them and then we had to improve on them." G2C6

"I liked the targets. I think because the targets were being acknowledged it also encouraged them." P3

"The kids need to be familiar with that person, so having like that school-based partner, that's really important, so there that familiar face because when they do see me around, they do remember their targets. There's been times when I've walked into their classroom and they've grabbed their target sheets out of their bags to show me, you know because I'm almost like, my face is the family group face to them, so they see me and they remember that." SBP1

Theme 2.2: Motivation

Being motivated to meet targets appeared to be a factor that facilitated change. Children were reported to have been motivated to change through both intrinsic and extrinsic factors. Three sub-themes emerged from this theme: 'competition'; 'pride'; and 'rewards'.

Sub-theme 2.2.1: Competition

Some of the children within the groups were reported to have been motivated by competition. Competing with their peers to make the most progress, or to be successful within the group activities was a motivating factor for them.

"He's very competitive, very competitive and when we talk about the targets and how the teachers are saying that they're seeing an improvement and how the mums are saying they have seen improvements, he wants that feedback". P1

Sub-theme 2.2.2: Pride

Children within the group were reported to be proud of their progress and this pride motivated them to keep trying to meet their targets. Some children were motivated by

making others proud, whereas others felt pride in their own progress and enjoyed sharing their success.

“Even in the playground they’ll come running up to be like ‘I got all 4s, I got all 4’s today’. It’s just something that they love, it’s just a really big thing for them.” SBP1

“He wants know that his teacher is proud of him, that his mum is proud of him. He wants to know that so, yeah, this kind of feedback is important.” P1

Sub-theme 2.2.3: Rewards

Within the focus groups, the children shared the ways in which they had been rewarded for making progress. In terms of motivation, extrinsic rewards were the only motivating factor that was reported by the children.

“What has changed is that I’ve got some teachers award and one time I got a one star award.” G2C1

“My parents were really happy that we were talking about our targets. She really liked the talking and after family group she made us cake.” G2C5

Theme 2.3 Parental Engagement

The parents are one of the key aspects of MFG. If a parent is unable to attend a session, then their child is also unable to take part in that session. By parents attending the sessions, they are able to find out more about the learning that is taking place in school, how behaviour is managed at school, share with the school how behaviour is managed at home and spend time with their child. All participant groups spoke about the impact of having parents in the school.

“It’s more like strengthened our bond, if that makes any sense. It’s like we have memories that we have made together, and we can talk about it like “do you remember that time we went to the school and we did this...” kind of thing and these are really precious.” P1

“So setting targets and reviewing them made parents kind of say ‘Oh, I didn’t know you were doing this’ or like were reading together and wanting to do it again kind of thing.” EP2

“I like it because like we get to spend time with our family and we get to all come together.” G1C3

“The time doing fun stuff with your family when there are no other demands on anyone was rare for a lot of people.” EP1

Theme 2.4 Facilitators

All of the groups were facilitated by an EP and SBP. This role requires many skills and personal attributes in order for the groups to run smoothly and for desired outcomes to be achieved. The personality of the professionals involved, their skills and their position within the school were important themes that emerged from the data.

Sub-theme 2.4.1: Personality

There were certain personality traits, described by the adult participants, that appear to make for a good facilitator. Being warm and attuned, so that relationships with the group members can be formed. Being assertive, in order for boundaries to be maintained and clear expectations communicated. Being positive and enthusiastic, so that energy levels within the sessions are high.

“Had good relationships and also quite boundaried and clear and could give very clear messages to the children and parents about expectations while maintaining those positive relationships.” EP3

“I think it works and (the EP) is very enthusiastic, very enthusiastic, her energy is like ‘wow’. It’s a good thing because it gets the kids inspired.” P1

Sub-theme 2.4.2: Skills

Being a facilitator was reported, by most adult participant groups, to require a certain skillset and knowledge. EP facilitators completed full training in MFG and then ran training for SBPs. Most SBPs were part of the pastoral team within the schools, so had experience working with the families of the children they support. EPs were reported to be the best placed professional to facilitate MFG within the school context.

“It does put us in a unique position to try and affect change in both systems in a way that not many other professions or groups would be able to.” EP3

“We can bring a set of clinical skills but also have an understanding of school systems because effectively multi family groups is about bringing the family and the school system together and EPs understand both.” EP3

Sub-theme 2.4.3: Relationship to the school

Having facilitators that know the school and that are known by the school were reported to be important factors that helped implement change. Some of the EP facilitators had an existing working relationship with the schools prior to the intervention starting, others did not. All of the SBP were employed by the school and had worked there for at least one academic year. Participants reported that knowledge of the children, the resources available to the children and parents, and the specific school’s context and systems were all important factors.

“[The SBP] from school, she knows the children inside out so it’s like she knows how they behave, what their issues are and other stuff.” P1

“We had one parent who was just really struggling with her financial side in her family.....so she works two jobs to look after the kids and we’ve got (specific support programme) in our school, so they can provide that support if necessary. So, obviously the EP didn’t know about that so I brought that forwards.” SBP1

“So the school wasn’t my link school but I think that if it were there is an advantage for an EP doing it and also being the link EP. There is stuff that kind of emerged from the group that you could pick up in your role as an EP or maybe even take on cases differently depending on.... So I think there is definitely something there that would make it unique if it were the EP in the school running the intervention.” EP2

Theme 2.5 Content of sessions

Aside from targets, which have formed a separate theme, the activities and boundary-setting were the most talked about element of the MFG sessions. These appear to have fostered group-cohesion and been an important factor in the success of the intervention.

Sub-theme 2.5.1: Activities

The theme of activities emerged most from the children’s focus groups. They readily reported their enjoyment of the activities and the type of activities that took place. Other participant groups also spoke of the activities in a way which suggests their importance in strengthening family bonds.

“We specifically gave them a session on it one week about creating, physically creating their genograms so we gave them straws and paper to cut out and the circles and the squares and they physically made it on sugar paper and so that was nice.....they able to talk to their parents about like ‘ok, mum, what’s my grandma’s name, because I’ve only written grandma here’. And they don’t know their grandparents names, which to me is mind-blowing that they didn’t know, but honestly, maybe all of them didn’t know their grandma’s name or their grandad’s name, so it’s just a nice way for them to talk to mum or talk to dad about family.” SBP1

“I liked the family group games and I started having fun.” G2C3

“I had fun with the playdoh.... We had to put the salt in it and the flour.... And then you put the paint in and you mix it.” G2C3

Sub-theme 2.5.2: Boundaries

Within the groups, boundaries were set in order for a safe environment to be created.

Facilitators reported encouraging parents to set the boundaries. Having ownership of the rules and clear boundaries may have helped to create an environment in which parents felt safe to share.

“Sometimes even having conversations about ‘is it ok if you tell so and so’s child off or correct them? How do we decide what the rules are around that, is it ok, or will you get upset or so or so said..?’ but actually created a contract for people to support each other’s children, yeah, that felt quite good.” EP3

Theme 2.6 Shared learning

Shared learning is part of the ethos of MFGT. Hearing from other parents about common difficulties, opening up about their own difficulties and coming together to solve problems were three common sub-themes that emerged under this theme.

Sub-theme 2.6.1: Seeing similarities with others.

Adults across all participant groups reported the importance of seeing similarities with other parents. One parent reported the importance of their child hearing that other children experience the same difficulties. The knowledge that other people are experiencing the same issues was reported to reduce feelings of being alone and encouraged further sharing.

“Me and the EP have had this conversation...and we feel like they (the parents) are almost too worried about being judged so they don’t speak up about it (a problem) but when they’re in a group of like 7 or 8 of them and one person has the courage to bring it out and put it in the middle of the table and everyone’s like ‘oh my god, me too, what do we do, what do we do?’ and they finally realise that they’re not alone.” SBP1

“If there was something they (the children) were struggling with it’s not only them struggling with it they can see their peers were being highlighted as well. I thought that was really good.” P3

Sub-theme 2.6.2: Sharing problems

MFG was reported to have created a forum in which parents felt comfortable to share their problems. SBP reported that when the parents were together, at the beginning of the sessions, they would use the time to share the issues they had been experiencing. Parents also reported that MFG was a place in which problems could be shared.

“They come in in the afternoon, grab a cup of tea and it’s kind of like word vomit, it [their problems] just all comes out.” SBP1

“Some people may feel like “am I doing it correctly?” and not have the confidence to ask or “I’m having this issue, how do I deal with it?” some people just prefer to like battle on with it, you know, if they have an issue and not know who to ask and stuff so the fact that they have somewhere where they can address issues that they might not be as confident to speak about. So I suppose that opens doors for those.” P3

Sub-theme 2.6.3: Joint problem solving

Having shared their problems, parents were reported to be working collaboratively to come up with solutions to help. Parents reported learning from each other, and the professionals shared examples of when this had happened.

“I learnt....looking at things from a different perspective and hearing other people’s opinions and how they go about whatever it is you know. So the information from other families, swapping ideas.” P3

“We’ve got parents teaching parents which like, peer-on-peer learning “I’ve been trying this at home and it’s really worked, do you want to try this yourself?”” SBP2

4.2.3 Overarching Theme 3: Barriers

A number of barriers were reported by the adult participant groups. These barriers either created hurdles that needed to be navigated before and during the intervention in order for MFGT to be successful, or actually inhibited the effectiveness of the intervention. Four key barriers emerged as themes: ‘time commitment of the people involved’; ‘attendance’; ‘systematic barriers’; and ‘cost of the intervention’. See Figure 8 for a breakdown of themes and sub-themes.

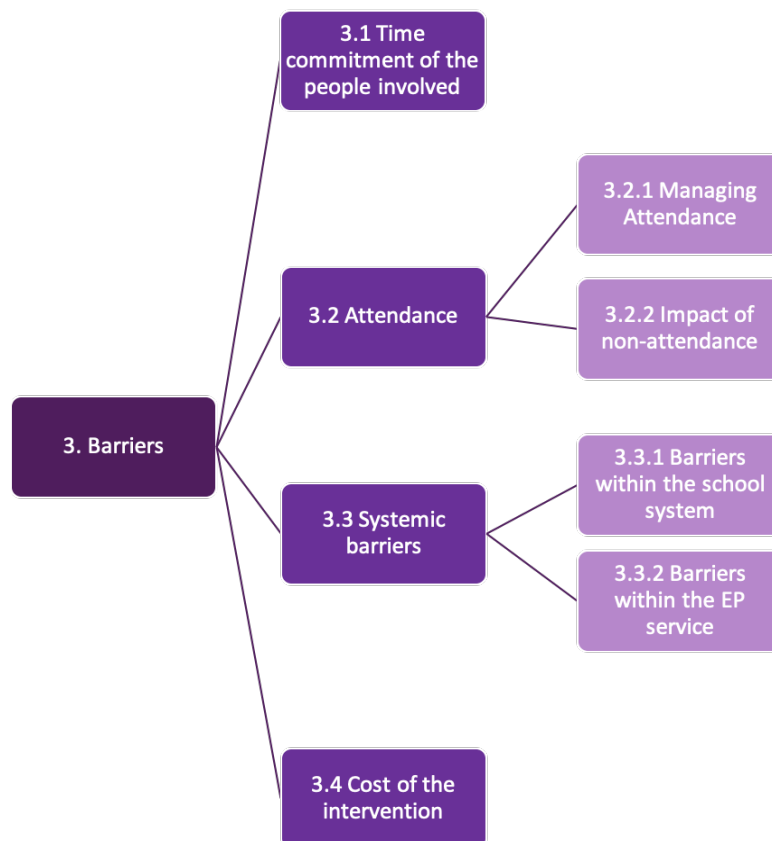


Figure 6: Overarching Theme 3: Barriers

Theme 3.1: Time commitment of the people involved

Running the intervention requires a large time commitment from the SBP and EP. All SBPs and EPs reported that MFGT related tasks over spilled into their other duties. Reminding parents about the sessions, organising resources, planning and reminding teachers to complete the targets were some of the tasks that took place outside of the group sessions.

“I had a bit of time before our session, which allowed me to prepare the room and stuff like that, but obviously that was only about say 45 minutes so everything had to be done in that small time. So if there was something that could have taken took longer, then it would have to be done during another time so it would have impacted on something else I was meant to be doing.”
SBP2

“I think sometimes I would have liked to have more time to plan but again that’s more demands on the school-based partner whose time’s a bit limited.”
EP2

Theme 3.2: Attendance

Attendance of parents was reported to be good in most of the groups. Both SBPs and EPs spoke of group attendance, the way in which it was managed and how attendance impacted upon progress.

Sub-theme 3.2.1: Managing attendance

The management of attendance appears to have been a task carried out by SBP. They reported strategies they used to maximise attendance, such as making phone calls the day before the intervention and sending out reminder texts on the day of the group. In general, the attendance was reported to be good and that the SBP would know in advance if a parent was unable to attend.

“We had a group of about 7 parents and 8 children because one had 2. So coordinating it was a bit tricky to start with, making sure that they came, we sent out texts.” SBP2

“We largely did get parents that would say if they couldn’t change a work shift or something like that. Things that were totally unavoidable. Largely we knew

in advance and that meant the child did as well and the child would understand that it was unmovable.” EP1

Sub-theme 3.3.2: Impact of non-attendance

Although attendance was reported to be high across groups, there were some parents whose attendance was low. This was reported by SBPs to have an impact on progress. When a parent cannot attend, it means that their child also has to miss out. The impact of this was mentioned in one of the children’s focus groups.

“The odd few, and you can really tell with like, when you look at the register, the ones who haven’t been here that often, like all the absences. Those are the children that I’d say I haven’t seen much of a change in. So it kind of gives you an idea about how much MFG has really genuinely impacted them, because this child here, he’s only been in 6 sessions out of the 12 and I haven’t really seen much of a change in him, and it’s probably because of that, you know.” SBP1

“I couldn’t go to all of the sessions because my mum said she couldn’t come into school and it was sad.” G2C3

Theme 3.3: Systemic barriers

The way in which the school system and EP service operates were reported to have created barriers.

Sub-theme 3.3.1: Barriers within the school system

Within the school system, there are often members of staff that perform multiple duties. For these duties to be performed effectively, the system needs to be well organised, have SBP with a certain level of status, have senior leaders who understand the importance of the duties and allocate enough time for these duties to be fulfilled. These three factors were

reported to be important in the successful running of MFGT. When the system is not able to provide these things, it creates barriers.

“The learning mentor had a good relationship with the Headteacher and I think had more status, was very good at galvanising the parents so the attendance was very good.” EP3

“The school were not that organised, but then I don’t feel that I was chasing them all the time which maybe I could’ve done more of.” EP2

“I think the school-based partner not having enough time or having lots of other responsibilities at the same time, had a huge impact because, yeah, starting times, availability, school based partner having to leave or collect the children.” EP2

Sub-theme 3.3.2: Barriers within the EP service

Within the EP service, having multiple duties and working in different settings throughout the day was reported to be a barrier.

“I think in an ideal world, if you’re running a MFG in the morning, you’d have the afternoon back doing admin. It would be the ideal scenario because I quite often found myself in the morning doing an assessment on a school visit and going straight to do the MFG and rushing home and it wasn’t...I suspect we were all in a similar position.” EP3

Theme 3.4: Cost of the intervention

As MFGT is facilitated by an EP, whose daily rate is quite high, the intervention may be seen as a large expense to schools. Having not seen the intervention in practice, schools who are new to MFGT may not want to commit to the cost. Also, in times of austerity, it may be viewed as an unnecessary expense.

“It’s a big thing for schools to commit to and pay for before seeing it in practice.” EP2

” I think it’s one of those things that in local authorities when cuts come it could go, as Headteacher’s may just see the amount of time that a member of staff is spending on one intervention they might think that’s too much.” EP1

4.2.4 Overarching Theme 4: Improvements to the intervention

Participants were directly asked to think about any ways in which the intervention could be improved. All participant groups provided suggestions. These suggestions have been broken down into themes and sub-themes. Figure 9 shows the themes in this area.

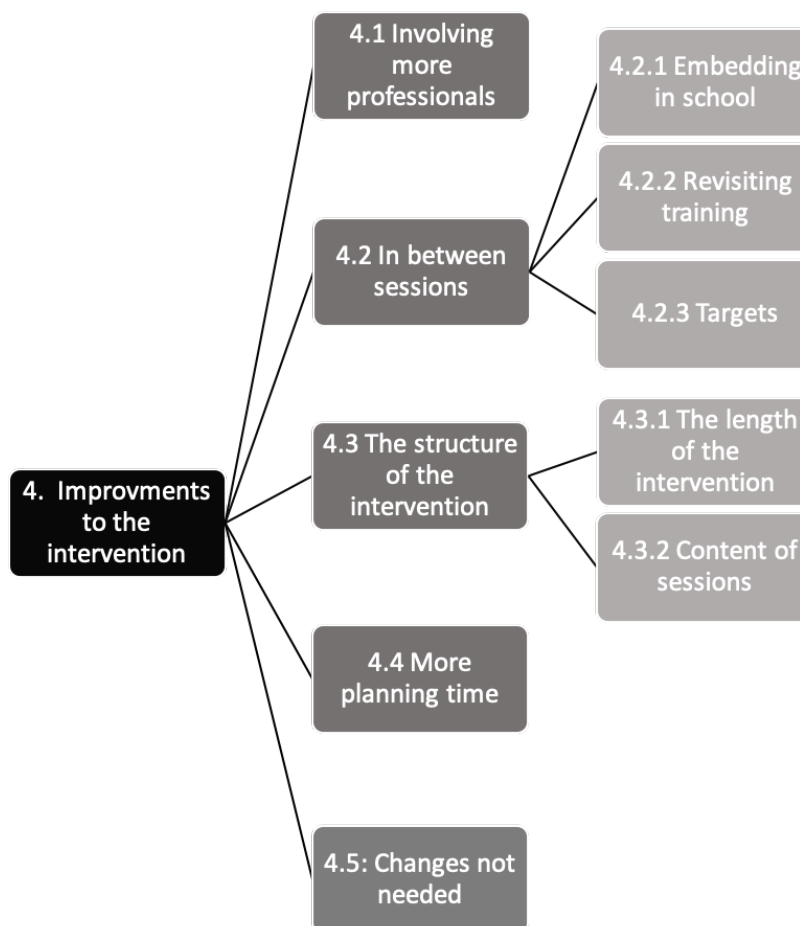


Figure 7: Overarching Theme 4: Improvements to the Intervention

Theme 4.1: Involving more professionals

Both EPs and SBP shared that it may be beneficial to increase the involvement of other professionals, for example the class teacher or social workers.

“We said one thing that we would do is to involve the teacher a bit more. Because they briefly know what it is, they’ve all been to the staff meetings, so they do know what it is and what impact it has on all the kids and stuff, but they don’t know what goes on in the sessions because they’re never there. For the children to see ‘oh, my teacher is also a part of this, my teacher also knows what’s going on.’ We’ve agreed that that’s what we’re going to try to introduce next year.” SBP1

“I felt like we could’ve improved the linkup between professionals, I thought about time for that. Maybe if I had been the link EP for that school it would’ve made that a lot easier.” EP1

Theme 4.2: In between sessions

Both EPs and SBPs spoke of seizing opportunities in between weekly sessions to improve the intervention. Three sub-themes emerged in this area: embedding aspects of the intervention within the school; revisiting training; and keeping track of targets.

Sub-theme 4.2.1: Embedding in the school

EPs reported that there is an opportunity for the intervention to be more embedded in the school. One suggestion to achieve this would be for the children from MFGT to share the games and activities with the rest of their class.

“I think that there is something, for me, about how to develop what happens in school between sessions a bit more and there might be more explicit opportunities for the children to show off the games they’ve been doing in the group, share activities in the playground, in the classroom.” EP3

Sub-theme 4.2.2: Revisiting training

All EPs and SBPs received training before running the MFGT. Both professional participant groups reported that the time in between the sessions could have been used to revisit training, for example to use the online training resources or contact peers who they trained with.

“They [the SBPs] all had access to the microsite [MFGT online resources] but I’m not sure that they used it and in hindsight we would have insisted, prior to the first session, go away and watch the first few clips.” EP3

“I think I could probably talk to the people that were on the course before, because I still have their emails, but I haven’t done so, as of yet.” SBP2

Sub-theme 4.2.3: Targets

Both EPs and SBPs suggested changes that could be made to the targets in order to improve the intervention. Getting schools to commit to having the teachers target data every week, and keeping targets in a book, rather than on loose sheets of paper.

“Like having the commitment of the school targets being done every time so the parents can see the value that been placed from the school teachers perspective as well, otherwise it’s quite difficult if you’re expecting them to come every week and they don’t feel they’re getting anything back...” EP2

“So we’ve still got the target sheet, but instead of having them as sheets, we put them in a book to keep more of a track of them and stuff like that.” SBP2

Theme 4.3: The structure of the intervention

Some suggestions regarding the structure of the intervention were made across all participant groups. Two sub-themes emerged within this theme: the length of the intervention and the content of the sessions.

Sub-theme 4.3.1: The length of the intervention

The most common improvement that was suggested by the children within the focus groups was to increase the length of the intervention. This was also reinforced by reports from SBPs.

“Not have it for like 12 weeks, have it for 20 weeks. Because then like if you improved in that time, then maybe you could just improve more.” G3C3

“I want it for the whole year.” G3C5

“I’ve still got children now that that come to me every week and be like “I know it’s not family group for us, but could we come this week?” SBP2

Sub-theme 4.3.2: Content of the sessions

Many children within the focus groups reported ways in which they would like to change the content of the sessions. Some reported that they would like to have more academic activities, whereas others reported wanting more games.

“Well we could do like more like maths games because I really like maths.....I’d like more educational games to make us more smarter.” G1C5

“It would make it better if we were to have more fun with playing more fun games and different games and new games.” G1C2

Theme 4.4: More planning time

Having more time to plan, both before the sessions and during the sessions, were reported to be an area that could be improved. A parent reported that time was taken up within the sessions to plan the activities they were going to do. They suggested that the planning could be done before the session, so that there is more time for the activity. An EP reported that additional time for planning would be beneficial.

“Set aside some more time and you kind of identify all the things that will create a context for change and be quite explicit about it really...there needs to be a text the day before and I think a lot of schools can do that now.” EP3

“I think what I would probably say is when it came to like planning I think we need a bit more planning because we would discuss the task what have you

and sometimes the process of preparing it there and then took away from the time kind of thing. So I think if they had done it in a way where you would plan and then you know next week you know exactly who is doing what and I think there would have a bit more smooth transition.” P3

Theme 4.5: Changes not needed

Two participants reported that the intervention was working well and that no changes were required. Both used very similar expressions to make this point.

“Yeah, so if it’s not broke, don’t fix it.” SBP2

“I think don’t fix it if it is not broken at the moment.” P1

4.2.5 Overarching Theme 5: Sustainability

Whether the MFGT intervention could be maintained within schools on a long-term basis was discussed within interviews and focus groups with the professionals. Three themes emerged that are reported to be important for the intervention to be sustainable. The themes were: long-term planning; reputation of the intervention; and the cost-benefit of the intervention. Figure 10 shows the themes and sub-themes in this area.

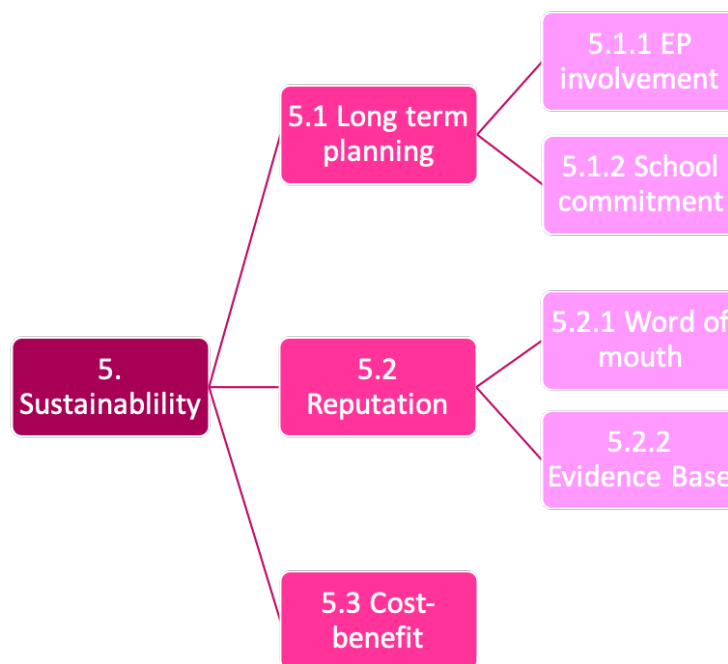


Figure 8: Overarching Theme 5: Sustainability

Theme 5.1: Long-term planning

For the intervention to be sustainable, professional participants talked about the need for long-term planning. This planning would cover the involvement of EPs over time and the commitment required from the schools.

Sub-theme 5.1.1: EP involvement

In the current study, EPs facilitate the MFGs with a SBP. The long-term plan is for a SBP to gain the necessary skills from sharing the facilitation with an EP and then run it alone. This plan was shared by an EP participant. The plan had already been implemented in one of the schools and was reported by the SBP.

“If you were to have a three-year plan and say ‘okay right’, in the first year we’re going to commit to quite a bit of EP time to get up and running but we train people. By year three you’re talking about really EPs just being involved in supervision of the school-based partner and staff that are running it and the school system understands it and responds and the structures are in place and the families know, by word-of-mouth in the school community, that it’s just something that happens. That would be ideal really.” EP3

“I learned a lot from (the EP). I took a lot in from what he was saying and doing and with me, I’m definitely... I analyse what’s going on. I’m looking at body language, the tone of language, no just what he’s saying but why he’s saying it, it’s how he’s delivering that whole message. So I learned a lot from (the EP) and took a lot from (the EP).” SBP2

The retention of staff is important in long-term planning. This is an issue that was raised by an EP participant.

“I suppose the other issue is that a lot of people that have trained in multi-family group therapy are not going to be here next year.” EP3

Sub-theme 5.1.2: School commitment

EP participants spoke of the need for commitment in order to see results across the whole school system, over time. One SBP reported the way that their school had committed to making MFG a long-term part of the school.

“If you keep at it for three years that’s when you see what the benefit really is and the system in school really change.” EP2

“I think we’ll definitely do another one after this one. We are hoping to do two a year. Trying to fit three in, one a term is too difficult so we’re going to try and do two year so definitely going to do another one from February. And the next year I’m guessing we’ll start again but as far as I heard will continue running it and the parents we have had in are the ones that senior management want to get in, so as far as I can see were ticking many boxes so I can see it carrying on.” SPB2

Theme 5.2: Reputation

The intervention having a good reputation was reported to be a key factor in ensuring its sustainability. Two sub-themes emerged in this area: ‘word-of-mouth’ and ‘evidence base’.

Sub-theme 5.2.1: Word-of-mouth

MFG appeared to have a positive reputation amongst those who had participated. When asked if they would recommend the intervention, both children and parents spoke highly of MFG and would recommend that others take part.

“Multi-family group, like, if you go there, then you’re lucky and also like you’d also know that you have you have to go there because you need it. And if you have any doubt in the first place then believe it or not it’s going to help you.” G3C3

“I’d say definitely have the experience. I don’t think you will feel any you know regret to do so, so yeah I would definitely recommend.” P3

Sub-theme 5.2.2: Evidence base

Having evidence that the intervention works is important for schools to see. For the intervention to be sustainable, schools need to know that the interventions that they are spending money on are having an impact.

“MFG is starting to get an evidence base of its impact therefore shouldn’t be a traded service, should it not be something that, in line with the green paper, if we’re going to target children and young people’s mental health then this would seem to be a good evidenced way.” EP3

Theme 5.3: Cost-benefit

Within the EP focus group, the idea that the benefits of the intervention outweigh the costs was a sub-theme that emerged. Although the intervention is expensive to run, each cycle of MFG targets multiple families and each family may have multiple children that could benefit from the learning that their parent is taking away.

“There is quite a lot of impact you can reach quite a lot of families even though on paper it’s quite a lot of time but for the number of families that are accessing it I don’t really think it is overall”. EP1

“So it looks like quite a commitment, but if you worked out what the time versus the number of people you’re reaching if it is actually that much.” EP1

4.3 Summary of quantitative and qualitative findings, in relation to the research questions.

Findings from both the quantitative and qualitative data will be combined, where appropriate, in order to answer the research questions.

4.3.1 RQ1: Does being part of a primary school based multi-family group therapy lead to positive emotional, social and behavioural outcomes?

Findings from the TME data (see Table 4) indicate that, on average, children made progress towards the targets that were set at the beginning of the intervention. All targets were either emotional, social or behaviour. This was reinforced by accounts from children,

parents, school-based partners and EPs within the focus groups and interviews (see sub-theme 1.3.1, Meeting Targets).

Findings from the SDQ data indicate that outcomes were mixed. There were differences between the schools and also differences between the people reporting the data. Parent ratings from 'School A' suggest at least some positive emotional, social and behavioural outcomes and a reduction in total difficulties (see Table 5 and Figure 3). These findings were reinforced by parent and EP accounts (see theme 1.3.2, Progress at Home and 1.3.3, Progress at School). Teacher ratings from 'School A' suggest that there were only positive social outcomes (see Appendix 17, Table 7). Positive social outcomes were reported by children, parents and SBPs in the focus groups and interviews (see theme 1.2.1, Meeting Targets). Both teacher and parent ratings from 'School A' suggest that the children were experiencing fewer difficulties after the intervention and that the children's difficulties were having less of an impact upon the children's lives.

Teacher rating from 'School B' suggest that there were no positive changes with social, emotional or behavioural outcomes (see Table 8). This was not reinforced in the focus groups and interviews as the EP (EP2) reported positive emotional outcomes (see sub-theme 1.3.2, Progress at Home).

Data collected from both interviews and focus groups suggest that there were many positive outcomes for both children and parents who attended the focus group. The three themes that emerged within the area of 'positive changes' were: increased parental involvement in the school community; increased social interactions for both the children and parents; and progress towards children's targets – both at home and at school. Figure 6 shows the themes and sub-themes in this area. The mismatch between quantitative and qualitative data is discussed in chapter five.

RQ2: How does primary school based multi-family group therapy bring about change?

This question is answered by data collected from the focus groups and interviews. A number of processes of change emerged from this data. Adult participants spoke of a

variety of factors that have potentially contributed towards change. Child participants tended to focus on targets and the activities and games they played in the sessions. The main themes that arose across all participant groups were: 'target setting'; 'motivation'; 'parental engagement'; 'facilitators'; 'content of sessions'; and 'shared learning'. See Figure 7 and Overarching Theme 2: Processes of change, for a breakdown of themes and sub-themes in this area.

RQ3: What factors contribute to the primary school based multi-family group being successful? and RQ4: What factors act as barriers to primary school based multi-family group being successful?

Both RQ3 and RQ4 are considered together, as the absence of a factor that is attributed to the group's success may be a barrier to success. Also, there were times during the focus groups where the mention of a barrier prompted another participant to discuss how the absence of that barrier helped their group be successful, or ways in which they had been able to remove the barrier to ensure success.

Overarching theme 3, 'barriers' highlighted many factors that may have affected the success of the intervention. Four key barriers emerged as themes: 'time commitment of the people involved'; 'attendance'; 'systematic barriers'; and 'cost of the intervention'. See Figure 8 for a breakdown of themes and sub-themes in this area.

4.4: Triangulation and Complementarity

When data is triangulated, it suggests the MFGT supports children to make progress towards targets. Quantitative data showed that, on average, children made nearly three points of progress towards their targets. Data from interviews and focus groups also supported the idea that all children made progress. All participant groups spoke of the importance of target setting and target monitoring in relation to making progress.

When looking at positive emotional, social and behavioural changes, there was a mismatch when comparing quantitative and qualitative data. Quantitative SDQ data did not show consistent patterns of positive change in all areas and across the two schools that returned

SDQ data. Qualitative data, however, did suggest that there were positive behavioural and social changes and that these changes were reported across all participant groups and provided insight into all four school.

Chapter 5: Discussion

In this chapter the implications of the research findings are explored in relation to the research aims, which are to establish the effectiveness of MFGT when used with primary school students in a mainstream school setting, including the practicalities of implementing such an intervention. The research questions are considered within the context of theories and models introduced in the literature review. The quantitative and qualitative data were used concurrently, where possible, to help understand the impact of the evaluated MFGT on children and families. The implications from these findings are discussed in regard to future use of the intervention, including the role for educational psychologists.

5.1 Research Question 1

RQ1: Does being part of a primary school based multi-family group therapy lead to positive emotional, social and behavioural outcomes?

5.1.1: Impact of the intervention on emotional outcomes

One of the main aims of the research was to evaluate MFGT intervention in terms of its positive outcomes. The SDQ was chosen as a measure as it enables multiple areas of a child's behaviour to be assessed. One of the areas it focuses on is emotional symptoms and an 'emotional distress' score is calculated. Based on previous research into Family Therapy (Shpigel, Diamond and Diamond, 2012) and Multi-Family Therapy (Salaminiou et al., 2017 and Fristad et al., 2003), it was anticipated that there would be positive emotional outcomes following the intervention and that there would be a decrease in 'emotional distress' scores.

When analysed both separately and together teacher SDQ data from 'School A' and 'School B' shows an increase in emotional distress scores after the intervention. This was not in line with previous research (Shpigel, Diamond and Diamond, 2012; Salaminiou, 2017 and Fristad et al. 2003) which reported positive emotional outcomes, such as improved

mood. However, previous research that has specifically reported on the impact of MFGT on emotional outcomes have all been within a clinical context with the aim of improving the symptoms of a psychiatric disorder, therefore may not be relevant to the population of this research. Previous research conducted within a school context (Morris, 2014; Kratochwill et al., 2004; Kratochwill et al, 2009; McDonald et al., 2006) did not specifically report on emotional outcomes.

'School A' also had SDQ data from the parents. The scores reported by parents differed from those of the teachers. Emotional distress scores reported by parents decreased following the intervention. Findings from research by Morris et al. (2014), which also used the SDQ to measure outcomes following school based MFGT intervention, were similar to the findings from the parent SDQ data from 'School A', in that they observed a reduction in 'total difficulties' scores for parents. However, Morris et al. (2014) also found a reduction in teacher-reported 'total difficulties' scores following the intervention, a pattern only observed in one school in the current study. As Morris et al. (2014) only reported total difficulties scores, it is not possible to see which specific areas of functioning were impacted, such as if there were improvements on emotional difficulties scores.

One of the main aims of family therapy is to improve communication within the family (Becvar & Becvar, 2013). Caldwell et al (2007) found that there were improvements in open communication, including the expression of emotions, between parents and children, following MFGT. It may be that, in the current study, the children became more able to communicate their feelings following MFGT, leading to increased emotional distress ratings on the SDQ. Those feelings may have been present before, but the children may not have been able to communicate them effectively. Within the interviews and focus groups, a specific question around changes in a child's ability to communicate their emotions may have been able to elicit this information.

The qualitative data did not provide much insight into emotional outcomes. Many of the participants spoke of positive behavioural or social outcomes, especially in relation to targets and progress, but did not touch upon emotional changes. It could be that the children were experiencing greater difficulties with behaviour and social interaction,

therefore their targets and the weekly discussion on progress would have been focussed on those areas. This may have then led them to focus on those areas when talking about progress in the interviews and focus groups. It may have been helpful to have analysed the targets in more detail in order to have data on the focus of each target, rather than just looking at numerical ratings. If children had been set a specific emotional-based target, the progress in this area may have featured more heavily in the qualitative data.

5.1.2: Impact of the intervention on social outcomes

SDQ data also provided information on the perceived changes to the 'social difficulties' scores for children before and after the MFGT intervention. Previous research in this area suggested that there would be a decrease in social difficulties and that children would experience improved peer (Gopalam et al., 2015; Kratochwill et al., 2004; McDonald et al., 2006) and family relationships (Meezan & O'Keefe, 1998; Fristad et al., 2003).

In contrast with this existing research, the combined teacher data for 'School A' and 'School B' showed no change in scores following the intervention, suggesting that social difficulties for the children in this study remained stable. However, when data for 'School A' and 'School B' were separated, there were differences in 'social difficulties' scores between the two schools. For 'School A' there was a decrease in social difficulties scores, indicating that the children were having fewer social difficulties. For 'School B', there was an increase in social difficulties scores, suggesting that the children were actually experiencing more social difficulties. Parent SDQ data from 'School A' also shows an improvement in social difficulties. Data from 'School A' is consistent with previous research and shows improved social functioning. However, this was not the case for 'School B'. These seemingly inconsistent results were similar to the findings reported by Colahan and Robinson (2002), who found that half of the families receiving MFGT had improved outcomes, based on parental reports and clinical observations, whereas the other half did not. They noted that in families where positive changes had occurred, for example a return to normal weight and increased social interaction, there were also noticeable changes in family members and family relationships. This suggests that there may be factors within families that make them more or less likely to respond well to MFGT.

Qualitative data from parents, children, SBP and EPs across all four schools are more in line with previous research. From the interviews and focus groups, children's friendships emerged as a theme (see sub-theme 1.2.1). All participants groups spoke of improved relationships and an increased number of friendships both within the MFG and in the wider school context suggesting that MFGT had positive outcomes. The only qualitative data from 'School B' came from the EP facilitator, therefore it cannot be assumed that their reports would have been consistent with the reports from the other participant groups.

5.1.3: Impact of the intervention on behavioural outcomes

SDQ data provided information on the perceived changes to the 'behavioural difficulties' and 'hyperactivity difficulties' scores for children before and after the MFGT intervention. Previous research in this area suggested that there would be a decrease in behavioural difficulties (Gopalam et al., 2015; Meezan and O'Keefe, 1998; and McDonald et al., 2006). There has been no research that has specifically looked at the impact of MFGT on hyperactivity difficulties; however, a review of family therapy found that it was no better than 'treatment as usual' when used as a treatment for ADHD (Bjornstad & Montgomery, 2005). Based on this research it was anticipated that there would be no significant change to 'hyperactivity difficulties' scores.

The combined teacher data for 'School A' and 'School B' showed that there was an increase, albeit not significant in 'behavioural difficulties' scores following the intervention, suggesting that MFGT did not help to reduce difficulties in this area. This was in contrast to previous research. There was a small, but not significant, decrease in 'hyperactivity difficulties' scores, suggesting that MFGT may help to reduce difficulties in this area.

When teacher SDQ data for 'School A' and 'School B' were separated, both had increases in 'behavioural difficulties' scores; however, there were differences in 'hyperactivity difficulties' scores between the two schools. For 'School A' there was a slight, although not significant, decrease in 'hyperactivity difficulties' scores, indicating that the children may have been having fewer difficulties with hyperactivity. For 'School B', there was a slight increase in these difficulties, suggesting that the children were experiencing more

hyperactivity difficulties. Parent SDQ data from 'School A' also showed small improvements in behavioural difficulties and no change in hyperactivity difficulties. Parent data from 'School A' appears more consistent with previous research as it shows improved behaviour and no change in hyperactivity difficulties. However, this was not the case for the teacher SDQ data from 'School A' and 'School B'.

The 'Pygmalion effect', or self-fulfilling prophecy, as described by Rosenthal and Jacobson (2003), could be used to explain the increases in 'behavioural difficulties' scores. The Pygmalion effect is a phenomenon whereby expectations of a target person can affect the target person's performance. By being allocated to an MFG, a teacher's belief about a child might change, for example 'the child's behaviour is of such a concern that the school have had to intervene'. Being highlighted as having behavioural difficulties could bias the teacher's interpretation of a child's actions, leading them to report more behaviour difficulties. Snyder and Stukas (1999) found that once a perceiver adopted a belief about a target person, they then interpreted the target person's behaviour as confirming that belief and the target individual's behaviour may begin to reflect the perceiver's perceptions of, and responses to them.

Interestingly, the data from the focus groups and interviews were inconsistent with the SDQ findings for 'behavioural difficulties'. All participant groups reported improved behaviour (see sub-theme 1.3.3), and many participants spoke of positive changes at home. Many of those positive changes were related to behaviour, for example:

"One mum in particular, I remember her saying, she had two children in the group, and talked about the fact that she always dreading shopping because of their behaviour and now she could go shopping and it would go ok". EP3

Positive changes, such as increased attention and concentration, were also reported to have happened at school (see sub-theme 1.3.4), for example:

"It feels more better that I can concentrate." G1C1

These reports are consistent with SDQ data from School A, suggesting MFGT can help to reduce hyperactivity difficulties.

5.1.4: RQ1 Summary

Overall, MFGT appears to have positive outcomes in relation to a reduction in hyperactivity difficulties when data from teacher SDQ's are considered. Parent SDQ's appear to have opposite findings and suggest that MFGT leads to positive emotional, behavioural (although not in relation to hyperactivity difficulties) and social outcomes. There were also differences between the two schools, with data from 'School A' suggesting that MFGT has positive social outcomes, whereas data from 'School B' suggests no positive emotional, social or behavioural outcomes. However, even where no positive outcomes were recorded, the intervention may still have had an impact. Harnett & Dadds (2004) argue that even when interventions show no immediate impact on functioning, they are still useful because all children are likely to face adversity in the future, and the interventions may provide them with skills to better cope with these. TME data also suggests that all children made progress, it is just not clear which area they made progress in as the focus of the targets were not analysed.

Qualitative findings appear to confirm some of the SDQ results, whilst contradicting others. Many participants reported improved behaviour, improved concentration and attention and strengthened peer relationships, suggesting positive behavioural and social outcomes. Evidence of impact on emotional outcomes did not emerge in the interviews or focus groups, therefore cannot provide additional support to the SDQ data in this area. These results raise a number of questions: Are the teacher SDQ reports more or less accurate than the parents'? Are the reports from the interviews and focus groups more reliable than the SDQ data? Why were the SDQ results from 'School A' and 'School B' so different?

Research suggests that it is common to have discrepancies between parent and teacher's reports. For example, Fält, Wallby, Sarkadi, Salari, and Fabian (2017) found low inter-rater agreement between parent and teacher SDQ ratings. Stone, Speltz, Collett & Werler (2013) researched discrepancies between teacher and parent ratings of behaviour and found that younger mothers were less likely to rate children's behaviour within the clinical range. However, the opposite was found by Briggs-Gowan et al. (1994) who reported that parents tend to report significantly more problems and fewer social competences than teachers. An

explanation of these discrepancies was offered by Bigras, Gosselin, Capuano, Normandeau, & Parent (2008) who argued that parent and teacher's reports are likely to be different as they are reporting behaviours from different contexts and that both are valid observers. Fält, Wallby, Sarkadi, Salari, and Fabian (2017) highlighted the importance of using a combination of both parent and teacher reports in order to gain a broader picture of the child's difficulties.

A number of studies have addressed the question of reliability of SDQ versus qualitative data. Van Roy, Veenstra & Clench-Aas (2008) suggested that SDQ scores relating to 'behaviour' should be interpreted with caution as they found that the internal reliability was low on this subscale. This could mean that the scores that were obtained for behaviour may not paint an accurate picture. Harris and Brown (2010) reviewed research that had used both questionnaire and interviews and found that consensus and consistency was weak between the two methods. They suggested several reasons for the differences, including: misinterpretation of questions within the questionnaire; different data collection procedures; complexity of construct being investigated; and sensitivity to the context. They also advised that both questionnaire and interview data sets should be analysed separately using methods suitable to each, before comparing to see if any common messages resonate from both sets of data – which is in line with the procedure of the current study.

It is also important to note that the teachers who completed the SDQs were not part of the interviews or focus groups. It was decided that as teachers did not directly take part the intervention, they would not be able to comment upon their experience of the intervention. However, for triangulation purposes, it may have been helpful to have spoken with the teachers so that they could justify their scores and potentially reflect upon further positives that may not have been captured by the SDQ.

In relation to the differences between 'School A' and 'School B', the qualitative data from the EP focus group suggested that there were systemic issues that may have prevented the MFG in 'School B' from running as smoothly as possible. These issues included parental attendance, relationships with SBP and parents, monitoring of targets and organisation. The differences may also be due to facilitator competence as 'School A' and

'School B' had different EP facilitators. Shaw et al. (1999) found that therapist competence was related to patient outcomes; the more competent the therapist, the better the patient outcomes. There are also contextual factors that may have influenced the outcomes, such as the demographic of the school and the group. 'School A' have a large Turkish population. The demographic of 'School B' was more mixed, without any dominant cultural or ethnic group. Turkish society is centred around collectivism and Turkish families have high levels of cohesion and mutual support (Zabriskie, Aslan, & Williamson, 2018). This cohesion and mutual support may have contributed to the success of the intervention. Also, when looking at the pre-intervention teacher SDQ data, the total difficulties scores for 'School B' were higher than 'School A'. It may be that the children in the MFG in 'School B' were experiencing a higher level of difficulty before the intervention started. These difficulties may have had an influence on the success of the intervention.

5.2 Research Question 2

RQ2: How does primary school based multi-family group therapy bring about change?

Previous research has highlighted improved family functioning (Huey et al., 2010), facilitators' behaviour (Patterson & Forgatch, 1985), including guidance (Lemmens et al., 2009; Hellemans et al., 2011) and modelling (Lemmens et al. 2009), parenting behaviour (Stoolmiller et al., 1993), group cohesion (Lemmens et al., 2005; Hellemans et al., 2011), including communality (Lemmens et al., 2005; Colahan & Robinson, 2002), learning through observation (Lemmens et al., 2005; Hellemans et al., 2011), self-disclosure and discussions (Hellemans et al., 2011), improved communication (McFarlane, 1983), stigma reversal (McFarlane, 1983) and socialisation (McFarlane, 1983) as important processes involved within MFGT. Many of these same processes emerged from the data that was gathered from interviews and focus groups. This data also suggested some additional processes, such as collaborative target setting, motivation to change, parental engagement, the facilitators and content of the sessions, which did not emerge from the

literature review. Each process will be discussed in turn, with reference to previous research and theory.

5.2.1: Collaborative target setting

All participant groups, SBPs, children's parents and EPs, spoke of collaborative target setting as an important process that facilitated change. Multiple people were involved in deciding what targets should be set for each child (the child, the parent, SBP and the teacher) with the task of target setting being supported by the EP. It appears that having multiple people invested in the target setting meant that the child was supported to meet their target across multiple contexts, such as at home, in the classroom, in the playground and around school. One SBP reported that when children would see them, they would be reminded about their targets:

"...because when they do see me around, they do remember their targets. There's been times when I've walked into their classroom and they've grabbed their target sheets out of their bags to show me..... they see me and they remember that." SBP1

Target setting was not a process of change that emerged from previous research into MFGT. However, research in other fields has highlighted the importance of involving children when setting their targets. Bruhn, McDaniel, Fernando and Troughton (2016) reviewed literature on goal and target setting and concluded that in order for targets to be reached and progress made, students needed to be engaged in the target setting process, for example having input into what the target is. A further conclusion from their research was the importance of regular monitoring of progress towards the target and regular feedback from the teacher, both of which are key elements of MFGT.

Having multiple people invested in the targets could also foster secure attachments. By having multiple people ask the child about their targets and progress, the child may regularly feel as though they are 'held in mind'. Feeling as though you are 'held in mind' has been found to increase feelings of containment and help to strengthen bonds (Howe, 2010).

Bruhn, McDaniel, Fernando and Troughton's (2016) research could also be used to explain the outcome differences between 'School A' and 'School B', as the EP from 'School B' spoke of the challenges within that school in relation to teachers not giving feedback about the targets. The absence of regular feedback may have hindered progress towards the targets.

Bronfenbrenner's ecological systems theory (Bronfenbrenner, 1979) can be applied to explain why collaborative target setting may have facilitated change. Bronfenbrenner and Neville (1994) wrote that effective child-rearing processes require exchange on information, two-way communication and mutual accommodation between systems. Collaborative target setting would be an example of exchange of information, as the child, their parent and the school would have to share information about current difficulties and changes that they would like to make. Mutual accommodation would also take place, as all parties involved would discuss strategies to help the child to achieve those changes, which would be repeated on a weekly basis. Szapocznik and Prado's (2007) findings, that involving different systems in an intervention leads to long terms success, can also be applied here, as target setting involved different systems.

5.2.2: Motivation

Both intrinsic and extrinsic motivators emerged from interviews and focus groups as being processes that facilitated change. Again, this was not a process had been reported by previous research.

One of the motivators that came from a parent focus group was the idea of competition. The parent stated that her child was competitive and wanted positive feedback like his peers.

"He's very competitive, very competitive and when we talk about the targets and how the teachers are saying that they're seeing an improvement and how the mums are saying they have seen improvements, he wants that feedback". P1

It is unclear whether this is an example of intrinsic or extrinsic motivation. Nicholls (1984) theorised that children's motivations are either task-oriented or ego-oriented. Children who

are task-orientated are concerned with personal improvement, such as learning new skills, and this motivation is more intrinsic. Children who are more ego-orientated are more extrinsically motivated and enjoy winning competitions and gaining accolades. Deci and Ryan (2000) suggest external rewards, such as winning, will dictate participation for children who are extrinsically motivated. For children who may meet targets as a way of 'beating' peers, it might be difficult continue to make progress once the intervention ends, as their weekly competition would no longer be there. Boos, Franiel and Belz (2015) found that individual competitive behaviour had a negative impact upon group members and group cohesion. This has implications for previous research that has found that group cohesion is a process that facilitates change (Lemmens et al., 2005; Hellemans et al., 2011) as these two factors could be in conflict.

Another motivating factor that emerged from the data was pride. Both parents and SBP reported that children appeared to be proud of their progress and enjoyed eliciting feelings of pride from their parents or school staff. One parent demonstrated this with the following quote:

"He wants know that his teacher is proud of him, that his mum is proud of him. He wants to know that so, yeah, this kind of feedback is important." P1

Williams and DeSteno (2008) found that pride acted as an incentive and increased perseverance on a task. Feelings of pride may have increased the children's motivation to persevere with their targets and want to make progress.

The final motivational factor that came out of the interviews and focus groups was that children received tangible rewards from their teachers and parents for making progress and reaching their targets. One child shared that they had received awards from their teacher:

"What has changed is that I've got some teachers award and one time I got a one-star award." G2C1

Benowitz and Busse (1976) found that offering material incentives to children helped them to make progress with their spelling. However, more recent research has

found that rewards can lead to short term increases in task persistence but can undermine intrinsic motivation and task persistence in the long term (Deci, Koestner, & Ryan, 2001). This has implications for children who are motivated by receiving rewards, as their intrinsic motivation could suffer, and they may find it harder to persevere with their targets after completing the intervention.

5.2.3: Parental Engagement

Reports from all participant groups suggested that parental engagement was an important factor that helped to facilitate change. Parents were reported to have increased engagement with their child, with what their child was learning and with behaviour management. Within this area there are similarities with the processes of change that have been described by other researchers, such as: improved family functioning (Huey et al., 2010) as parents reported improved relationships with their children; parenting behaviour (Stoolmiller et al., 1993) as parents were reported to be more involved in the school community and more invested in their child's school work; and improved communication (McFarlane, 1983) as parents were reported to be communicating more with the school, the other parents and their children.

One quote that demonstrates improved family function came from a parent who shared that the intervention had strengthened the parent-child bond:

"It's more like strengthened our bond, if that makes any sense. It's like we have memories that we have made together, and we can talk about it like "do you remember that time we went to the school and we did this..." kind of thing and these are really precious." P1

Research into attachment theory has found that a person's attachment type has been linked with academic attainment (Richters & Waters, 1991), behavioural problems and peer relationships (Carlson & Sroufe, 1993). Improving bonds between parent and child could help to foster a secure attachment type, thus improving a child's attainment or behaviour. Dickerson and Crase (2005) researched MFGT and also found that the intervention improved parent-child bonds, with participants reporting increased closeness.

The improved communication that was reported could also have had an influence upon attachment, as Kafta and London (1991) suggest that when parents use open communication, they send the message that they care about their child and have respect for their feeling and opinions. The improved communication may also have an impact upon behaviour as Marta (1997) found that open communication was related to a greater ability to deal with stress and with children displaying appropriate behaviours. From the SDQ data, there was a reduction in children's emotional distress, as reported by parents. This change could be attributed to improved communication, as found by Marta (1997).

Bronfenbrenner's ecological systems theory could be applied to explain why increased parental involvement in the school community could have led to positive outcomes. As highlighted by Bronfenbrenner and Neville (1994), strong links between the principal settings in which a child resides enables effective child-rearing. The more present a parent is within the school, the more likely they are to communicate and build relationships with key adults there. This kind of school-directed involvement has been found to lead to positive achievement outcomes for children (Kurtz-Costes, 2015).

5.2.4: Facilitators

Factors relating to the facilitator of the intervention emerged from the interviews and focus groups as being key in promoting change. The personality of the facilitator, their skills, and their relationship to the school were the main themes that participants spoke of. Previous research also highlighted facilitators behaviour (Patterson & Forgatch, 1985), including guidance (Lemmens et al., 2009; Hellemans et al., 2011) and modelling (Lemmens et al. 2009), as important processes involved in MFGT.

The personality of the facilitator was a theme that featured in parent interviews and the EP focus group. Having high energy, being able to build relationships and assertiveness were some of the personality traits that were mentioned as important

(see subtheme 2.4.1). One parent commented on the enthusiasm of the EP and the impact of the enthusiasm on engagement:

"I think it works and (the EP) is very enthusiastic, very enthusiastic, her energy is like 'wow'. It's a good thing because it gets the kids inspired." P1

Within a clinical setting, research has found that the therapist can have an effect on treatment outcomes, with personality traits such as empathy, having an impact upon patient progress (Ackerman & Hilsenroth, 2003). The facilitator's ability to be strong and committed to upholding boundaries has been found to create an environment of safety within group therapy and enable participants to feel able to share (Hargaden, 2014). Patrick, Hisley and Kempler (2000) found a positive correlation between teacher enthusiasm and children's intrinsic motivation, supporting the parent's comment. Although the facilitators do not operate in the same way as teachers, there are similarities to the role, such as managing a group of children in a school context, facilitating learning and establishing boundaries, which makes this research relevant. The EP facilitators for 'School A' and 'School B' shared contrasting experiences in relation to the SBP facilitators:

School-Based Partner in 'School A'

"the SBP.....had good relationships and also quite boundaried and clear and could give very clear messages to the children and parents about expectations while maintaining those positive relationships." EP3

School-Based Partner in 'School B'

"the SBP wasn't really, didn't really have that relationship (with the group members) and I think that's quite important, who does it. That the appropriate person be the SBP, not only in terms of SLT, but how they engage I guess, with parents." EP2

These differences may have had an impact upon the success of the intervention in those two schools.

Within the EP focus groups, the facilitator's relationship with the school was considered to be important. The EPs believed that being the link EP for the school (the LA allocated EP for the school) had advantages, as the EP would already have some systemic knowledge about the school, so could anticipate barriers, may have already-established relationships with key members of staff and may have already worked with some of the families. This opinion can be linked to Bronfenbrenner's ecological systems theory. If the EP is already working with the school, before starting the intervention, they would already be part of the school's microsystem and possibly the child's mesosystem which may increase their influence on the child as well as the school.

The skills of the facilitator were considered by the EPs in the EP focus group. Training, understanding of the school system and clinical skills were all commented on. The influence of therapist competence on therapeutic outcomes has been the subject of much research. One such example is Shaw et al. (1999) who found that therapist competence was related to patient outcomes; the more competent the therapist, the better the patient outcomes.

These three facilitator factors – personality, skills and relationship to the school – may have had an impact upon the delivery of MFGT in the current study and could explain the differences in SDQ scores between 'School A' and 'School B'.

5.2.5: Content of sessions

The content of the sessions was the main theme that emerged from the children's focus group. When asked about the positives of MFGT, the activities and games were reported to be a source of enjoyment (see sub-theme 2.5.1). One example of this is:

"I liked the family group games and I started having fun." G2C3

The games and activities may have helped maintain children's motivation to continue with the intervention and to work towards their targets. Nemerow (1996) found that playing

classroom games increased children's motivation to learn. Other positive effects were found, such as improved peer relationships and increased self-esteem.

The games also required interaction between the children and their parents, which may have helped to strengthen parent-child attachments. Levenstein and O'Hara (1993) suggest that mother-child attachments are linked to play and that mother-child play interactions can help to build social-emotional competencies. Based on Levenstein and O'Hara's (1993) findings, playing games with parents may have supported the reported increases in peer-relationships.

In an interview with a SBP, genograms were discussed as an activity that the children seemed to find engaging.

"We specifically gave them a session on it one week about creating, physically creating their genograms so we gave them straws and paper to cut out and the circles and the squares and they physically made it on sugar paper and so that was nice.....they able to talk to their parents about like 'ok, mum, what's my grandma's name....." SBP1

Tobias (2018) researched the use of genograms within EP practice and found the genograms have multiple benefits when used with children and young people, including: being a rich source of information; enhancing engagement; communication and rapport; improving self-awareness; and highlighting areas for further intervention. When used with the family, it can be used to identify strengths within the family system and how those strengths could be harnessed to support the child.

The genogram can also give an insight into the childhood relationships with parents and attachment patterns and in itself can be a therapeutic intervention (Rovers, 2004). The use of genograms within MFGT may have helped to elicit communication between child and parent, as found by Tobias (2018), as well as offering insight and reflection upon the parent's own attachments with their family members.

A further sub-theme that emerged in relation to the content of the sessions was boundaries (see sub-theme 2.5.2). Within the EP focus group, the collaborative setting of boundaries was discussed. During MFGT, the facilitators encouraged the parents and children to

decide what the rules should be and to collectively discuss acceptable behaviour. One example of this was parents deciding if it would be acceptable to discipline a child from another family.

Hargaden (2014) writes of the importance of participants feeling safe within group therapy and that implementing firm boundaries is the most important factor in ensuring those feelings. Feelings of safety have been found to encourage the sharing of personal information and emotions (Erskine, 2013). Setting boundaries within the MFGs may have contributed to the parents being able to share their difficulties and challenges.

5.2.6: Shared Learning

One of the key processes that was discussed by adult participants was shared learning (see theme 2.6). The three sub-themes within this are were: seeing similarities with others; sharing problems; and joint problem solving. This ties in with one of the main aims of MFGT – to encourage families to learn for themselves and to ‘educate’ other families by sharing experiences (Asen & Scholz, 2010). Previous research has found that learning through observation (Lemmens et al., 2005; Hellemans et al., 2011), self-disclosure and discussions (Hellemans et al., 2011) were all important processes involved in family therapy and all promote shared learning.

Speaking to others experiencing similar difficulties was reported to be helpful and that when one parent shared a challenge that they were facing, it reduced the stigma and enabled others to share. An example of this was shared by a SBP:

“...one person has the courage to bring it out and put it in the middle of the table and everyone’s like ‘oh my god, me too, what do we do, what do we do?’ and they finally realise that they’re not alone.” SBP1

This is consistent with previous research that found MFGT achieved stigma reversal (McFarlane, 1983). Morris et al. (2014) similarly found that being part of MFGT helped individuals to feel less isolated and that the stigma that parents felt about their child’s difficulties were reduced. Research has found that when stigma is reduced, it creates opportunities for honest and open communication (Benson,

O'Toole, Lambert, Gallagher, Shahwan & Austin, 2016), which links to the next sub-theme of sharing problems.

Again, all adult participant groups spoke of parents sharing problems and that this led to joint problem solving. One parent shared that they learnt from having the advice and opinions of other group members.

"I learnt....looking at things from a different perspective and hearing other people's opinions and how they go about whatever it is you know. So the information from other families, swapping ideas." P3

This sharing of learning and opinions is a key element of the Marlborough Model of MFGT as it helps to reduce stigma and help group members to develop their voices (Asen and Scholz, 2010). The theme of shared learning is consistent with the findings of Conahan and Robinson (2002) who found that families were more open to receiving advice from families who were experiencing similar difficulties, compared with professionals. Shared learning also seems to be reliant on parents feeling comfortable to share their problems in the first place. Creating an environment of safety, for example implementing firm boundaries, may have enabled parents to feel safe to share (Hargaden, 2014).

To summarise, there are a number of key processes that appear to have facilitated change in the current study. Collaborative target setting enabled links between the different systems to be strengthened as it involved regular communication between home and school. The frequency of reviewing the targets also appeared to be important to sustain positive progress. Motivation was important to ensure that children were able to keep working towards their targets over time. Regular feedback, rewards and enjoyable sessions all seem to have contributed to the children being motivated. Parental engagement, such as increased presence in the school community appears to have strengthened links within the child's mesosystem as well as reinforcing parent-child bonds. Personality traits, such as enthusiasm and empathy, were deemed to be important in a facilitator, as well as skills, such as upholding boundaries. The content of the sessions appears to have motivated the children, as they enjoyed the games and setting clear boundaries created a safe space in

which parents were able to share their problems. The sharing of problems was also a key process that led to a reduction in stigma and joint problem solving.

5.3 Research Question 3 and RQ4

RQ3: What factors contribute to the primary school based multi-family group being successful?

RQ4: What factors act as barriers to the primary school based multi-family group being successful?

These two research questions will be considered together, as it appears as though the absence of a factor that contributes to MFGT being successful has been reported to be a barrier in some schools and may have inhibited the success of the intervention. Four factors appear to be important to the success of MFGT: time commitment; attendance; systemic barriers; and the cost of the intervention.

The time commitment of MFGT was a theme that emerged as contributing to the success of the intervention in some schools (when schools allocated enough time) and was a barrier in others. Running an MFG was reported to be a demanding role which could be time consuming. Both the EP and SBP spent two hours per week directly running the intervention, as well as spending time preparing sessions and following-up on issues and questions that arose within the sessions. EPs reported that they had been allocated adequate time for the intervention, but that other commitments could get in the way. Some schools were reported to have allocated enough time to the role of a SBP, whereas others did not. Having adequate time to fulfil a role can increase a person's feeling of satisfaction and happiness when completing a task (Zauberman & Lynch, 2005) and being allocated adequate time increases people's perception of the value of a task (Barnett & Hyde, 2001). Further research suggests that perceived time pressure can inhibit performance and can also increase task-avoidance (Beck & Schmidt, 2013). It may be that in the schools that had not allocated SBP adequate time, the SBP felt under pressure and could not perform to the best of their ability, for example in 'School B' the SBP was reported to have not had

enough time, which could have affected their ability to get the teachers to update the target sheets.

Parental attendance was a factor that featured across interviews and focus groups with all participant groups. Attendance was important, as if parents were unable to attend a session their child also had to miss the session. The managing of attendance was a role that was taken on by the SBP and often involved numerous phone calls to remind parents to attend. This role added to the time pressure of the role (see above). Attendance was reported to have had an impact upon progress:

“.....he’s only been in 6 sessions out of the 12 and I haven’t really seen much of a change in him, and it’s probably because of that, you know.” SBP1

These reports are in line with previous research that found that the best predictor of therapy outcomes was inconsistent attendance (TARRIER, SOMMERFIELD, PILGRIM AND FARAGHER, 2000). The EPs for ‘School A’ and ‘School B’ shared contrasting reports regarding the parental attendance in their schools:

Parental Attendance in ‘School A’

“The learning mentor had a good relationship with the Headteacher and I think had more status, was very good at galvanising the parents so the attendance was very good.” EP3

Parental Attendance in ‘School B’

“I’d say that we had some parents that had great attendance and some that were a bit bitty and that was consistent throughout, the same parents.” EP2

These differences in attendance may have contributed to the differences in outcomes between the two schools.

Dickerson and Crase (2005) found that attendance was one of the most important factors for the success of MFGT and wrote of the negative messages being sent to a child when their parent does not attend. It is also possible that poor parental attendance could signify other problems in the family that may have directly contributed to that child’s progress, for example a single parent who is the sole earner (Dickerson & Crase, 2005).

Systemic factors within the school system and within the EP service were also reported within the EP focus group. Within the school system: organisation; time allocation; status of SBP; and a school leader who values the intervention, were all factors that were reported to have contributed to the success of the intervention or acted as a barrier.

The school being unorganised could have an impact upon the success of the intervention and being prepared for a session. Making sure the room is ready and that all resources are prepared can contribute to the smooth-running of the sessions (Sugar, 1991). Organisation appears to be linked with time and it could be that the 'unorganised' school had not allocated the SBP enough time to complete the required tasks (see time commitment, above). The EP for 'School B' reported that there were systemic issues within the school related to organisation and that the SBP did not have enough time.

Monitoring of targets in 'School B'

"The school-based targets weren't monitored as well by the teachers." EP2

Organisation in 'School B'

"the school were not that organised" EP2

These factors may have hindered the SBP from performing their role to the best of their ability.

The status of the SBP within the school was also considered to contribute to towards the success of the intervention. Those who had more status, such as a senior leader within the school, were reported to be more able to galvanise parents and improve attendance. In relation to Bronfenbrenner's ecological systems theory, a SBP with more status may have increased links within the child's exosystem, for example having a relationship with the school governors who make decisions about the school and could potentially be more influential in the school and to the child.

The systemic issues within the EP service were around EPs having multiple duties and how these duties impact upon time pressure. The most recent research on the EP workforce

(Lyonette, Atfield, Baldauf & Owen, D. 2019) found that 73% of EPs reported that they did not have enough time to get all of their work done, suggesting that there is a systemic issue within the profession around workload.

The cost of the intervention was a theme that emerged from EP focus groups as a barrier to the intervention. As the EPs were talking in the context of future success and sustainability, this will be discussed within the 'implications' section.

To summarise, there are certain factors that appear to promote or inhibit the success of the intervention. Having good parental attendance, a SBP who has been allocated adequate time, a SBP who has status and influence within the school and an EP who has been allocated enough time all appear to help the intervention run more smoothly and contribute to its success.

5.4 Implications for MFGT intervention

From the findings of the current study there appears to be certain factors that, when in place, lead to better outcomes for the families involved.

Having multiple collaborators involved in setting and reviewing the targets appears to have helped children to make and sustain progress. An implication of this is that progress may not continue to be made after the intervention has been finished. It may, therefore, be useful for facilitators to help the school set up a system whereby progress can still continue to be monitored by multiple people in the child's life. Continued target monitoring could also help to sustain parent's involvement in the school community and maintain positive communication with their child's teacher, which research suggests enables effective child-rearing (Bronfenbrenner and Neville, 1994) and positive achievement outcomes (Kurtz-Costes, 2015).

Having children that are motivated to make progress also seems to be important for change to happen. When children were asked about any improvements they would like to make to MFGT, some suggested that the games should be more educational, or that there should be more variety. Suggesting different games suggests that the current activities may not have been as enjoyable, and therefore not as motivating for some children. Therefore, it

may be important to ensure that all children have the opportunity to choose the activities that take place during the intervention. Also, some children spoke of receiving rewards for meeting targets, with some of these being material rewards, such as cake. Research suggests that material rewards may undermine long term intrinsic motivation (Deci, Koestner, & Ryan, 2001). Gambrell (1996) developed the reward proximity hypothesis which proposes that intrinsic motivation is less likely to be undermined if the reward is proximal to the desired behaviour. For example, Marinak and Gambrell (2008) found that when trying to increase children's reading engagement, a reward of a book was found to be less undermining to intrinsic motivation than tokens. Less proximal rewards such as points or sweets, which are unrelated to the desired behaviour, would undermine motivation. Within MFGT parents and the school could be discouraged from giving rewards that could reduce intrinsic motivation.

There appears to be certain skills or characteristics of a facilitator that are linked to better outcomes. The person that facilitates the intervention should be enthusiastic in order to motivate the children as well as empathetic. They should be able to implement firm boundaries and have an understanding of the school context. When all of these factors are considered, it appears as though not everyone may be suitable to facilitate MFGT, and any service that is commissioned to deliver the intervention should carefully consider the skill set of potential facilitators.

Poor parental attendance has been linked to poorer outcomes (Dickerson and Crase, 2005); therefore, it is important for facilitators to try to maximise attendance. One of the schools within the current research used a voucher incentive and reported good attendance; therefore, facilitators may want to consider whether an incentive may be appropriate with their client group, or whether to explore other options.

In the current study, parents opening up and sharing their problems appears to have helped to reduce stigma and foster joint problem solving. Facilitators should consider how to create an environment that is conducive to openness, such as implementing firm boundaries (Hargaden (2014).

Ensuring that the SBP has adequate time to complete all MFGT tasks was an important theme that emerged from EP and SBP interviews and focus groups. Without adequate time, targets may not be able to be updated or parents may not be reminded to attend, both of which appear to affect the success of the intervention. Grawitch, Barber and Justice (2010) found that appropriate time allocation for a task greatly differs from person to person and is reliant on a number of factors. They advise that regular appraisal of time is helpful in order accurately judge time allocation. The facilitator may want to have regular catch-ups or supervision with the SBP to ensure that they have the correct time allocation. Additional time for the SBP may then need to be negotiated with the school.

5.5 Implications for EP practice

The implications of this study for EP practice will be considered using Bronfenbrenner's ecological systems theory as a framework. This model is a useful framework as it considers the interactions between different systems. Beaver (2011) wrote of the importance of exploring different systems and relationships which impact on CYP in relation to EP practice.

Microsystem: The research has implication for the EPs role within the microsystem and the work that the EP directly does with a child. EPs have a therapeutic role within schools, working directly with children, and also have a responsibility to contribute to research into the effectiveness of therapeutic approaches to ensure that they are appropriate for the needs of the child (Dunsmuir & Hardy, 2016). The use of TME to foster and measure progress has been shown by the current research to be a successful tool. Currently, TME is mainly used by EPs within home-school consultations to set targets (Connor, 2010).

Children do not tend to present in those meetings, but based on the current research and previous research, involving children in the process of target setting could be beneficial. Bruhn, McDaniel, Fernando and Troughton (2016) reviewed literature on goal and target setting. They concluded that in order for targets to be reached and progress made, students needed to be engaged in the target setting process, such as having input into what the target is.

A finding of the current research is that there is a particular skill set required to facilitate the MFGT, and that an already established facilitator-school relationship led to better outcomes, suggesting that EPs are best placed to run MFGT within the school context. EPs consultation work helps to develop skills such as boundary setting (Cording, 2011) and interaction that focuses on acceptance, non-judgment and empathy (Conoley & Conoley, 1990), suggesting that EPs have the required skillset. Also, EPs within the LA of the current research have a set of 'link schools' in which they complete all of their traded work. Being the 'link EP' would mean that the EP has an already established relationship with the school and may be aware of systemic issues that could impact upon the success of the intervention and could therefore make adaptations to MFGT to ensure its success in a particular school context.

Mesosystem: The research also has implications for the EPs role within the mesosystem and the interactions the EP has with people in a child's microsystem, such as their parent or teacher. The research has highlighted the importance of connections between home and school and is supported by previous research which shows that positive development is promoted by rich, positive, and diverse connections between the microsystems, and the sharing and promotion of common values and goals (Garbarino, 1982). Consultation is a method of service delivery which is used in most EP services (Nolan & Moreland, 2014) and can be a way of bringing a parent together with the school to discuss a child's difficulties. In the researcher's own experience, schools do not always release teachers from class to attend these meetings, or parents are not given enough notice to attend. Based on the research findings, it is important to insist that schools ensure the attendance of both teacher and parent in order to support the home-school connection.

This research also highlighted the challenges that can arise when working within the mesosystem. Gaining access to people within the mesosystem, in order to gather their views, proved to be difficult. Once the intervention had ended it appeared as though many parents did not want to speak about their experiences. One SBP hypothesised that the unwillingness to participate could be due to feelings around the ending of the intervention. The SBP reported that many parents wanted to continue with the intervention past 12

weeks and that because it was over, they did not want to talk about it anymore. If this is the case, then it could have implications for the home-school connections that were formed through the MFGT intervention. If parents are unwilling to speak about their experiences in MFGT, are they also unwilling to attend other meetings that are associated with MFGT? Does ending the intervention also disrupt these connections? It may be important to establish some form of aftercare for families once the intervention has ended so that they still feel supported by the school and 'held in mind'. EPs could be involved in the planning and facilitation of this 'aftercare' provision.

A further implication of the research is an opportunity for EPs to potentially support schools who decide to move from EP facilitated MFGT to in-house facilitated MFGT that is run solely by the SBP. EPs could contract a supervisory role with the school and have regular supervision with the SBP. This supervision could help support the SBP to ensure that factors shown to be important for the successful running of MFGT are in place, such as setting and maintaining firm boundaries and regular reviewing of targets. Currently, a SBP in a school that has moved from EP-facilitated to SBP-facilitated MFGT reported having support from their line manager, but not formal supervision. Research suggests that a supervisor should be chosen based on their supervisory skills, rather than being chosen because they are in the same professional domain, such as a fellow teacher (Lilley, David & Hinson, 2007). Dunsmuir, Lang and Leadbetter (2015) write that there has been an increase in the number of EPs who are supervising education personnel in schools and that EPs can contribute in a valuable and relevant manner in that context.

Exosystem: The research has implications for the EPs role within the exosystem of the child and the link that the EP has to environments that indirectly affect the child, such as their involvement in educational policies. Within the current research EPs raised concerns around the sustainability of the intervention and the perceived cost to the school. When delivered by EPs and paid for by the school, it may seem expensive and schools may prioritise other work over MFGT. The MFGT used in the current research was funded by CAMHS and therefore did not affect the school budget. It is important for EP services to explore opportunities that may enable EPs to run therapeutic interventions without costing

the school money, such as securing bid from CAMHS. Alternatively, some work may need to be done across the education system to change the perception of EP work, as many schools are not aware of the therapeutic work that EPs can offer, instead believing that an EPs role is in individual casework (Ashton and Roberts, 2007). Kelly and Gray (2000) suggest that directly marketing the services the EPs offer to SENCOs could encourage the contracting of more diverse work in schools. This also links to the issues with the current EP workforce, as research has found that there is a shortage of EPs in the field and that many EPs have moved to part-time working (Lyonette, Atfield, Baldauf & Owen, 2019). A decrease in the variety of EP work was one of the explanations for why EPs were moving to part-time working (Lyonette, Atfield, Baldauf & Owen, 2019). Being involved in interventions, such as MFGT, not only supports multiple children, their families and potentially other siblings, but could also offer more work variety and increased job satisfactions to EPs, thus contributing to sustaining the number of EPs in the workforce.

Also, the EP profession should continue to engage in national conversations around SEMH and the position of schools within SEMH provision, for example responding to the government's green paper on children and adolescent mental health, through organisations, such as the Association of Educational Psychologists (AEP) and the British Psychological Society (BPS), and through research involving EP practice in this area. This will ensure that the EP voice is heard and that they are included in any SEMH agenda.

5.6 Implication for future research

The implications from this study suggest that further research is needed into the long-term impacts of MFGT by tracking the pupils over time to see if any of the changes are sustained, or to see if any further changes emerge. Further research using a control group would also be useful in order to confirm whether changes were due to the intervention.

The difference in outcomes between the schools could also be explored further using additional data collection, for example ensuring that parent and teacher SDQs are collected for all child participants. Asking children to complete a pre- and post-intervention SDQ may also be useful. Becker, Hagenberg, Roessner, Woerner & Rothenberger (2004) found that

when children and adolescents completed the self-report version of the SDQ, their scores were consistent with adult informant scores. They concluded that self-rated SDQs from children and young people are reliable and valid and can be used in the absence of adult informant reports. Further interviews with teachers may also elicit explanations of SDQ scores or provide information regarding additional changes which may not get captured by the SDQ.

Research within a secondary school context may be useful as although MFGT is used regularly with adolescents within a clinical context, there has been no research looking at MFGT within a UK secondary school context. Parents are much less involved in the school community when children reach secondary school (Epstein, 2008), therefore MFGT may have a different impact when used in this context.

Further research may also need to look at the unique contribution of the EP when delivering MFGT in a school context. Comparisons could be made with SBP-run and clinical psychologist-run interventions to find out if the professional background of the facilitator has an impact upon outcomes.

5.7 Limitations

The above discussion makes the assumption that the results presented here are valid. However, there are a number of potential limitations which may have impacted these results. For example, due to the naturalistic context in which the intervention took place, variables and limitations were not controlled. However, by not controlling variables the findings have higher external validity (Dunsmuir, Brown, Iyadurai & Monson, 2009). The small nature of the study and the fact that it took place in a single borough of London may effect the generalisability of the study. Similarly, the local context also affects the generalisability of the study, for instance the demographic of the children, families and staff, funding and services that are available to the school, and future opportunities available to the children due to the proximity to central London.

The lack of control group is a methodological limitation. The intervention took place over 12 sessions, which in the context of a school is nearly a whole term. Over a school term, you would expect a child to make progress with their academic achievement and social skills,

based on the learning that takes place in the classroom and social interaction in the playground. It could be that the changes captured by the SDQ were due to the child participating in schooling, rather than being impacted by the intervention.

One of the key limitations of the current study was not having a full data set. Many failed attempts were made to secure the SDQ data from schools and to schedule focus groups and interviews. One reason for the poor return of SDQ data could have been a language barrier. Many of the parents spoke English as an additional language and therefore may not have been able to access the questionnaire. The questionnaire is available in other languages, but this still requires a level of literacy proficiency to access. The missing data could also indicate that the SBPs were overstretched and unable to find time to coordinate the return of questionnaires or to make phone calls inviting parents to be interviewed. This overload may have also had an impact upon the running of the MFGT.

The schools within the research were not randomly selected; they self-selected themselves to receive the intervention. The ethos of the schools that requested the intervention may be more geared towards pupil wellbeing, or may have adequate staffing, which in turn could influence the results of the study. Schools with a different ethos, or limited staff resources may have had different outcomes.

Across all of the MFGs only mothers attended. Having fathers attend as well as mothers may have had a greater impact upon the family system, leading to greater outcomes. However, from the perspective of attachment theory (Bowlby, 1951, 1979), the first and most powerful and enduring social influence upon the child is likely to be the mother, suggesting that the presence of the father may have minimal impact.

Finally, a limitation of the qualitative data is that extra steps could have been taken to validate themes. Member checking has been suggested as a method of ensuring the validity of themes (Harvey, 2015). Once transcribed and coded, the themes could have been discussed with the participants to confirm that they have been correctly interpreted.

5.8 Conclusion

In the current national context, improving the provision to support the mental health of children and young people appears to be high on the government agenda (Department of Health and Social Care and Department of Education, 2017), as well as reducing the number of school exclusions (DfE, 2019). Because of this, it is important to ensure that any provision and interventions that are put in place are effective. MFGT has a large evidence base within the clinical field, yet little is known about its success within a school context. This study has addressed the need for MFGT's use to be evaluated within the school context, with particular focus on the processes involved in change and the experiences of group members.

The research also highlighted implications for EP practice, for example, having already-established facilitator-school relationships led to better outcomes, suggesting that EPs are best placed to run MFGT within the school context. Another implication based on the research findings, it that it is important to insist that schools ensure the attendance of both teacher and parent in consultations as this can help to support the home-school connection.

The quantitative analysis of target data in this study suggests that MFGT can support children to make progress towards their targets, a finding that was also supported by qualitative data. Pre- and post-SDQ data provided mixed results, with some schools seeing more success, in relation to positive outcomes, than others. This highlighted the possibility that contextual factors within the schools may contribute towards the success of the intervention. Contextual factors included: SBP's time allocation; parental attendance; organisation of the school; status of SBP; and having school leader who values the intervention. Anticipating these and making adaptations in order to prevent these factors becoming a barrier is a key implication for the role of the facilitator and for the future use of MFGT in a school context.

The qualitative analysis of interviews and focus groups with children, parents, SBPs and EPs provided an interesting insight into the processes of change. Analysis revealed six overarching themes encompassing factors that contributed to change, these were:

collaborative target setting; motivation; parental engagement; facilitators; content of sessions; and shared learning. Considering these factors and trying to incorporate them when planning the intervention is a further implication for the role of the facilitator and for the future use of MFGT in a school context.

Within this research, even when contextual factors created barriers, all children made progress towards their targets. When barriers were minimised, and key processes of change were present, positive outcomes were greater.

References

- Ackerman, N.W. (1937). The family as a social and emotional unit. *Bulletin of the Kansas Mental Hygiene Society*, 12 (2).
- Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical psychology review*, 23(1), 1-33.
- Ainsworth, M.D. (1969). Object relations, dependency, and attachment: A theoretical review of the infant-mother relationship. *Child Development*, 40, 969-1025.
- Ainsworth, M.D., Bell, S.M., & Stayton, D.J. (1971). Individual differences in strange-situation behaviour of one-year-olds. In H. R. Schaffer (Ed.). *The origins of human social relations*. Academic Press: Oxford, England.
- Ainsworth, M.D. (1985). Attachment across the lifespan. *Bulletin of the New York Academy of Medicine*, 61, 792-812.
- Anna Freud National Centre for Children and Families (2019) *Multi-Family Groups in Schools*. Available at: <https://www.annafreud.org/what-we-do/our-help-for-children-and-families/our-clinical-work-and-projects/our-work-in-schools/multi-family-groups-in-schools/>
- Anderson, A. R. & Henry, C. S. (1994). Family system characteristics and parental behaviors as predictors of adolescent substance use. *Adolescence*, 29(114): 405–420.
- Anderson, C.M. (1983) A psychoeducational program for families of patients with schizophrenia. In McFarlane, W. (ed.) *Family Therapy in Schizophrenia*. New York: Guilford Press.
- Anderson, A. R., Henry, C. S., Anderson, A. R., & Henry, C. S. (1994). Family system characteristics and parental behaviors as predictors of adolescent substance abuse. *Adolescence*, 29(114), 114.
- Asen, E. (2002). Multiple family therapy: An overview. *Journal of family Therapy*, 24(1), pp.3-16.
- Eia. Asen, Neil. Dawson, & Brenda. McHugh (2001). *Multiple family therapy: the Marlborough model and its wider applications*. London. Routledge.
- Asen, E., & Scholz, M. (2010). *Multi-family therapy: Concepts and techniques*. Routledge.

- Asen, K., Stein, R., Stevens, A., McHugh, B., Greenwood, J., & Cooklin, A. (1982). A day unit for families. *Journal of Family Therapy*, 4(4), 345-358.
- Ashton, R., & Roberts, E. (2006). What is valuable and unique about the educational psychologist?. *Educational Psychology in Practice*, 22(02), 111-123.
- Barnett, R.C., & Hyde, J.S. (2001). Women, men, work, and family. *American Psychologist*, 56, 781-796
- Bateson, G. (1973) *Steps to an Ecology of Mind*. London and New York: Paladin.
- Beaver, R. (2011). *Educational Psychology Casework, (2nd Ed): A Practice Guide*. Jessica Kingsley Publishers
- Beck, J. W., & Schmidt, A. M. (2013). State-level goal orientations as mediators of the relationship between time pressure and performance: A longitudinal study. *Journal of Applied Psychology*, 98(2), 354–363.
- Becker, A., Hagenberg, N., Roessner, V., Woerner, W., & Rothenberger, A. (2004). Evaluation of the self-reported SDQ in a clinical setting: Do self-reports tell us more than ratings by adult informants?. *European child & adolescent psychiatry*, 13(2), ii17-ii24.
- Becker, A., Rothenberger, A., Sohn, A., Ravens-Sieberer, U., Klasen, F., & BELLA Study Group (2015). Six years ahead: a longitudinal analysis regarding course and predictive value of the Strengths and Difficulties Questionnaire (SDQ) in children and adolescents. *European child & adolescent psychiatry*, 24(6), 715-725.
- Becvar, D. S., & Becvar, R. J. (2013). *Family therapy: A systemic integration*. Pearson Education.
- Benowitz, M. L., & Busse, T. V. (1976). Effects of material incentives on classroom learning over a four-week period. *Journal of Educational Psychology*, 68(1), 57.
- Benson, A., O'Toole, S., Lambert, V., Gallagher, P., Shahwan, A., & Austin, J. K. (2016). The stigma experiences and perceptions of families living with epilepsy: Implications for epilepsy-related communication within and external to the family unit. *Patient education and counseling*, 99(9), 1473-1481.

- Bigras, M., Gosselin, C., Capuano, F., Normandeau, S., & Parent, S. (2008). A Comparison of Parent and Teacher Ratings of Child Behaviours: the Pygmalion Effect Revisited. <https://core.ac.uk/reader/9537850>
- Bjornstad, G., & Montgomery, P. (2005). Family therapy for attention-deficit disorder or attention-deficit/hyperactivity disorder in children and adolescents. *The Cochrane database of systematic reviews*, (2)
- Boos, M., Franiel, X., & Belz, M. (2015). Competition in human groups—Impact on group cohesion, perceived stress and outcome satisfaction. *Behavioural processes*, 120, 64-68.
- Bouchard, K. L., & Smith, J. D. (2017, January). Teacher–student relationship quality and children's bullying experiences with peers: Reflecting on the mesosystem. *The Educational Forum* (Vol. 81, No. 1, pp. 108-125). Routledge.
- Bowlby, J. (1951). *Maternal care and mental health*. Geneva: World Health Organisation.
- Bowlby, J. (1969). *Attachment and Loss. Vol. 1: Attachment*. Hogarth Press: London.
- Bowlby, J. (1973). *Attachment and Loss. Vol. 2: Separation, Anxiety and Anger*. Hogarth Press; London.
- Bowlby, J. (1979). *The making and breaking of affectional bonds*. London: Tavistock Publications.
- Bowlby, J. (1980). *Attachment and Loss. Vol. 3: Loss, Sadness and Depression*. Hogarth Press: London
- Bowlby, J. (1982). *Attachment and Loss: Vol. 1. Attachment (2nd Ed)*. New York: Basic.
- BPS (2014). *Code of Human Research Ethics*. [online] Available at: http://www.bps.org.uk/system/files/Public%20files/code_of_human_research_ethics_dec_2014_inf180_web.pdf
- Braun, V. & Clarke, V. (2006) Using Thematic Analysis in Psychology. *Qualitative Research in Psychology*, 3, 77-101.
- Bretherton, I. (1985). Attachment theory: retrospect and prospect. *Monographs for the Society for Research in Child Development*, 50, 3-35.

- Briggs-Gowan, M. J., Carter, A. S., & Schwab-Stone, M. (1996). Discrepancies among mother, child, and teacher reports: Examining the contributions of maternal depression and anxiety. *Journal of abnormal child psychology*, 24(6), 749-765.
- Brinkmann, S. (2014). Unstructured and semi-structured. *The Oxford handbook of qualitative research*, 277-299.
- Broderick, C. B., & Schrader, S. S. (1991). The history of professional marriage and family therapy. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of family therapy, Vol. 2* (p. 3–40).
- Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge: Harvard University Press.
- Bronfenbrenner, U. (1995). Developmental ecology through space and time: A future perspective. In P. Moen, G.H. Elder, Jr., & K. Lüscher (Eds.), *Examining lives in context: Perspectives on the ecology of human development* (pp. 619 – 647). Washington, DC: American Psychological Association.
- Bronfenbrenner, U. (2005). The bioecological theory of human development. In U. Bronfenbrenner (Ed.), *Making human beings human: Bioecological perspectives on human development* (pp. 3 15). Thousand Oaks, CA: Sage.
- Bronfenbrenner, U., & Neville, P. (1994). America's children and families: An international perspective. In S. L. Kagan & B. Weissbourd (Eds.), *Putting families first* (pp. 3-27). San Francisco: Jossey-Bass.
- Bruhn, A. L., McDaniel, S. C., Fernando, J., & Troughton, L. (2016). Goal-setting interventions for students with behavior problems: A systematic review. *Behavioral Disorders*, 41(2), 107-121.
- Burnham, S. (2013). Realists or pragmatists? "Reliable evidence" and the role of the educational psychologist. *Educational Psychology in Practice*, 29(1), 19-35.
- Byng-Hall, J. (1995). creating a secure family base: some implications of attachment theory for family therapy. *Family Process*, 34, 45–58.
- Byng-Hall, J. (1998). *Rewriting family scripts: Improvisation and systems change*. New York, NY: Guilford Press.

- Caldwell, C., Horne, A.M., Davidson, B. and Quinn, W.H. (2007). Effectiveness of a multiple family group intervention for juvenile first offenders in reducing parent stress. *Journal of Child and Family Studies*, 16(3), pp.443-459.
- Carlson, E.A., & Sroufe, L.A. (1993). Reliability in attachment classification. *Society for Research in Child Development Newsletter*, p. 12.
- Cohen, L., Manion, L. & Morrison, K. (2007) *Research Methods in Education: Sixth Edition*. Routledge, Oxford
- Colahan, M., & Robinson, P. H. (2002). Multi-family groups in the treatment of young adults with eating disorders. *Journal of Family Therapy*, 24(1), 17-30.
- Colapinto, J. (2019). Structural family therapy. *Encyclopedia of Couple and Family Therapy*, 2820-2828.
- Cook, J. M., Biyanova, T., Elhai, J., Schnurr, P. P., & Coyne, J. C. (2010). What do psychotherapists really do in practice? An Internet study of over 2,000 practitioners. *Psychotherapy: Theory, Research, Practice, Training*, 47(2), 260.
- Cook-Darzens, S., Gelin, Z. and Hendrick, S., (2018). Evidence base for Multiple Family Therapy (MFT) in non-psychiatric conditions and problems: a review (part 2). *Journal of Family Therapy*, 40(3), pp.326-343.
- Cording, J. (2011). *A study of Educational Psychologists' use of consultation and users' views on what a service should deliver*. Unpublished Doctoral Thesis
- Creswell, J.W. (2003) *Research Design: Qualitative, Quantitative and Mixed Methods Approaches (2nd Edition)*. London: Sage Publications.
- Creswell, J.W. & Plano Clark, V.L. (2011). *Designing and conducting mixed methods research (2nd Edition)* Thousand Oaks, CA: Sage.
- Crittenden, P.M. (1988). In J. Belsky & T. Nezworski (Eds.), *The clinical implications of attachment* (pp.136-174). Hillsdale, N.J.: Lawrence Erlbaum.
- Cytrynbaum, S., Ginath, Y., Birdwell, J., & Brandt, L. (1979). Goal Attainment Scaling. A critical review. *Evaluation Quarterly*, 3, 5–40.

- Daatland, S. O., Herlofson, K., & Lima, I. A. (2011). Balancing generations: on the strength and character of family norms in the West and East of Europe. *Ageing & Society*, 31(7), 1159-1179.
- Dallos, R., & Draper, R. (2010). *An introduction to family therapy: Systemic theory and practice*. McGraw-Hill Education (UK).
- Deci, E.L., Koestner, R. & Ryan, R.M. (2001). Extrinsic rewards and intrinsic motivation in education: Reconsidered once again. *Review of Educational Research*, 71(1): 1–28.
- Deci, E.L., & Ryan, R.M. (2000). The ‘what’ and ‘why’ of goal pursuits: human needs and the self-determination of behaviour. *Psychological Inquiry*, 11, 227-268.
- Department for Education (2015). *Revised Special Educational Needs and Disabilities Code of Practice*. London: DfE.
- Department for Education (2016) *Revised GCSE and equivalent results in England, 2014 to 2015*. London: DfE
- Department for Education (2019) *Permanent and fixed period exclusions in England: 2017 to 2018*. London: DfE.
- Department for Education (2019) *Timpson Review of School Exclusion*. London: DfE.
- Department for Education (2019) *School exclusion: a literature review on the continued disproportionate exclusion of certain children*. London. DfE
- Department for Education and Skills (2003) *Every Child Matters*. London, Stationery Office.
- Department of Health and Social Care and the Department of Education (2017). *Transforming Children and Young People’s Mental Health Provision: A Green Paper*. London. Department of Health and Social Care and the Department of Education
- Deuze, M. (2002). National news cultures: A comparison of Dutch, German, British, Australian, and US journalists. *Journalism & Mass Communication Quarterly*, 79(1), 134-149.
- Diamond, G.S, Wintersteen, M.B., Brown, G.K., Diamond, G.M., Gallop, R., Shelef, K., & Levy, S. (2010). Attachment-Based Family Therapy for Adolescents with Suicidal Ideation: A Randomized Controlled Trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, 49(2), 122-131.

- Dickerson, A., & Crase, S. (2005). Parent-Adolescent Relationships: The Influence of Multi-Family Therapy Group on Communication and Closeness. *The American Journal of Family Therapy, 33*(1), 45-59
- Dreher, A. U., & Sandler, J. (2013). *What do psychoanalysts want?: The problem of aims in psychoanalytic therapy*. Routledge.
- Dunsmuir, S., Brown, E., Iyadurai, S., & Monsen, J. (2009). Evidence-based practice and evaluation: from insight to impact. *Educational Psychology in Practice, 25*(1), 53-70.
- Dunsmuir, S., & Hardy, J. (2016). Delivering psychological therapies in schools & communities. *British Psychological Society. Handbook of adolescent psychology* Leicester: The British Psychological Society.
- Dunsmuir, S., Lang, J., & Leadbetter, J. (2015). Current trends in educational psychology supervision in the UK. *Educational and child Psychology, 32*(3), 8-21.
- Epstein, J. L. (2008). Improving family and community involvement in secondary schools. *The Education Digest, 73*(6), 9.
- Erskine, R. G. (2013). Relational group process: Developments in a transactional analysis model of group psychotherapy. *Transactional Analysis Journal, 43*, 262–275.
- Fadul, J. A. (2014). *Encyclopedia of theory & practice in psychotherapy & counseling*. Raleigh. Lulu Press.
- Fallon, K., Woods, K., & Rooney, S. (2010). A discussion of the developing role of educational psychologists within Children's Services. *Educational Psychology in Practice, 26* (1), 1-23.
- Fält, E., Wallby, T., Sarkadi, A., Salari, R., & Fabian, H. (2018). Agreement between mothers', fathers', and teachers' ratings of behavioural and emotional problems in 3–5-year-old children. *PloS one, 13*(11), e0206752.
- Farrell, P., Woods, K., Lewis, S., Rooney, S., Squires, G. & O'Connor, M. (2006). *A review of the functions and contribution of educational psychologists in England and Wales in light of "Every Child Matters: Change for Children"*, London: DfES Publications.
- Farrington, D. P., & Welsh, B. C. (2003). Family-based Prevention of Offending: A Meta-analysis. *Australian & New Zealand Journal of Criminology, 36*(2), 127- 151.

- Fonagy, P., Target, M., & Gergely, G. (2000) Attachment and borderline personality disorder: A theory and some evidence. *The Psychiatric Clinics of North America*, 23, 103-121.
- Fristad, M.A., Goldberg-Arnold, J.S., & Gavazzi, S.M. (2003). Multiple-family psychoeducation groups in the treatment of children with mood disorders. *Journal of Marital and Family Therapy*, 29(4), 491–504
- Gambrell, L. B. (1996). Creating classroom cultures that foster reading motivation. *Reading Teacher*, 50, 14-25.
- Garbarino, J. (1982). *Children and families in the social environment*. New York, NY: Aldine.
- Gelin, Z., Cook-Darzens, S., Simon, Y., & Hendrick, S. (2016). Two models of multiple family therapy in the treatment of adolescent anorexia nervosa: a systematic review. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity*, 21(1), 19-30.
- Gill, K., Quilter-Pinner, H., & Swift, D. (2017). *Making the difference: Breaking the link between school exclusion and social exclusion*. Institute for Public Policy Research.
- Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry*, 38, 581-586.
- Goodman, R., & Scott, S. (1999). Comparing the Strengths and Difficulties Questionnaire and the Child Behavior Checklist: is small beautiful? *Journal of abnormal child psychology*, 27(1), 17-24.
- Gopalan, G., Chacko, A., Franco, L., Dean-Assael, K. M., Rotko, L. E., Marcus, S. M., & McKay, M. M. (2015). Multiple family groups for children with disruptive behavior disorders: child outcomes at 6-month follow-up. *Journal of child and family studies*, 24(9), 2721-2733.
- Grawitch, M. J., Barber, L. K., & Justice, L. (2010). Rethinking the work–life interface: It's not about balance, it's about resource allocation. *Applied Psychology: Health and Well-Being*, 2(2), 127-159.
- Greenbaum, T. (2003). The gold standard? Why the focus group deserves to be the most respected of all qualitative research tools. *Quirk's Marketing Research Review*, 17, 22–27.
- Greene, J. C., Caracelli, V. J., & Graham, W. F. (1989). Toward a conceptual framework for mixed method evaluation designs. *Educational Evaluation and Policy Analysis*, 11, 255–274.

- Greene, J C., Kreider, H., Mayer, E. (2005). Combining qualitative and quantitative methods in social inquiry. In Somekh, B and Lewin, C (eds). *Research methods in the social sciences*. London. Sage
- Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). Thousand Oaks, CA: Sage.
- Guest, G., Namey, E., & McKenna, K. (2017). How many focus groups are enough? Building an evidence base for nonprobability sample sizes. *Field methods*, 29(1), 3-22.
- Guest, G., Namey, E., Taylor, J., Eley, N., & McKenna, K. (2017). Comparing focus groups and individual interviews: findings from a randomized study. *International Journal of Social Research Methodology*, 20(6), 693-708.
- Guttman, H.A. (1991). Systems theory, cybernetics, and epistemology. *Handbook of family therapy*, 2, 41-62.
- Hargaden, H. (2013). Building resilience: The role of firm boundaries and the third in relational group therapy. *Transactional Analysis Journal*, 43(4), 284-290.
- Harnett, P. H., & Dadds, M. R. (2004). Training school personnel to implement a universal school based prevention of depression program under real-world conditions. *Journal of School Psychology*, 42, 343-357.
- Harris, L.R., & Brown, G.T. (2010). Mixing interview and questionnaire methods: Practical problems in aligning data. *Practical Assessment, Research, and Evaluation*, 15(1), 1.
- Harvey, L. (2015). Beyond member-checking: A dialogic approach to the research interview. *International Journal of Research & Method in Education*, 38(1), 23-38.
- Health and Care Professions Council. (2015). *Standards of proficiency: Practitioner psychologists*. London. HCPC.
- Heatherington, L., Friedlander, M. L., & Greenberg, L. (2005). Change process research in couple and family therapy: methodological challenges and opportunities. *Journal of Family Psychology*, 19(1), 18.

- Hellemans, S., De Mol, J., Buysse, A., Eisler, I., Demyttenaere, K., & Lemmens, G.M.D. (2011). Therapeutic processes in multi-family groups for major depression: Results of an interpretative phenomenological study. *Journal of Affective Disorders, 134*(1-3), 226-234
- HM Treasury and Department for Education and Skills (2007) *Aiming High for Children: Supporting Families*. The Stationery Office, London
- Holloway, I., & Todres, L. (2003). The status of method: Flexibility, consistency and coherence. *Qualitative Research, 3*, 345–357.
- Howe, D. (2010). The safety of children and the parent-worker relationship in cases of child abuse and neglect. *Child Abuse Review, 19*(5), 330-341.
- Howitt, D., & Cramer, D. (2007). *Introduction to Research Methods in Psychology*. Pearson Education.
- Huey Jr, S.J., Henggeler, S.W., Brondino, M.J., & Pickrel, S.G. (2000). Mechanisms of change in multisystemic therapy: reducing delinquent behavior through therapist adherence and improved family and peer functioning. *Journal of consulting and clinical psychology, 68*(3), 451.
- Johnson, R.B. & Christensen, I.B. (2004). *Educational Research: Quantitative, Qualitative and Mixed Approaches*. Boston, MA: Allyn and Bacon.
- Johnson, R.B., & Onwuegbuzie, A.J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher, 33* (7), 14– 26.
- Kafka, R.R. & London, P. (1991). Communication in relationships and adolescent substance use: The influence of parents and friends. *Adolescence, 26*(103): 587–598.
- Kaufman, E. & Kaufman, P. (1979) Multiple family therapy with drug abusers. In E. Kaufman and P. Kaufman (eds) *Family Therapy of Drug and Alcohol Abuse*. New York: Gardner.
- Keiley, M. K., Zaremba-Morgan, A., Datubo-Brown, C., Pyle, R., & Cox, M. (2015). Multiple-family group intervention for incarcerated male adolescents who sexually offend and their families: Change in maladaptive emotion regulation predicts adaptive change in adolescent behaviors. *Journal of marital and family therapy, 41*(3), 324-339.
- Kelly, D., & Gray, C. (2000). *Educational psychology services (England): current role, good practice and future directions: the research report*.

- Kerr, Michael E. (2000). "One Family's Story: A Primer on Bowen Theory." The Bowen Center for the Study of the Family. <http://www.thebowncenter.org>.
- Kidd, P. & Parshall, M. (2000). Getting the focus and the group: Enhancing analytical rigor in focus group research. *Qualitative Health Research*, 10, 293–308.
- King, N. & Horrocks C. (2010) *Interviews in qualitative research*. London: Sage.
- Kiresuk, T.J., & Sherman, R.E. (1968). Goal Attainment Scaling: A general method for evaluating community mental health programs. *Community Mental Health Journal*, 4, 443–453.
- Kirby, P. (2001). Participatory research in schools. *Forum*, 43, 74-77
- Kobak, R. R., & Sceery, A. (1988). Attachment in late adolescence: Working models, affect regulation, and representation of self and others. *Child Development*, 59(1), 135–146.
- Korner, S., & Brown, G. (1990). Exclusion of children from family psychotherapy: Family therapists' beliefs and practices. *Journal of Family Psychology*, 3,420-430.
- Kratochwill, T. R., McDonald, L., Levin, J. R., Bear-Tibbetts, H. Y., & Demaray, M. K. (2004). Families and schools together: An experimental analysis of a parent-mediated multi-family group program for American Indian children. *Journal of School Psychology*, 42(5), 359-383.
- Kratochwill, T. R., McDonald, L., Levin, J. R., Scalia, P. A., & Coover, G. (2009). Families and schools together: An experimental study of multi-family support groups for children at risk. *Journal of school Psychology*, 47(4), 245-265.
- Kreuger, R.A. (1994) *Focus Groups: A Practical Guide for Applied Research*. California: Sage.
- Kurtz-Costes, B. (2015). Families as educational settings. In J. D. Wright (Ed.), *International encyclopedia of the social and behavioral sciences: Education* (2nd ed., Vol. 8, pp. 731-737). Oxford: Elsevier.
- Laqueur, H.P., LaBurt, H.A., & Morong, E. (1964). Multiple Family Therapy. *Current Psychiatric Therapies*, 4, 150.
- Law, J., & Martin E.A (2020) *The Oxford concise medical dictionary* (Ed. 10). Oxford: Oxford University Press.

- Lemmens, G., Eisler, I., Heireman, M., Houdenove, B. and Sabbe, B. (2005) Family discussion groups for patients with chronic pain: a pilot study. *Australian and New Zealand Journal of Family Therapy*, 26: 21– 32.
- Lemmens, G. M., Eisler, I., Dierick, P., Lietaer, G., & Demyttenaere, K. (2009). Therapeutic factors in a systemic multi-family group treatment for major depression: patients' and partners' perspectives. *Journal of Family Therapy*, 31(3), 250-269.
- Levenstein, P., & O'Hara, J. (1993). The necessary lightness of mother-child play. *Parents and children playing*, 221-237.
- Lilley, L., David, M. and Hinson, P. (2007) Implementing inter-professional supervision within a hospice setting. *Cancer Nursing Practice*, 6: 25-28
- Liu, Q.X., Fang, X.Y., Yan, N., Zhou, Z.K., Yuan, X.J., Lan, J., & Liu, C.Y. (2015). Multi-family group therapy for adolescent Internet addiction: Exploring the underlying mechanisms. *Addictive Behaviors*, 42, 1-8.
- Lofland, J. & L. H. Lofland (1995). *Analyzing Social Settings: a guide to qualitative observation and analysis*. Belmont, CA, Wadsworth Publishing Company.
- Lyonette, C., Atfield, G., Baldauf, B., & Owen, D. (2019). *Research on the educational psychologist workforce: research report, March 2019*. London. BPS
- Lyons-Ruth, K., & Jacobvitz, D. (1999). Attachment disorganization: Unresolved loss, relational violence, lapses in behavioural and attentional strategies. In J. Cassidy and P. R. Shaver (Eds.), *Handbook of Attachment: Theory, research and clinical applications* (pp. 520-544). New York: Guilford Press.
- Marinak, B.A., & Gambrell, L.B. (2008). Intrinsic motivation and rewards: What sustains young children's engagement with text?. *Literacy Research and Instruction*, 47(1), 9-26.
- Marta, E. (1997). Parent-adolescent interactions and psychosocial risk in adolescents: An analysis of communication, support and gender. *The Association for Professionals in Services for Adolescents*, 20(5): 473–487.
- Marzola, E., Knatz, S., Murray, S.B., Rockwell, R., Boutelle, K., Eisler, I., & Kaye, W.H. (2015). Short-term intensive family therapy for adolescent eating disorders: 30-month outcome. *European Eating Disorders Review*, 23(3), 210-218.

- Mental Research Institute (MRI). (2008) Family therapy pioneers: A directory: Gregory Bateson. *Family Therapy Magazine*, 7(5).
- Meezan, W., & O'Keefe, M. (1998). Multifamily group therapy: Impact on family functioning and child behavior. *Families in Society*, 79(1), 32-44.
- McDonald, L.D., Moberg, P., Brown, R., Rodriguez-Espiricueta, I., Flores, N.I., Burke, M.P. & Coover, G. (2006) After-school multifamily groups: a randomized controlled trial involving low-income, urban, Latino children. *Children & Schools*, 28: 25– 34.
- McFarlane, W.R., (1983). Multiple family therapy in schizophrenia (pp. 141–172). In W.R. McFarlane (ed.), *Family therapy in schizophrenia*. New York: Guilford Press
- Minuchin, S. (1972). Structural family therapy. In G. Caplan (Ed.), *American handbook of psychiatry (Vol. 2)*. New York: Basic Books.
- Morgan, D.L. (1998). *The focus group guidebook*. Sage: London.
- Morgan, D.L. (2007). Paradigms Lost and Pragmatism Regained: Methodological Implications of Combining Qualitative and Quantitative Methods. *Journal of Mixed Methods Research*, Vol. 1, No. 1, 48-76
- Morris, E., Le Huray, C., Skagerberg, E., Gomes, R. and Ninteman, A., (2014). Families changing families: The protective function of multi-family therapy for children in education. *Clinical child psychology and psychiatry*, 19(4), pp.617-632.
- Nemerow, L. G. (1996). Do Classroom Games Improve Motivation and Learning?. *Teaching and Change*, 3(4), 356-66.
- NHS (2015) *City and Hackney CAMHS Transformation Plan, Phase One*. NHS. London
- NHS (2016) *City and Hackney CAMHS Transformation Plan, Phase Two (2016 /17 Refresh)*. NHS. London
- Nicholls, J. (1984). Achievement motivation: Conceptions of ability, subjective experience, task choice, and performance. *Psychological Review*, 91, 328-346.
- Nichols, M.P. & Schwartz, R.C. (2012). *Family therapy: Concepts and methods (10th ed.)*. Boston, MA: Pearson Education.

- Nolan, A., & Moreland, N. (2014). The process of psychological consultation. *Educational Psychology in Practice*, 30(1), 63-77.
- Nowell, L.S., Norris, J.M., White, D.E., & Moules, N.J. (2017). Thematic analysis: striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, 16, 1.
- Office for National Statistics (ONS). (2016). *Population estimates for UK, England and Wales, Scotland and Northern Ireland*. London: ONS.
- Ofsted (2017) *Inspection report: The Family School London, 21–22 June 2017*. Ofsted, Manchester
- Patrick, B.C., Hisley, J., & Kempler, T. (2000). "What's everybody so excited about?": The effects of teacher enthusiasm on student intrinsic motivation and vitality. *The Journal of Experimental Education*, 68(3), 217-236.
- Patterson, G.R., & Forgatch, M.S. (1985). Therapist behavior as a determinant for client noncompliance: A paradox for the behavior modifier. *Journal of consulting and clinical psychology*, 53(6), 846.
- Petrik, A.M., & Cronin, T.J. (2014). Defining and measuring mechanisms of change in psychological therapies: The path not taken. *Australian Psychologist*, 49(5), 283-286.
- Pitchforth, J., Fahy, K., Ford, T., Wolpert, M., Viner, R.M., & Hargreaves, D.S. (2019). Mental health and well-being trends among children and young people in the UK, 1995–2014: analysis of repeated cross-sectional national health surveys. *Psychological medicine*, 49(8), 1275-1285.
- Richters, J.E., & Waters, E. (1992). Attachment and socialization: The positive side of social influence. In M. Lewis & S. Feinman (Eds.), *Social Influences and Behavior* (pp. 185-214). New York: Plenum.
- Rigter, H., Henderson, C., Pelc, I., Tossmann, P., Phan, O., Hendriks, V., Schaub, M., & Rowe, C. (2013). Multidimensional family therapy lowers the rate of cannabis dependence in adolescents: A randomised controlled trial in Western European outpatient settings. *Drug and Alcohol Dependence*, 130(1-3), 85-93.
- Robbins, M.S., Feaster, D.J., Horigian, V.E., Rohrbaugh, M., Shoham, V., Bachrach, K., Miller, M., Burlew, K.A., Hodgkins, C., Carrion, I. & Vandermark, N. (2011). Brief strategic family therapy versus treatment as usual: Results of a multisite randomized trial for substance using adolescents. *Journal of consulting and clinical psychology*, 79(6), 713.

- Robson, C. (2011). *Real World Research (3rd Edition)*. West Sussex: Wiley & Sons
- Rosenthal, R., & Jacobson, L. (2003) *Pygmalion in the classroom (2nd Ed.)* New York: Crown House
- Rosnow, R.L., Rosenthal, R. (1997). *People studying people: Artifacts and ethics in behavioural research*. New York, NY: WH Freeman.
- Rovers, M. (2004) Family of Origin Theory, Attachment Theory and the Genogram. *Journal of Couple & Relationship Therapy*, 3(4), 43-63
- Saayman, R.V., Saayman, G.S., & Wiens, S.M. (2006). Training staff in multiple family therapy in a children's psychiatric hospital: from theory to practice. *Journal of Family Therapy*, 28(4), 404-419.
- Salaminiou, E., Campbell, M., Simic, M., Kuipers, E. and Eisler, I., (2017). Intensive multi-family therapy for adolescent anorexia nervosa: an open study of 30 families. *Journal of Family Therapy*, 39(4), pp.498-513.
- Shaw, B.F., Elkin, I., Yamaguchi, J., Olmsted, M., Vallis, T.M., Dobson, K.S., Lowery, A., Sotsky, S. M., Watkins, J.T., & Imber, S.D. (1999). Therapist competence ratings in relation to clinical outcome in cognitive therapy of depression. *Journal of Consulting and Clinical Psychology*, 67(6), 837.
- Shpigel, M.S., Diamond, G.M., & Diamond, G.S. (2012). Changes in Parenting Behaviors, Attachment, Depressive Symptoms, And Suicidal Ideation In Attachment-Based Family Therapy For Depressive And Suicidal Adolescents. *Journal of Marital and Family Therapy*, 38, 271-83. doi:<http://dx.doi.org.libproxy.ucl.ac.uk/10.1111/j.1752-0606.2012.00295.x>
- Simmons, B. S. (2010). *Family Therapy Legacies and the Patterns that Connect: Transcending the Modern/postmodern Dichotomy in Family Therapy*. PhD Dissertation. University of Louisiana at Monroe.
- Smith, L., Jackson, L., & Comber, N. (2013). *Therapeutic early interventions to prevent school exclusion and truancy: Evaluation of three contemporaneous projects*. London. Office for Public Management.

- Snyder, M., & Stukas, A.A., Jr. (1999). Interpersonal processes: The interplay of cognitive, motivational, and behavioral activities in social interaction. *Annual Review of Psychology*, 50, 273.
- Stone, L.L., Otten, R., Engels, R.C.M.E., Vermulst, A.A., & Janssens, J. (2010). Psychometric properties of the parent and teacher versions of the Strengths and Difficulties Questionnaire for 4- to 12-year-olds: A review. *Clinical Child and Family Psychology Review*, 13(3), 254– 274.
- Stone, S., Speltz, M., Collett, B., & Werler, M. (2013). Socioeconomic factors in relation to discrepancy in parent versus teacher ratings of child behavior. *Journal of Psychopathology and Behavioral Assessment*, 35(3), 314– 320.
- Stoolmiller, M., Duncan, T., Bank, L., & Patterson, G.R. (1993). Some problems and solutions in the study of change: Significant patterns in client resistance. *Journal of Consulting and Clinical Psychology*, 61(6), 920.
- Sugar, M. (1991). Planning group therapy for children. *Journal of Child and Adolescent Group Therapy*, 1(1), 5-14.
- Sullivan, H.S. (1938). Psychiatry: Introduction to the study of interpersonal relations: The data of psychiatry. *Psychiatry*, 1, 121-134.
- Swick, K.J., & Williams, R.D. (2006). An analysis of Bronfenbrenner's bio-ecological perspective for early childhood educators: Implications for working with families experiencing stress. *Early childhood education journal*, 33(5), 371-378.
- Szapocznik, J., & Prado, G. (2007). Negative effects on family functioning from psychosocial treatments: A recommendation for expanded safety monitoring. *Journal of Family Psychology*, 21(3), 468.
- Tang, N., & Cousins, C. (2005). Working time, gender and family: an East-West European comparison. *Gender, Work & Organization*, 12(6), 527-550.
- Tarrier, N., Sommerfield, C., Pilgrim, H., & Faragher, B. (2000). Factors associated with outcome of cognitive-behavioural treatment of chronic post-traumatic stress disorder. *Behaviour research and therapy*, 38(2), 191-202.
- Tobias, A. (2018) The use of genograms in educational psychology practice. *Educational Psychology in Practice*, 34:1, 89-104

- Treadwell, K.R., & Kendall, P.C. (1996). Self-talk in youth with anxiety disorders: States of mind, content specificity, and treatment outcome. *Journal of consulting and clinical psychology, 64*(5), 941.
- Turner, S., Randall, L., & Mohammed, A. (2010). Doing an effective job? Measuring the impact of casework. *Educational Psychology in Practice, 26*(4), 313-329.
- Van Roy, B., Veenstra, M., & Clench-Aas, J. (2008). Construct validity of the five-factor Strengths and Difficulties Questionnaire (SDQ) in pre-, early, and late adolescence. *Journal of Child Psychology and Psychiatry, 49*(12), 1304-1312.
- Varghese, M., Kirpekar, V., & Loganathan, S. (2020). Family Interventions: Basic Principles and Techniques. *Indian Journal of Psychiatry, 62* (Suppl 2), 192.
- Voriadaki, T., Simic, M., Espie, J., & Eisler, I. (2015). Intensive multi-family therapy for adolescent anorexia nervosa: Adolescents' and Parents' Day-to-day experiences. *Journal of Family Therapy, 37*(1), 5-23.
- Weber, M. (1949). *The Methodology of the Social Sciences*. The Free Press: Illinois
- Williams, L.A., & DeSteno, D. (2008). Pride and perseverance: The motivational role of pride. *Journal of Personality and Social Psychology, 94*(6), 1007–1017.
- Willig, C. (2001). *Qualitative Research In Psychology: A Practical Guide to Theory and Method*. Buckingham: OUP
- Zabriskie, R.B., Aslan, N., & Williamson, M. (2018). Turkish family life: A study of family leisure, family functioning, and family satisfaction. *Journal of Leisure Research, 49*(1), 8-27.
- Zauberman, G., & Lynch, J.G. (2005). Resource slack and propensity to discount delayed investments of time and money. *Journal of Experimental Psychology: General, 134*, 23–37

Appendices

Appendix 1: MFGT Flyer

Multi-Family Groups in Schools

Developing partnerships between families and schools



WHAT IS FAMILY GROUP?

The aim of Multi-Family Groups is to work with families and school partners to:

- Give children at risk of exclusion access to psychological help that challenges and reduces problematic behaviour
- Develop the child's social and emotional skills
- Enable parents to improve their relationships with their child and the school
- Develop mini communities capable of sustaining improvement
- Raise children's achievement

KEY SKILLS WE WILL FOCUS ON

Interpersonal skills:

- Classroom behaviour
- Relationships
- Communication

Self Regulation:

- Focus
- Concentration
- Attention

These key skills are tracked through the children's individual targets. The targets are set before family group starts and are monitored every week during the group.

RATIONALE

'Evidence shows that if parents can be supported to better manage their children's behaviour, alongside work being carried out with the child at school, there is a much greater likelihood of success in reducing the child's problems, and in supporting their academic and emotional development' (P21, Mental health and behaviour in schools - Departmental advice for school staff, DFE 2014).

The Multi-Family Groups in school model provides an evidenced approach to addressing underlying factors that influence behaviour by focusing on wellbeing and mental health within the context of family and

WHO WILL BE PART OF FAMILY GROUP?

- Between 6-10 families from the same school
- Children who cause concern at school for either behaviour, learning or low self esteem may be targeted.

WHAT PROGRESS MIGHT WE SEE IN THE CHILDREN AND FAMILIES?

- Improved academic attainment
- Improved attendance
- Reduction in incidents of negative behaviour in schools leading to reduction in the risk of exclusion
- Improved parenting competencies e.g. clear boundaries and communications
- Improved relationships and communication between home and school
- Increase in school staff reported competence and confidence in promoting positive behaviour.

WHAT DO THE SCHOOL NEED TO PROVIDE?

In order to run the group successfully and get the best value for money, the school will need to provide:

- A consistent **senior** member of staff to be available to run the group alongside an Educational Psychologist. This is one of the most important aspects of Family Group. A senior member of staff being involved means that the whole school are aware of the intervention. It also helps to ensure that parents stay engaged. This member of staff is called the School Based Partner (SBP);
- An appropriate room or space for Family Group to take place every week. Very often schools have an allocated 'Community' or 'Parents' room which is an ideal space for Family Group;
- Allocated time before The Family Group intervention begins to set individual targets for the child with the class teacher, School Based Partner, family, Educational Psychologist and Child;
- Time for the School Based Partner to check in on the children in the week and ensure the targets are being tracked through the week;
- Tea, coffee and biscuits to make the parents feel welcome!

WHAT MIGHT A SESSION LOOK LIKE?

Warm up	10 min
Target review	20 min
Activity	45 min
Coffee for parents (break for children)	15 min
Reflection time	20 min
Game	25min
Session ends	

TME Example

Re: Child A

1. Child A will improve their focus on learning activities									
1	2	3	4	5 B	6	7	8 P	9	10
2. Child A will speak in longer sentences using a connective									
1	2	3	4 B	5	6	7 P	8	9	10
3. Child A will use their sound chart when spelling words									
1	2	3	4 B	5	6	7 P	8	9	10

B = Baseline (before the intervention)

P = Progress (after the MFGT intervention)

Strengths and Difficulties Questionnaire

T 4-17

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months or this school year.

Child's Name

Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children (treats, toys, pencils etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often has temper tantrums or hot tempers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, tends to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally obedient, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries, often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Multi-Family Group Therapy in Schools: Effectiveness, Processes and Challenges
September 2018 – May 2020

Information sheet for families involved in the group

My name is Penny Whittles and I am inviting you to take in part in my research project, 'Multi-Family Group Therapy in primary schools: effectiveness, processes and challenges. I am a Trainee Educational Psychologist and I am conducting this research as part of the professional doctorate, which is required in order to become a qualified Educational Psychologist. I am hoping to find out more about the use of Multi Family Groups in a school setting and to measure the outcomes of this intervention.

This information sheet will try and answer any questions you might have about the project, but please don't hesitate to contact me if there is anything else you would like to know. Please explain the research to your child and discuss whether or not they want to take part.

Who is carrying out the research?

Penny Whittles, with supervision from Dr Katie Quy and Dr Frances Lee

Why are we doing this research?

This research aims to answer the following research questions:

1. Does being part of multi-family group lead to positive outcomes?
2. How do Multi-Family groups bring about change?
3. What factors contribute to the multi-family group being successful?
4. What factors act as barriers to multi-family group being successful?

Why am I being invited to take part?

You have been invited to take part as your family is part of a Multi Family Group (MFG) within a school. Filing in questionnaires will help to evaluate the success of the intervention and to find out whether the intervention would benefit other children and families.

What will happen if I choose to take part?

If you choose to take part, you would agree to the questionnaire and target monitoring and evaluation (TME) data being shared with the researcher. The questionnaire data comes from the 'Strengths and Difficulties Questionnaire' (SDQ) which was completed at the beginning and end of the MFG programme. The TME data will be taken from the targets that are set and evaluated in each session.

When I receive the data, I will anonymise the personal data you provide e.g. remove name and anything else that could identify you before analysing it and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

Contact for further information

If you have any further questions before you decide whether to take part, you can reach me at



Institute of Education

Multi-Family Group Therapy in Schools: Effectiveness, Processes and Challenges
Consent for Data Collection: Group Members

(tick as appropriate)

- I confirm that I have read and understood this information sheet, and have had the opportunity to consider the information, ask questions, and have had these questions adequately answered.
- I agree to the data from the questionnaires and target monitoring and evaluation (TME) being shared with the researcher for the purposes of this research.
- I understand that my family's involvement in this research is voluntary and that I can opt-out at any time.
- I understand that the data will remain anonymous and confidential.

Name:.....

Signature: Date:

Multi-Family Group Therapy in Schools: Effectiveness, Processes and Challenges

September 2018 – May 2020

Information sheet for the focus group

My name is Penny Whittles and I'm training to be an Educational Psychologist. I am inviting you to take in part in my research project.

I am hoping to find out whether Multi-Family Groups is something that helps children and their families.



I very much hope that you would like to take part. This information sheet will try and answer any questions you might have about the research. If there is anything that you don't understand, you could ask your parents to contact me.

Who is carrying out the research?

Penny Whittles, with supervision from Dr Katie Quy and Dr Frances Lee

Why are we doing this research?

1. We would like to find out if taking part in the group makes things better



HOW?

2. If the being in the group makes things better, then we would like to know how that happens

3. We would also like to know what helps the groups to run smoothly and what changes could be made to make them better



Why am I being invited to take part?

You have been asked to take part because you have been a member of the group and will know all about how it went.

What will happen if I choose to take part?



If you choose to take part, you would meet with Penny and all of the other members of the group at your school. She will ask everyone questions about the group that you were in. This will last for about an hour.



Everything that you say will be confidential, which means that no one will be able to find out about who said what. The information that you share will be used to get a better understanding about the views of children who are part of a multi-family group.

If you have any worries about this, then you can talk to your parents or the member of staff that was in the group.

Contact for further information






If you have any further questions before you decide whether to take part, you can ask your parents or the member of staff in the school to contact me at



Institute of Education

Multi-Family Group Therapy in schools: effectiveness, processes and challenges

Focus Group Consent: Children

	(tick as appropriate)
 <p>I have read the information sheet and I have had chance to speak to an adult if I was unsure about anything.</p>	<input type="checkbox"/>
 <p>I know that I only have to take part in this research if I want to and that I can change my mind at anytime</p>	<input type="checkbox"/>
 <p>I know that I can refuse to answer any or all of the questions and that I can leave the focus group any time.</p>	<input type="checkbox"/>
 <p>I understand that what I say will be kept private and cannot be identified to me, unless what I say puts myself or someone else at risk/in danger.</p>	<input type="checkbox"/>
 <p>I agree for the focus group to be recorded and that the recording will be deleted at the end of the research.</p>	<input type="checkbox"/>
<p>The next part of the research to speak to members of the group by themselves. If you would like to talk to the researcher, by yourself, about the group then please circle yes. The researcher will then contact the school to arrange a time to meet with you. If you don't want to do this, circle no.</p> <p style="text-align: right;">Yes/No</p> <p>Name:</p> <p>Signature: Date:</p>	



Multi-Family Group Therapy in Schools: Effectiveness, Processes and Challenges
September 2018 – May 2020

Information sheet for focus groups

My name is Penny Whittles and I am inviting you to take part in my research project, 'Multi-Family Group Therapy in primary schools: effectiveness, processes and challenges. I am a Trainee Educational Psychologist and I am conducting this research as part of the professional doctorate, which is required in order to become a qualified Educational Psychologist.

I am hoping to find out more about the use of Multi Family Groups in a school setting and to measure the outcomes of this intervention.

I very much hope that you would like to take part. This information sheet will try and answer any questions you might have about the project, but please don't hesitate to contact me if there is anything else you would like to know.

Please explain the research to your child and discuss whether or not they want to take part.

Who is carrying out the research?

Penny Whittles, with supervision from Dr Katie Quy and Dr Frances Lee

Why are we doing this research?

This research aims to answer the following research questions:

1. Does being part of multi-family group lead to positive outcomes?
2. How do Multi-Family groups bring about change?
3. What factors contribute to the multi-family group being successful?
4. What factors act as barriers to multi-family group being successful?

Why am I being invited to take part?

You have been invited to take part as you attended a Multi Family Group (MFG) within school.

Taking part in a focus group will allow the researchers to find out in-depth information about MFGs.

What will happen if I choose to take part?

If you choose to take part, you will meet with the researcher and the other members of your multi-family group. You will collectively be asked questions about your experiences of being part of the group. These answers should be your honest opinion and the focus group will last for no more than 1 hour.

We will anonymise the personal data you provide and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

Contact for further information

If you have any further questions before you decide whether to take part, you can reach me at



Institute of Education

Multi-Family Group Therapy in schools: effectiveness, processes and challenges

Consent for Focus Group: Group Members

(tick as appropriate)

I confirm that I have read and understood this information sheet, and have had the opportunity to consider the information, ask questions, and have had these questions adequately answered.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

I know that I can refuse to answer any or all of the questions and that I can withdraw from the focus group at any point.

I agree for the focus group to be recorded, and that recordings will be kept secure and destroyed at the end of the project. I know that all data will be kept under the terms of the General Data Protection Regulation (GDPR).

I agree that small direct quotes may be used in reports (these will be anonymised).

I understand that the safeguarding procedures and protocols will be followed, should any concerns be raised in relation to this area.

Name:.....

Signature: Date:

Multi-Family Group Therapy in Schools: Effectiveness, Processes and Challenges

September 2018 – May 2020

Information sheet for EPs

My name is Penny Whittles and I am inviting you to take in part in my research project, 'Multi-Family Group Therapy in primary schools: effectiveness, processes and barriers. I am a Trainee Educational Psychologist and I am conducting this research as part of the professional doctorate, which is required in order to become a qualified Educational Psychologist.

I am hoping to find out about the use of Multi Family Groups (MFGs) in a school setting and to measure the outcomes of this intervention.

This information sheet will try and answer any questions you might have about the project, but please don't hesitate to contact me if there is anything else you would like to know.

Please explain the research to your child and discuss whether or not they want to take part.

Who is carrying out the research?

Penny Whittles, with supervision from Katie Quy and Frances Lee

Why are we doing this research?

This research aims to answer the following research questions:

1. Does being part of multi-family group lead to positive outcomes?
2. How do Multi-Family groups bring about change?
3. What factors contribute to the multi-family group being successful?
4. What factors act as barriers to multi-family group being successful?

Why am I being invited to take part?

You have been invited to take part as you were running MFGs in schools. This unique insight will provide researchers with valuable information. Taking part in a focus group will allow the researchers to find out in-depth information about MFGs.

What will happen if I choose to take part?

If you choose to take part, you would meet with Penny and the other EP facilitators at a time and place that is convenient for you. You will be asked questions about your experiences of running the group. The focus group should last no more than one hour.

We will anonymise the personal data you provide and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

Contact for further information

If you have any further questions before you decide whether to take part, you can reach me at



Institute of Education

Multi-Family Group Therapy in Schools: Effectiveness, Processes and Challenges
Consent for focus group: Educational Psychologists

(tick as appropriate)

- I confirm that I have read and understood this information sheet, and have had the opportunity to consider the information, ask questions, and have had these questions adequately answered.
- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.
- I know that I can refuse to answer any or all of the questions and that I can withdraw from the interview at any point.
- I agree for the interview to be recorded, and that recordings will be kept secure and destroyed at the end of the project. I know that all data will be kept under the terms of the General Data Protection Regulation (GDPR).
- I agree that small direct quotes may be used in reports (these will be anonymised).
- I understand that the safeguarding procedures and protocols will be followed, in accordance to both my professional body and organisational role, should any concerns be raised in relation to this area.

Name:.....

Signature: Date:

Multi-Family Group Therapy in Schools: Effectiveness, Processes and Challenges

September 2018 – May 2020

Information sheet for interviewing members/SBP of the MFG

My name is Penny Whittles and I am inviting you to take in part in my research project, 'Multi-Family Group Therapy in primary schools: effectiveness, processes and barriers. I am a Trainee Educational Psychologist and I am conducting this research as part of the professional doctorate, which is required in order to become a qualified Educational Psychologist.

I am hoping to find out more about the use of Multi Family Groups in a school setting and to measure the outcomes of this intervention.

I very much hope that you would like to take part. This information sheet will try and answer any questions you might have about the project, but please don't hesitate to contact me if there is anything else you would like to know.

Please explain the research to your child and discuss whether or not they want to take part.

Who is carrying out the research?

Penny Whittles, with supervision from Katie Quy and Frances Lee

Why are we doing this research?

This research aims to answer the following research questions:

1. Does being part of multi-family group lead to positive outcomes?
2. How do Multi-Family groups bring about change?
3. What factors contribute to the multi-family group being successful?
4. What factors act as barriers to multi-family group being successful?

Why am I being invited to take part?

You have been invited to take part as you attended a Multi Family Group (MFG) within school.

Taking part in an interview will allow the researchers to find out in-depth information about MFGs.

What will happen if I choose to take part?

If you choose to take part, you would meet with Penny at a time and place that is convenient for you. You will be asked questions about your experiences of being part of the group. These answers should be your honest opinion and the interview will last for no more than 45 minutes.

We will anonymise the personal data you provide and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

Contact for further information

If you have any further questions before you decide whether to take part, you can reach me at



Institute of Education

Multi-Family Group Therapy in Schools: Effectiveness, Processes and Challenges

Consent for Interviews: Group Members/SBP

(tick as appropriate)

I confirm that I have read and understood this information sheet, and have had the opportunity to consider the information, ask questions, and have had these questions adequately answered.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

I know that I can refuse to answer any or all of the questions and that I can withdraw from the interview at any point.

I agree for the interview to be recorded, and that recordings will be kept secure and destroyed at the end of the project. I know that all data will be kept under the terms of the General Data Protection Regulation (GDPR).

I agree that small direct quotes may be used in reports (these will be anonymised).

I understand that the safeguarding procedures and protocols will be followed, should any concerns be raised in relation to this area.

Name:.....

Signature: Date:

Appendix 14: Interview schedule for focus groups

Focus Groups

Krueger (2002) recommends the following structure for introducing the group discussion which includes:

(1) Welcome, (2) Overview of the topic (3) Ground rules and (4) First activity. Here is an example of a typical introduction:

Good afternoon and welcome to our session. Thanks for taking the time to join us to talk about multi-family groups. My name is Penny and I'm from UCL and I'm interested to find out about what you liked about MFGT, what you didn't like, and how the programme could be improved. I'm having similar discussion groups with parents who have been part of MFG in other schools in Hackney

You were invited because you have participated in MFGT, so you're familiar with the programme and what was involved.

There are no wrong answers but rather differing points of view. Please feel free to share your point of view even if it differs from what others have said. Keep in mind that we're just as interested in negative comments as positive comments.

I will be tape recording the session because I don't want to miss any of your comments. People often say very helpful things in these discussions and I can't write fast enough to get them all down. When this session gets written up, not names will be used so can be assured of complete confidentiality.

EPs

Q: What do you think well with your groups?

Q: Were changes observed in the children?

Q: How do you think that MFGT has helped these changes occur?

Q: Were there any barriers to running the groups?

Children

Free-listing activity to capture changes (recommended by Krueger, 2014)

Q: Does anyone want to share any of the changes that they have written down?

Q: Why do you think that x changed happened?

Q: What did you like about MFGT?

Q: If you were running the group, what would you do to make it better?

Appendix 15: Example of coded transcript

Focus group: School A

I: What we're going to be talking about today is family group. First of all, I just want to hear from you, what you thought was good about family group?

C1: It was nice

Commented [WP1]: Positive feelings

I: It was nice? What was nice about it?

C1: Er, where we get to play with the playdoh

Commented [WP2]: Activities in MFG. Enjoyed activities

C2: It was better than having to sit down and do learning

Commented [WP3]: MFG was better than the regular routine

C3: I like it because like we get to spend time with our family and we get to all come together

Commented [WP4]: Being with family. Coming together

I: That's nice. Did anyone else enjoy having family in school?

C4: I liked it when there was the party

Commented [WP5]: Activities in MFG

C1: I loved it and I was dancing, and it was really funny

Commented [WP6]: Enjoyed activities

C2: I liked the football bit when we had to kick the ball into the goals

Commented [WP7]: Activities in MFG; enjoyed the activities

I: Did anyone meet their targets?

C2: Sometimes I got fours (NB was the highest you could get on the day-to-day targets that fed into the overall targets)

Commented [WP8]: Meeting targets

C5: Always!

Commented [WP9]: Meeting targets

C1: The first time that I wasn't good I got twos and ones and then I got better

Commented [WP10]: Meeting targets; making progress

I: It sounds like a lot of you made progress towards your targets. What helped you meet your targets?

C6: Nothing

Commented [WP11]: Meeting targets; nothing helped

C5: When we followed the instructions

Commented [WP12]: Meeting targets; reason for meeting targets; having instructions

I: So you had instructions?

C5: Yeah

C3: Family group because it helped me like, know that I should be good at home and at school.

Commented [WP13]: Meeting targets

C2: It has made me be more awake

Commented [WP14]: Improvements; daily routine

I: Be more awake? How did it help you be more awake?

C2: My target was to leave my house at 8:20. I stopped turning my mum's alarm off because if I turn it off then we would just be more late, so I stopped that and I tell my mum we need to go to school.

Commented [WP15]: Meeting targets; specific target; lateness

I: Did you all know each other before you came to family group?

C1: Yeah, we're all in the same class

Commented [WP16]: Children knew each other

C6: No, we're not, x and y are in another class.

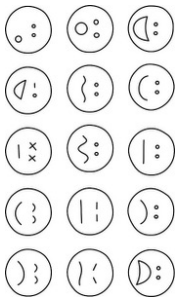
Commented [WP17]: Some children didn't know each other

I: So has anyone made any friends in family group?

Me (before being part of the group)

Think about:

How you feel?



How you behave?



What it is like to be in your family?



What it is like to be in your class/school?



You can draw pictures or write words or do both

Me (after being part of the group)

Appendix 17: Additional Pre and Post SDQ Tables

Table 7: Pre and Post Teacher SDQ ratings for 'School A' and 'School B

Domain	Mean score				95% confidence interval of the difference					
	Pre	Post	Mean change	SD	Std Error Mean	lower	upper	t	df	Sig (2-tailed)
Total Difficulties	15.54	16.54	1	4.06	1.13	-3.46	1.46	-0.89	12	0.392
Emotional distress	3.23	3.69	0.46	1.33	0.37	-1.27	0.34	-1.25	12	0.235
Behavioural difficulties	3.85	4.54	0.69	1.18	0.33	-1.41	0.22	-2.11	12	0.056
Hyper difficulties	5.54	5.38	-0.16	2.23	0.61	-1.19	1.5	0.25	12	0.808
Social difficulties	2.92	2.92	0	1.63	0.45	-0.99	0.99	0	12	1
Helpful behaviour	5.46	6.23	0.77	3.28	0.63	-2.15	0.61	-1.22	12	0.247
Impact on life	2.38	2	-0.38	0.65	0.18	-0.01	0.78	2.13	12	0.054

Table 8: Pre and Post Teacher SDQ Rating for 'School A'

Domain	Mean score				95% confidence interval of the difference					
	Pre	Post	Mean change	SD	Std Error Mean	lower	upper	t	df	Sig (2-tailed)
Total Difficulties	14.00	13.88	-0.12	4.42	1.56	-3.57	3.82	0.80	7	0.392
Emotional distress	2.25	2.63	0.38	1.69	0.60	-1.78	1.03	-0.63	7	0.235
Behavioural difficulties	3.63	4.00	0.37	1.19	0.42	-1.37	-0.62	-0.89	7	0.056
Hyper difficulties	5.38	4.75	-0.63	2.56	0.91	-1.52	2.77	0.69	7	0.808
Social difficulties	2.75	2.50	-0.25	1.58	0.56	-1.07	1.57	0.45	7	1
Helpful behaviour	5.38	6.63	1.25	2.49	0.88	-3.33	-0.83	-1.00	7	0.247
Impact on life	1.75	1.25	-0.50	0.76	0.27	-0.13	1.13	2.13	7	0.054

Table 9: Pre and Post Teacher SDQ Rating for 'School B'

Domain	Mean score				95% confidence interval of the difference					
	Pre	Post	Mean change	SD	Std Error Mean	lower	upper	t	df	Sig (2-tailed)
Total difficulties	18.00	20.80	2.80	2.95	1.32	-6.46	0.86	-2.12	4	0.101
Emotional distress	4.80	5.40	0.60	0.55	0.25	-1.28	0.08	-2.45	4	0.070
Behavioural difficulties	4.20	5.40	1.20	1.10	0.49	-2.56	0.16	-2.45	4	0.070
Hyper difficulties	5.80	6.40	0.60	1.52	0.68	-2.48	1.28	-0.89	4	0.426
Social difficulties	3.20	3.60	0.40	0.82	0.81	-2.66	1.86	-0.49	4	0.648
Helpful behaviour	5.60	5.60	0.00	1.87	0.84	-2.32	2.32	0.00	4	1.000
Impact on life	3.40	3.20	-0.20	0.45	0.20	-0.36	0.76	1.00	4	0.374