A Systems Oriented Model for Description and Analysis of Intensive Familj Therapy Units. A Pilot study.

Johan Sundelin

Running head: Intensive family therapy

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Abstract

This is the second of two articles concerning the development of a systems-oriented model for description of intensive family therapy. This article concerns the introduction of the units for Intensive Family Therapy participating in the study and a presentation of similarities and differences among them. Some preliminary instruments according to the model for a systems-oriented description of Intensive Family Therapy are introduced to the reader. These instruments are preliminary efforts to operationalize in order to make possible un empirical validation of the model.

These questionnaires and scales are administered to the intensive family therapy units in the study and the results are evaluated to some extent in respect to reliability and validity of the scales and in respect to similarities and differences between the units.

Although the different units give answers mainly in similar fashion, some differences concerning context, commissions, treatment ideology and resources are found between the different intensive family therapy units (IFTU:s). Differences are noticed concerning responsibilities, mandate and organisational arrangements as well as in resources, ideological issues and group climate in staff groups for different IFTU:s.

Differences found will be further evaluated in later articles to see if they provide significant criteria for explaining differences between the IFTU's "therapeutic effectiveness".

Keywords: Aptitude by Treatment Interaction: Family Therapy; Family Therapy Outcome; Group Climate; Milieu Therapy.

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As part of an ongoing multi-center study of intensive family therapy in Sweden, a description of the units providing this form of therapy is indicated. Within the multi- center study, 109 families are investigated with an extensive test-battery on different occasions over a period of two years following the start of treatment at intensive family therapy units (IFTU:s). These units offer a full day multi-impact treatment program for families during an intensive period of approximately one month which is preceded by a period of planning and preparation and followed up for a period varying between 1 - 6 months at different IFTU’s.

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A theoretical model for describing this kind of family therapy has been developed (1). The purpose for developing the model is to describe certain significant dimensions along which different units may be placed. In order to do this we operationalize these dimensions through measures under development. The different units are then compared along these measures. The different IFTU's positions in these dimensions will later be used in a comparison with different outcome measures of different kinds for intensive family therapy done at these units. The different units' outcome results will then be discussed in relation to the different units' profiles. These results will hopefully be informative and add to the discussion concerning further development of Intensive Family Therapy.

The model describes important dimensions chosen from research on organisations and treatment institutions, clinical experience and clinical theories: Context (micro and macro organisation, mutuality concerning treatment ideology), commissions towards families and referrals, team resources of different kinds and different perspectives on outcome/effects.

The theoretical model stems from many years experience of this model for Intensive Family Therapy. Theoretically, we refer to different sources such as organisational psychology when looking for answers concerning what every effective organisation needs to possess: goal orientation, sensitivity for feedback, flexibility and shared values (2, 3). Furthermore we refer to research concerning different premises for institution-based treatment programs summarised in the terms "outer and inner factors" and good pre-requisites through adequate and recognized leadership, a trustworthy structure for descisionmaking processes and interrelatedness and a good staff policy (4, 5). In addition, we refer to different family therapeutic theories concerning the connection between and the joining of client family and institution and the interplay between reflection on family dynamics and social training in the therapeutic process (6, 7, 8). "Family reality" and "The Language of Change" are central concepts coming from systemic, post-systemic, narrative and solution-focused tradition (9,

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10, 11, 12, 13). For a contextualized perspective of the space within which the therapeutic impact takes place, we draw on the Model for Contextualization for inspiration (14). Knowledge from multi-systemic treatment models give us tools to produce intense, contemporaneous achievements, all together sufficient to create change (15, 16, 17).

The aim of this paper is:

1. To develop tentative scales according to the model of description previously presented (1) which measure critical dimensions in the treatment model of intensive family therapy and
2. To see if the units differ along these dimensions in a meaningful way.The model for description of IFTU:s already was introduced in detail (1) is built on the following concepts: context, commission/referral, resources, effects.

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Method

The study group

The study group consists of seven intensive family therapy units at the child and youth psychiatric clinics in Falun, Växjö, Uddevalla, Karlshamn, Helsingborg, Lund and "Skutan" Social Welfare Göteborg. These units accepted an invitation from the Department of child and youth psychiatry at the University of Lund to participate in the study. They are representative for the treatment model in Sweden although they only constitute about 1/4 of the total number of this type of unit within child and youth psychiatry and social welfare in Sweden.

The study group is presented according to significant dimensions concerning their respective context, commissions and resources in table 1. The columns to the left in table 1 need some explanation in order for the reader to grasp the information in the table more fully.

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Table 1 about here

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Day-care (x) 24 hour care (xx) differentiate the units as to whether they meet their families under treatment during daytime or if the families stay in the institution Monday through Friday. Referrals from describes whether the units get their referrals only from outpatient units in the same organisation or if referrals come from different sources. Different solutions indicate different therapeutic tasks, different degrees of autonomy and considered competence. Intensive family Therapy tasks in % other tasks indicates to what degree the different units focus on intensive family therapy in comparison with other forms for therapeutic and investigation work. Estimated duration of total contact with the families indicates the time for therapeutic responsibility put more or less solely on the unit. Number of staff with diploma in psychotherapy gives information

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concerning formal level of competence in the staff group. Number of staff describes the size of the unit. The "+" means number of affiliated therapists with a looser connection to the teamwork done at the unit. Further training milieu and family therapy means my classification of reported accomplished further educational programs at the units. Starting year and employed staff N working years at the unit (1995) give an idea of the unit's collected experience as an intensive family therapy unit and an idea of the stability of the staff group. N intensive family therapy cases per year indicate how many families go through an intensive program per year.

All units within child- and youth psychiatry except Falun, have a child psychiatrist in charge of the treatment. Falun has a social worker as responsible as has Skutan which is organised within social welfare.

All units are family-oriented and have obvious similarities which can be defined within this treatment model. All of them work with families in a daily intensive program over a period of time. The work is carried out by a team of milieu therapists and family therapists working together. There are some differences in the capacity to provide night accommodation for families. The duration of the therapeutic work with families differs considerably. The units differ in size and resources available as well as flexibility in the unit's program. Differences are also noticed concerning organisational affiliation, tasks and commissions. The basic training profile among staff is very similar consisting of nurses, psychiatric nurses, children's nurses, pedagogues of different kinds, pre-school teachers etc. Formal further training of staff groups differs quite a bit. The units are of different ages but none of them is quite new. A noticeable characteristic is the stability of the staff groups.

The data collection procedure

Questionnaires and scales were constructed from the model presented above. They were constructed by the author of this article after seminars with local staff groups and tested for

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comprehensibility on a staff group not included in the study. The construction was built on face-validity catching different facets of the concepts through a number of questions or scales (18).

The questionnaires and the original scales were distributed and collected during September 1995. The answers on the different scales were factor-analysed. Criteria for an item to be included in a factor were determined (> .50, < .25 in another factor). The factor-analysed scales constituted the basis for the different units' results.

Statistical Methods

In the process of homogenisation of scales, factor analysis with orthogonal transformation solution - varimax rotation has been used. When comparing analyses between the IFTU:s, one factor Anova has been used (Statview II). In the concluding cluster analysis, factor analysis as above was used. Numeric results of the factor analyses as well as the newly constructed scales may be obtained from the author.

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Results

Development of questionnaires and scales

Before we introduce the different operationalised measures, an overview of the different questionnaires and scales are presented in connection to the model and it's theoretical references in table 2.

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Table 2 about here

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Context

RA (Referral Attitude)

The questionnaire RA is administered to the directors of the referring units and belongs to the "context" dimension in the model of description. The questionnaire refers to the theoretical model of the importance of a clear and mutually accepted relation between the commissioner and the performer (14). The answers to RA provide information about the "working alliance" and " experienced mutually" in the relation between referrals and the IFTU from the referral perspective. The questionnaire consists of two sections: The descriptive section consists of 10 open questions concerning the local IFTU from the perspective of the referring units as, for

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instance experienced climate of co-operation. The other section consists of twelve 10-point attitude items. This scale is supposed to catch a general measure of knowledge of and confidence in the local IFTU on the part of the directors of referring units by asking them to judge the degree of agreement from their point of view, on the local IFTU's treatment ideology.

The second part of RA, the attitude form, is homogeneous. Every single item correlates highly with the total score (M .69 range .52-.86). Internal consistency (Cronbach's Alpha) is .84. (19)

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FB (Form Background)

The questionnaire FB is administered to the IFTU´s leader. It consists of four broad category questions concerning inner and outer organisation such as structure of leadership, number of staff, organisational relations for the IFTU, tasks in %, etc.
(1, 3, 17).

Resources

WP (Working Profile)

Referring to sources pointing to the importance of a shared treatment ideology (3, 4) and to some important polarisations within family therapy theories (6, 9, 11,12,13) we developed the form Working Profile (WP). It was filled in by every member of the respective staff, including resource personnel and addressed 5 hypothetical aspects*:*
1. Team style 2. Time 3. Structure 4. Style 5. Focus.
1. Organisational level:*Team style*: i.e. if family therapy sessions and milieu therapy activities functioned in close collaboration or if they were separate from each other.
2. Commissional level: *Time:* is the unit working on short or long-term commissions?
3. Ideological level:*Structure*: Is the unit operating in a generalised and predictable structure with a program-directed treatment process or is the treatment process individualised, need-directed?
4. Treatment level:*Style*: Supportive style or challenging style?
5. Treatment level: *Focus*:: Problem/solution and behaviour oriented or process/growth and meaning focused?

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Factor analysis yielded a two-factor solution. Factor 1 included 7 items and was named "Profile concerning Structure, Directiveness and Responsibility". Lower values on these scales mirror a tendency towards a high and predictable Structure in the unit, a directive therapeutic style and assuming responsibility for change, while higher values mirror a differentiated structure, a non- directive reflective therapeutic style and shared responsibility with the family. Internal Consistency (Cronbach's Alpha) was .73.

Six items make up factor 2 named "Profile concerning Length of Time for Treatment Process, Locus of Change, Degree of Problem/Solution Focus". Lower values on these scales mirror a tendency towards short time focus, focus on external behavioural change and a problem/solution oriented style while higher values mirror a tendency towards the perspective of a longer therapeutic process, focus on experience rather than behavioural change and on growth rather than on problem/solution one. Internal consistency (Cronbach's Alpha) was .74.

SG (Salutogenic Group)

The significant importance of staff groups' comfort and well-being for successful therapeutic programs has been stressed by several researchers (4, 20, 21).

Well-being at work and Sense of Coherence were measured by a form named SG**.** The form was tested for homogeneity and a two-factor solution was chosen on 16 of these items. Factor 1 was named "Job Satisfaction - me and my job" (9 items). Internal Consistency (Cronbach's Alpha) was .87. One example of the type of item in this factor is "During the last six months, questions of conflicts and different opinions have been solved very unsatisfactorily/very satisfactorily". Factor 2 was named Comprehensibility, Meaningfulness and Manageability (7 items). Internal Consistency (Cronbach's Alpha) was .90. One example of the type of item in

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this factor is " During the last six months, it is my opinion that my chores and tasks together with the families I worked with, have been of importance to them“.

GC (Group Climate)

GC (22) was filled in by the staff at the IFTU:s including resource personnel. GC consists of a list of 85 words from which one has to choose at least 15 words describing characteristics of a group’s climate. Five factors are described: Solidarity, Split, Conflict Avoidance, Structure/Control, Negativism. This test was chosen because it is an established instrument for measuring group climate constructed from the perspective of experienced group processes whereas SG is constructed more from existential hypotheses.

AWP (Attitude Working Profile)

The importance of a clear and trustworthy ideological frame together with an experience from every staff member of being part of and sharing this ideology are considered very important for good outcomes in therapeutic programs (3, 4).

AWP is concerned with staff attitude to its own working profile and is filled in by the staff at the IFTU’s including resource personnel. It was constructed by first asking the staff to estimate the usual profile (WP) at their work and afterwards asking for their personal opinion, item by item, about that profile. This attitude was measured by an attitude schedule consisting of ten 10-point rating scales. Each item correlates with total score M .80 range .87 - .71. Internal Consistency (Cronbach’s Alpha) .93.

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ANK (Attitude to New Knowledge)

The importance of openness to feedback and a flexibility towards change and development in accordance with a constant flow of new challenges from theoretical as well as from empirical perspectives, are considered very important for a staff group (2, 4). This scale was constructed on this issue. However it did not work at this stage and is therefore excluded from further presentation.

Results from internal correlation concerning Group Climate in our study group show agreement with the manual for the Group Climate test (22). Table 3 and table 4 show correlations between Group Climate scales and the other scales and correlations between the new scales. These results are further discussed under ”Discussion Instruments”.

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Table 3 about here

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Table 4 about here

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Results

Comparison of units

A comparison of the units will now be made according to the systems-oriented model presented earlier.

Commission

Short resume of referral units' attitudes towards respective IFTU´s (summarised conclusions made by author from answers to 10 open questions RA).:

Unit 1: "The milieu therapeutic setting is an excellent complement to other forms for investigation and therapy." Difficulties are reported concerning continuity in the therapy process when a family has been in the ward for a period and is referred back to the out-patient unit. Unit 1 is also criticised for a non-flexible form for structuring the intensive period.

Unit 2: "One strength is the possibility to join families for a therapeutic process otherwise out of reach for out-patient family guidance." Some difficulties were reported concerning continuity in the therapy process when families were followed up as out-patients.

Unit 3: "The climate of co-operation between referral unit and the IFTU is good. A tendency of diverging interests among personnel at the intensive unit has been noticed recently." This discussion mainly concerns the role of the intensive family therapist and the level and length of responsibility that is placed on the intensive unit.

Unit 4: Representatives from the referring units report a very good climate of co-operation around family investigations. The group at the unit is very competent and people are impressed by the group's ability to formulate the commission in a constructive dialogue.

Unit 5: The family intensive unit offers the possibility for intensive family work in a milieu therapeutic setting. More flexible forms for intensive work are desired as well as a discussion concerning the problem of reconnecting to local resources and continuity in the therapy process.

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Unit 6: The treatment structure is important for many families. The competence is high but, of course, limited. Some problems are reported concerning continuity and an inflexible treatment structure.

Unit 7: Special difficulties are reported concerning dialogue and contact. Ideological differences between the outpatient unit's more traditional child guidance perspective and the family therapy unit's family perspective are reported. More flexible forms for using the competence at the unit are asked for in order to increase the climate of co-operation.

Results from the referral attitude form is presented in table 5. We started from a total median value of the attitude to the IFTU of all participating referring units. Each referring unit was then positioned in regard to "their" IFTU as above median (means generally positive to their IFTU) or below median (means generally negative to their IFTU).

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Table 5 about here

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Different attitudes from referrals can be noticed concerning the way the local IFTU meets the expectations from the referring units. Units 2, 3, and 4 seem to meet the referring units better than units 1, 5, 6 and 7. For unit 4 only 40% of referring units answered the questionnaire.

Resources (Treatment Ideology)

Questionnaire Working Profile (WP)

WP was based on hypothetical dimensions according to aspects of the units´ "therapeutic cultures" or ”treatment ideology”. Results are presented in a two factor solution: Factor 1 "Profile Concerning Structure, Directiveness and Responsibility and factor 2 "Profile Concerning Time, Locus of Change and Problem/Solution Focus".

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Table 6 about here

Differences between units were tested. Results of a comparison on factor 1 “Profile concerning Structure, Directiveness and Responsibility" show apparent differences between the units. Units 1, 4, 5 and 6 show lower values and units 2, 3 and 7 higher values. Lower values mirror a tendency towards a high and predictable structure in the unit, a directive therapeutic style and taking on a responsibility for change. Higher values mirror a differentiated structure, a non-directive reflecting therapeutic style and a shared responsibility with the family.

Differences between units were also tested on factor 2. On this factor, lower values mirror a tendency towards short-time focus, focus on external behavioural change and a problem/solution oriented style while higher values mirror a tendency towards a longer therapeutic process, focus on experience rather than behavioural change and a growth perspective rather than a problem/solution one. Results on factor 2 point out unit 7 as different from the other units with a working profile towards a more non-directive reflecting therapeutic style (1-factor Anova: F= 4.94, P=.0003.)

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Resources (other staff-related factors)

Attitude to one's own Working Profile (AWP)

The AWP was measured by a rating scale of ten 10 point scales. The different units' results were compared.

A high rate of satisfaction was registered. Differences between the units were tested. No total differences were seen (1-factor Anova: F-test = 1.95, P= .86.)

In a comparison between pairs, significant differences were found between unit 1 and unit 7(**) and between unit 6 and unit 7(*) * - 0.05, ** - 0.01.

Salutogenic Group (SG)

Factor 1: "Job Satisfaction - me and my job". Factor 2: "Comprehensibility, Meaningfulness, Manageability". Higher scores correspond to higher satisfaction.

Job Satisfaction has been judged as high on all units except unit 3 (One-factor Anova: Factor 1: F-test 2.36, P= .04.). On this factor, a total difference was seen. Unit 3 differed from other units with a lower score (unit 1(*), unit 4 (*), unit 5 (*), unit 7 (**). On factor 2, no total difference was observed (Factor 2: F-test 1.26, P=.29). In a comparison between pairs, a difference was found between unit 6 and unit 7 (*).

Group Climate (GC)

The different units were compared with the test Group Climate. The form was completed by each member of the staff.

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Table 7 about here

Solidarity: : A comparison between pairs shows a significant difference (*) between unit 1 and unit 7.

Split: A total difference was found. A comparison between pairs shows significant differences between unit 1 and 3 (**), 1 and 4 (*), 1 and 5 (*), 1 and 6 (**), 2 and 3 (**) and 3 and 7 (**).

Conflict Avoidance:: A total difference was found. A comparison between pairs shows significant differences between unit 1 and 2 (**), 1 and 4 (*), 1 and 5 (*), 2 and 4 (*) and 2 and 7 (*).

Structure: No total difference was found. A comparison between pairs shows significant differences between unit 3 and 1 (*) and 3 and 7 (*).

Negativism: No significant differences were found

Most notable are the differences found between units for factors Split (unit 1 especially low, unit 3 especially high), Conflict Avoidance (unit 2 especially high) and Structure (units 1 and 7 especially high).

Cluster analysis was made on Style- and Climate factors over units (RA, GC factors, WP factors, AWP, SG factors, figure 2). For each factor a 1 or 0 value was scored for respective unit due to an original score above or below the total median value for all units. The two cluster factors were named "Structure" and "Degree of Comfort".

Figure 1 about here

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Three clusters of units may be distinguished, namely, cluster 1: units 1 and 4 , cluster 2: units 2, 5 units 6. Units 3 and 7 differentiate in unique ways.

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Discussion

Instruments

Most of the scales developed in order to describe and measure the different IFTU's staff groups' resources and styles, give hope for the future, as they differentiate the units in different ways. However, at this stage they have to be considered and judged as very provisional paths towards a better understanding of potentially important therapeutic factors within Intensive Family Therapy. The validation of the scales is at this point insufficient. The scales are constructed from hypothetical dimensions experienced in a clinical context although there is support from different fields of psychological theory. The proof for generalizability and stability of the scales is of course not at all sufficient at this point and the results must be replicated in order to draw more than tentative conclusions.

However, some comments can be made concerning the results so far.

The significant correlation between WP2 and Split is expected from the fact that a more time-limited and temporary perspective probably puts more pressure on a staff group than a more total therapeutic process with the unit in charge over a longer period of time. If this difference is important for outcome in a shorter or a longer perspective, it will be very interesting, indeed. The significant correlation between SG1 and Split is also expected as "comfortable with my job" reasonably should correlate with an experience of cohesion in the staff group. WP1 is not at all correlated to group climate in line with the central ideas in the systems-oriented model introduced in a previous article (1) where it is stated that comfort among staff

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and group climate probably is more related to organisation and structure of the unit. This is also true for WP factors and AWP which do not correlate.

WP1 and WP2 correlate, as they probably reflect a conjoint therapeutic strategy in line with a structural family therapeutic style. As expected SG1 and SG2 correlate to a great extent.

Differences between the IFTUs

The theoretical model described in the previous article (1) seems to be relevant in the sense that it creates guidelines for construction of scales that would seem to capture different styles and profiles at the IFTU's.The differences between the seven units may be summarised as follows: Concerning attitude from referring partners one notices that unit 3 and unit 4 are described in more positive terms than the other units concerning contact and flexibility. The treatment model is often respected, but considered rigid and too highly structured as far as the other units are concerned. It seems as if a balance between accommodation to expectations from outpatient perspectives of how to do therapy and how to find the most constructive ways to get help from a unit for special care, collides with unique experiences within these units about what is needed in treatment programs to this target group of families concerning bonding, intensive caring, structure and endurance. Concerning organisation, three patterns can be noticed. Unit 3 is very closely related to the out-patient clinic with all psychotherapists as affiliated co-workers, while the other units are more independently related to the organisation. To a certain degree this is so for unit 1 and 4. Unit 7 has a very independent position. The described difference is also valid for internal structure and leadership with unit 3 as loosely structured and the other units with varying degrees of a more highly structured way of operating. The time during which responsibility is solely put on the IFTU unit differs.

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The more independent and resourceful units assume responsibility for the families for a longer period of time. The comfort, experiences of shared values among staff is also slightly different. Unit 3 describes itself as a group with split and relational difficulties. The other units describe themselves having moderate comfort and units 1 and 7 describe themselves as having a high degree of comfort and a good group climate. It seems also that some of the units count themselves as working according to a structural tradition (unit 1, 4, 5 and 6) while other units see themselves as adhering more to a systemic tradition (unit 2, 3 and 7). Except for unit 3 this difference does not seem to covary with the idea of a fairly highly structured organisation within the unit and between the unit and the partners. The important relationship pointed out in our previously mentioned references concerning a fairly high degree of structure, clear and recognized leadership, clear commissions etc. to comfort issues for the staff, seems to be supported by our study. Another question of special interest, is if it is more informative to look for differences along organisational and structural criterias in understanding effectiveness concerning the IFTU model instead of experienced content differences. The question is whether an available structure containing more general principles for good caring and space for questioning, training and reflecting related to the special needs associated with the selected group of clients referred to these units, is more important than a described specific treatment content related to a specific family therapeutic school?

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Table 1: Some significant characteristics for the IFTU:s involved in the study.

	Karlshamn	Lund	Helsing-borg	Skutan	Uddevall	Växjö	Falun[1]
Day care (x) 24 hours care (xx)	x	xx	x	xx	xx	xx	xx
Referrals from	Own outpatient unit	Own outpatient unit region	Own outpatient unit	Soc welfare bureaus	Own outpatient u	Own outpatient u	Own out p 35% region other sources 6
Intensive fam .ther. tasks in %	65%	87%	90%	50%	100%	85%	55%
Other tasks	35%	23%	10%	50%		15%	45%
Estimated dura-tion of tot con-tact with fam intens+extens.	1 month	3 months	2 months	2 months	5 months	6 months	8 months
Number of staff with dipl. in psychotherapy	0	0	1	7	0	3	4
Number of staff	10 + 6 aff. ther.	12 + 6 aff. ther.	6 + 0 aff. ther.	10 + 0	10 + 2 aff. ther.	7 + 0	15 + 0
Further training	internal	internal	internal	internal	internal	internal	internal
Milieu and				external		external	external
Family therapy		high		high		high	high

[1] The order of presentation is different from the numerical order in which the units are presented elsewhere in this article

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Unit starting year	1981	1985	1982	1981	1990	1983	1981
Employed staff N	8.5	9	9	10	5	7	11
working years at unit (1995)							
N Intens Family cases per year	30	40	17	17	27	12	25

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Table 2: An overview of the connections between the model of description and the different questionaires and scales.

Questionaires and scales	Location in model	Theoretical reference
Referral Attitude (RA)	Context/Commissions	Contextualisation Pettit, Olson
Form Background (FB)	Context/structure	Organisation/Leadership Fridell
Working Profile (WP)	Resources	Ideology Fridell, Ekvall
Salutogenic Group (SG)	Resources	Sense of meaning/ Antonowsky
Group Climate (GC)	Resources	Group Climate/Olsson, Hansson
Attitude Working profile (AWP)	Resources	Sense of sharing/Ekvall
Attitude new Knowledge (ANK)	Resources	Ideology, Flexibility/Schein, Fridell

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Different measures of outcome	Outcome	Effect/ Fridell

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Table 3: Correlations between the different scales in Group Climate and the other tests (n=69).

G C	WP 1	WP 2	WPA	SG 1	SG 2
Solidarity	-.02	.12	.21	.18	-.15
Split	-.07	-.36**	-.01	-.29*	-.02
Confl av	.08	-.04	-.12	-.18	-.03
Structure	.01	.20	-.10	.15	-.09
Negativity	-.07	-.16	-.13	-.21	-.19

G C= Group Climate, WP= Working profile, WPA= Attitude to working Profile, SG= Salutogenic group. Critical value (n=69) is .23 at 0.5 level of significance and .30 at 0.1 level of significance.

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Table 4: Correlations between Working profile-factors (WP), Salutogenic group-factors (SG) and (n 69 out of n 78).

	WP 1	WP2	WPA	SG 1	SG 2
WP 1		.26*	-.03	-.01	.09
WP 2			-.05	.18	.02
WPA				-.13	-.13
SG 1					.43**
SG 2					

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Table 5: Results from the Referral attitude form (RA) filled in by the directors of referring outpatient teams. A comparison between units.

Unit	1	2	3	4	5	6	7
Positive attitude	0	2	2	4	1	1	1
Negative attitude	3	1	0	0	3	2	3
(No answer	2	0	0	6	0	0	1)
Total	5	3	2	10	4	3	5

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Table 6: Working profile factor 1 ”Profile concerning structure, directiveness and responsibility”. Results from different units. Lower values mirror a tendency towards a high and predictable structure in the unit, a directive therapeutic style and taking on a responsibility for change. (N= number of filled in forms/total number of staff.)

Units	N	M	Sd	1	2	3	4	5	6
1	16/18	45.7	(6.7)						
2	5/6	61.4	(6.3)	**					
3	10/10	56.9	(6.7)	**					
4	10/10	40.8	(7.0)			**			
5	07/10	49.8	(7.6)			**	*		*
6	7/7	51.6	(5.8)			*	*	**	
7	14/15	61.8	(5.3)	**			**	**	**
Total	69/76								

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1-factor Anova: F = 13.5, P = .0001, * - 0.05. ** - 0.01.

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Table 7: Group Climate. Comparison of units over the five factors. (N= number of filled in forms/total number of staff.)

		Solidarity	Split	Conflict Av	Structure	Negativism
Unit	N	M (Sd)	M (Sd)	M (Sd)	M (Sd)	M (Sd)
1	16/18	1.7 (0.6)	0.1 (0.3)	0.3 (0.4)	2.0 (1.5)	0.7 (1.1)
2	6/6	1.6 (1.1)	0.3 (0.4)	1.9 (2.1)	1.5 (1.4)	0.9 (1.5)
3	09/10	1.2 (0.6)	1.2 (1.0)	0.8 (1.2)	0.5 (1.0)	0.9 (1.3)
4	10/10	1.2 (0.3)	0.7 (1.0)	1.2 (0.7)	1.5 (2.0)	0.3 (0.8)
5	07/10	1.2 (0.7)	0.8 (0.7)	1.3 (1.7)	1.7 (1.6)	0.7 (1.2)
6	7/7	1.3 (0.5)	0.9 (0.6)	0.6 (1.3)	1.6 (1.5)	0.6 (1.7)
7	14/15	1.2 (0.6)	0.3 (0.5)	0.7 (0.9)	2.2 (1.5)	0.7 (0.2)
Total	69/76					

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Solidarity: F = 1.5, P= .18.*Split:* F = 4.0, P= .02.*Conflict Avoidance*: F = 2.23, P= .05.*Structure:* F= 1.33, P = .26.*Negativism:* F= .62, P= .71.

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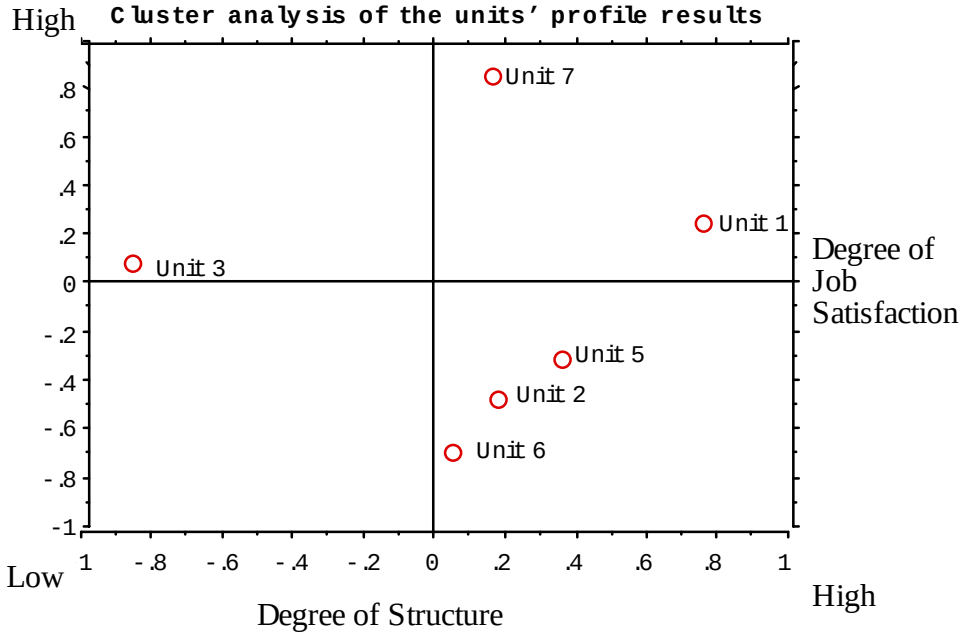

Figure 1. Cluster analysis for Style- and Climate factors over units. The two cluster factors were named "Structure" and "Degree of Comfort".