Intensive Family Therapy

- a way to change family function in multiproblem families.

Johan Sundelin
Lic Psych. Lic Psychoter.

Kjell Hansson
Ass Prof.
University of Lund
Department of Child and Youth Psychiatry
Box 638
SE-220 09 Lund
Sweden

Corresponding adress:
Johan Sundelin
Myrvägen 2
791 31 Falun
Sweden

tel/fax 023-24008
e-mail: "Johan Sundelin" <johan.sundelin@falun.mail.telia.com>

Abstract

Intensive Family Therapy

- a way to change family function in multiproblem families.

109 families in a Swedish multi-center project are presented - a co-operation among five units offering Intensive Family Therapy (IFT). The treatment results on family measures for 86 of these families are reported. This multi-center study is the biggest study so far of this treatment model. It is also one of the few which have used a multi-metod model evaluation battery. These units for Intensive Family Therapy (IFTUs) offer a full day multi-impact treatment program for families during an intensive period of approximately one month preceded by a period of planning and a follow-up period. Measures used are the self-rating forms "Family Climate" and "FARS" (Family Relation Scale) and observer ratings of videotaped family sessions in accordance with the CRS-Turbo and the Beavers' Observational Scale. Significant changes in the direction towards a better family climate and a higher family function are shown after treatment. Given the very difficult circumstances for these families compared to other groups of families, before and after their treatment, these results are considered very promising.

Keywords: Family Therapy. Milieu Therapy. Family Therapy Outcome. Family Climate. FARS. CRS-Turbo. Beavers' Observational System Scale.

Running headline: Intensive Family Therapy

Acknowledgements

Introduction

Intensive family therapy is defined in this project as a method to treat the whole family in an full-day treatment setting during a period of 3-4 weeks. The milieu therapy and the family therapy sessions supplement each other. Themes discussed in the sessions are worked through in practical exercises and daily activities in different environments. For example if a single mother has lost control and authority as a parent in a chaotic family system this can be focused on in a family therapy session. The mother can then practice being in control, supported by the therapists, by visiting a supermarket together with her children and negotiating what to buy and not to buy.The feelings and thoughts evoked in each family member by the new parental role performance are then discussed in a family therapy session. The mother is encouraged to practice her new hierarchical position in various daily situations, until it has stabilised. The same theme may later be discussed between mother and the therapeutic team together with the local network consisting of preschool teachers and other supportive resources.

Our way of working was inspired by writings on the effectiveness of a multi-systemic perspective (Henggeler et al., 1995, MacGregor, 1962, Hallström, 1991, 1992). For the milieu work we used techniques from earlier reports on therapeutic communities (Kennedy et al., 1987, Gillis et al., 1989, Jones, 1970, Feldman, 1970) and the ”Flying teams in Norway” (Haugsgjerd, 1974). The therapy methods used have been based on structural, strategic and systemic family therapy and milieu therapy (Minuchin 1974, Minuchin and Fishman, 1981, Haley, 1980, Boscolo et al., 1987). A treatment team trained in familt therapy and consisting of psychologists, psychiatrists, social workers, pre-school teachers, school teachers etc works together with the family and referring institution in a coordinated multi-impact approach. The

intensive, multi-impact approach could be said to be the trademark of the treatment model. Although similar approaches are described from other parts of the world (Johnson and Savage, 1967, Nakhla et al. 1969, Lynch et al., 1975, Ney and Mills, 1976, Riddle, 1978, Goren, 1979, Harbin, 1979, Combrinck-Graham et al., 1982, Dydyk et al., 1982, Churven and Cinito, 1983, Cooklin et al., 1983) the special "hot-house treatment" approach where the whole family are given the support of intensive family work seems to have been mainly a Scandinavian approach (Ringstad and Spurkland, 1978, Larsen and Eldrup, 1989, Sundelin, 1995). Since this is an expensive treatment method it must be thoroughly evaluated. Some evaluation studies of different size, design and ambition have been made (Johnson and Savage 1967, Churven & Durrant, 1983, Abroms et al., 1971, Ro-Trock et al., 1977, Dydyk et al., 1989, Ringstad and Spurkland, 1978, Larsen and Eldrup, 1989) showing the model's effectiveness. In Sweden there are a number of minor evaluation studies (Braaf and Hedlund, 1981, Sundelin et al., 1991, Hansson et al., 1992, Lindberg, 1993, Nerström-Bjerre, 1993, Johansson, 1995, Sköld and Österholm, 1995, Abrahamsson, 1996).

The aim of this study is to present the evaluation of intensive family therapy using multiple methods to assess changes in the family system.

Method

Participating families

Totally 109 families from 5 treatment units participated in this study and went through an intensive treatment program. Participation in the study was voluntary. All families up to a certain number (the number varies among the different units) during 1993 - 1994 were invited to participate in the study. The criteria of exclusion were difficulties with the Swedish language to such an extent that it was not considered meaningful for the families to fill in the questionnaires (n= 8) and also families who felt extremely insecure or threatened by participating in the study (n= 5). A few families were excluded as they broke up in the course of events. In some cases the family or family members moved from the district or other changes occurred making further contact with the project impossible (n = 4) . 86 (79%) of these families were followed up. The included treatment units are not random but consist of established Intensive Family Therapy Units (IFTUs) in Sweden. The five units participating in the study are all organised in a similar fashion. The families under treatment are referred from outpatient-units, where they most often have received family-oriented therapy on an outpatient-basis without satisfactory results. The period for treatment includes a period for planning and preparation, an intensive period with daily treatment contact for about one month and a follow-up period with a more extensive contact between the family and the unit during 2 - 6 months. The size of the different units measured in employed personnel varies between 7-15 and treated families varies between 12 - 40 families/year (Sundelin , 1998,b). The single parent family is most common at all the units (53%), nuclear families 31% and step families 16%. In general, the families are socioeconomically underprivileged with a high

degree of unemployment and dependency on social welfare and a low educational level. The difference between the units is not significant in this respect. The size of the families in our study corresponds on the whole with what is common in Sweden, but must be understood in the light of the relatively high number of single parent families in our sample (family size 3.3). There is no significant difference in the age of the mothers (M = 37 years, Sd 7.3). Boys (64 %) as IPs are definitely more common than girls (n=boys 70, n=girls 39). Regarding the age of the IP, the units differ significantly (One factor Anova, F-test 4.55, p = .002). Total average age for the children was 10.8 years (Sd 3.8). The families come to the IFTUs mainly because of a problem presented as a behavioural-acting-out problem (60 %). The remaining 40 % are distributed equally among internalised problems and other problems such as attention problems and social problems, which are not easily categorised as either acting-out or internalisation.

We have also included a small waiting-list control group, taken from three of the units after the main project was ended, comparable in size, age and other demographic data to the families in the study. In this group we managed to recruit 12 families and administred to them some of the instruments used in the study on two occasions (first occasion: three - one months before entering treatment and second occasion: one week before entering treatment).

Instruments

Family climate. The Family Climate Test consists of 85 adjectives describing the family's current emotional climate (Hansson 1989). The Family Climate Test homogenized by factor analysis into four factors: Closeness, Distance, Expressiveness and Chaos. The test - retest reliability is satisfactory (three weeks r = .95, 5 months r = .89) and Cronbachs alpha was for Closeness .98, Distance .91, Expressiveness .71 and Chaos .92 (Non-clinical group, n=123)

(Hansson, 1989). On Closeness a high value indicates a nonclinical position, on Distance and Chaos a low value indicates a nonclinical position. The Expressiveness factor is not reported in this study as it did not function satisfactorily either here or in earlier studies (Sundelin et al.,1991).

FARS. FARS (Family Relations Scale) (Cederblad and Höök, 1992) also measures family function. The rating scale consists of 46 statements about "my family" that the person filling out the test has to take into consideration as to whether the statements fit or not. Factor analysis gave five factors: Attribution, Interest, Isolation, Chaos and Enmeshment. Alpha-coefficients and stability over a long time have shown that FARS has a high reliability (Cronbachs alfa .90 for mothers and .89 for fathers). Covariance between this measurement of family function and other family measurements and the differences of the results on this instrument between the clinical and non-clinical samples showed that the validity is satisfactory (Cederblad and Höök, 1992). A low value indicates a nonclinical position.

CRS-Turbo. CRS-Turbo was developed in accordance with Olson's circumplex model. Olson's circumplex model describes two orthogonal axes, Cohesion and Adaptability (Cederblad and Hansson 1989, Olson et al., 1983). The rating scale consists of three scales: Adaptability, Cohesion and Hierarchical Organisation. Low values on Adaptability indicate rigidity while high rated values indicate a chaotic family functioning. Low values on Cohesion indicate disengagement while high values indicate enmeshment. High values on Hierarchical Organisation indicate unclear generation borders. Interobserver reliability has been regarded as good, Adaptability $r = .88$, Cohesion $r = .87$, Hierarchical organisation $r = .92$ (Cederblad and Hansson, 1989).

Beavers' Observational System Scales. The scales emanate from Beavers -Timberlawn family model (Cederblad and Hansson, 1989). The two scales are Family Competence and Family

style. The higher the value on the Competence scale the higher the family's competence and level of functioning. The Family Style scale relates to the family's way of interaction. The scale goes from a centripetal tendency (satisfaction is sought within the family, high values) to a centrifugal tendency (satisfaction is sought in the world outside the family, low values). A global rating measurement for each scale is also established. In earlier studies, inter-rater reliability of the scale Competence was r=.94 and for Style r=.79 (Hansson, 1989, Cederblad and Hansson, 1989).

Procedure

The families were asked to participate in the study at the introductionary interview. All family members over the age of 11 years filled in the instruments at the beginning of the treatment period. At the same time the family tasks also were videotaped. The family tasks were an interview about the families' life (Kinston and Loader, 1984, 1986) and a structured problem solving task "the Puzzle" (Hansson, 1989) done by staff not involved in the treatment of the family. Six months after the start of treatment the families were contacted for a follow-up performed in the same way. The assessments of self-rating instruments were conducted by research assistents at the local IFTU.

Results

The instruments Family Climate and FARS were filled in as selfrating instruments and later coded according to the manuals. Observer ratings of family function were checked initially for inter-rater reliability . Ratings were made by two raters for each of the forty-two families. The ratings were correlated for all the dimensions of the CRS-Turbo and Beavers' Observational System Scales. The correlations ranged from .80 - .97 indicating good inter-rater reliability. Dependant t-tests (paired t-test) were used to assess the significance of clinical change from pre-treatment assessment to the assessment occurring six month after the beginning of treatment

Family Climate

The results regarding the Family Climate Test for mothers, fathers and all children (over 11 years old) measured before treatment and six months after the start of treatment are presented in table 1.

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TABLE 1 ABOUT HERE

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Statistically significant changes in the expected direction are reported in the other scales. The change is most profound in the mothers' ratings. The results from this scale give strong support for the treatment in the expected direction.

FARS

The results of the test FARS for mothers, fathers and identified patients (over 11 years old) administered before treatment and six months after the start of treatment are presented below in table 2.

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TABLE 2 ABOUT HERE

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A self-rated improvement of family function according to FARS has taken place. This is most obvious for the mothers but also for the identified patients and, to a somewhat less extent, fathers. Table 2 shows strong support for the hypothesis that family members can benefit from the treatment so that the family function develops in a more positive direction.

CRS-Turbo and Beavers' Observational System Scales

Ratings of 42 families' patterns of functioning according to CRS-Turbo and Beavers' scales are presented. Of a potential number of 73 families treated at four of the five units, 66 families agreed to participate. Later, 42 of these families were followed up. Unit number 2 did not take part in this part of the study due to technical problems. As the scales Adaptability, Cohesion and Family Style are supposed to be non-linear we have constructed a "deviance index" e.g. each rating's deviance from a supposed normal value (for Adaptability and Cohesion M= 15 and for Style M= 26) (Thernlund, 1996). This means that the lower value the more close it is to a non-clinical value. These results are presented in table 3.

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TABLE 3 ABOUT HERE

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The results of these two tests show statistically significant changes from a dysfunctional position to a more functional one.

On CRS-Turbo, Family function changed from a chaotic and disengaged function to a more normal one. On this scale we also find a non- significant change to a more normal hierarchical organisation.

On Beavers' Observational System Scales we find a change from low competence to increased competence and from a centrifugal function to a more a balanced function (see table 3).

A small study of a waiting list control group has been done. We measured these families twice before entering treatment (first occasion: 1-3 months before entering treatment and second occasion: one week before entering treatment). The mothers' results are reported. We found no changes in the family functioning variables. The results are statistically at the same level as the initial levels on the different tests for the treatment group.

Clinical significance

As far as clinical significance over the treatment period is concerned, we have looked for changes in the families in the expected direction in Family Climate and FARS. We decided to use 1 Sd in a non-clinical material as a significant difference (Family Climate: Closeness Sd= .63, Distance .23 and Chaos .21 Hansson, 1989) and FARS Sd 11 (Cederblad and Höök, 1992). We found that the mothers rated family function after six months as being much better than at the start of treatment. On Closeness 48%, Distance 57% and on Chaos 56% of the mothers rated family function as changed to the better. On FARS 45% of the mothers rated a

positive change. 29% of mothers rated a positive change on three out of four of the variables in Family Climate and on FARS total.

We were also interested to see if self rated-family function changed to a non-clinical position. Critical values for clinical and non-clinical positions were chosen as M + - 1 Sd according to values for non-clinical groups (FARS M= 13, Sd + - 11 (Cederblad and Höök, 1992); Family Climate: Closeness M=2.0, Sd + - .63, Distance M=.30, Sd + -23, Chaos M= .20, Sd +- .21. (Hansson, 1989); Adaptability M= 15.0 +- 2.5, Cohesion M= 15.0 +- 2.5, Hierarchy M= 1 +- 1, Competence M= 36 +- 7.0, Style M= 26 +- 2.5 (Thernlund, 1996).

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TABLE 4 ABOUT HERE

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Quite a lot of the mothers rated their family function as clinical on both occasions (15-47 %). Chaos seems to be less changed, according to the mothers. We found, however, also that several of the mothers rated a change to a non-clinical family function especially on Family Climate (35-45%). On the two observer rating instruments we notice that between 30 - 40% of the families are rated as moving from a clinical to a non-clinical position on the different scales. About 50% of the families are rated as clinical on both occasions.

Discussion

Regarding family function as measured by Family Climate and FARS, it is evident that the experience of these aspects of family life has improved for quite a number of the families during the treatment period and show statistical significant changes. These changes are most obvious concerning the mothers, but are also reported for the fathers and the children who filled in the questionnaires. Regarding the results from CRS-Turbo and Beavers' scales, we also find a shift among the participating families that participated towards values indicating normalisation. In this case it is usually a shift from Disengagement and Chaos towards a higher Structure, Cohesion and Competence. It can be argued that such extreme values as these families show can only change in one direction, to a more positive one (regression to the mean). However the positive results from the treatment program are also verified by measures of clinical significance for each family.

Clinical research on this or similar treatment models has so far been very rare, especially in an international perspective. Reports of pre-post-treatment designs are even more rare. To our knowledge, this is the first study including standardised measures of family functioning, both self-rating and observer-ratings, before and after treatment.

Often the family has had previous negative experiences of out-patient help, often with different kinds of therapies. To be able to report any constructive changes at all in this group of treatment resistant families is in itself very positive. Since one of the aims of the systemic treatment model is to influence family function it is encouraging to find that family function has actually been changed.

The drop-out in this study is high (21%) but compared to similar studies it is not that remarkable (Borduin et al., 1995). In many studies of multiproblem families there is a drop-

out between 25-50 % has been reported. In this connection, it is worth mentioning that the drop-out only concerns participation in the study. Very few families broke off their engagement in the actual therapy. This fact itself describes a problematic reality that the clinical researcher is challenged with when collecting information and supervising the research process at the units. The pre-treatment values of the group that was not followed up, do not seem to diverge from those of the group that participated during the whole period. This way of defending representativity despite a high drop-out rate is also used elsewhere (Borduin et al., 1995). It indicates that the drop out group does not systematically differ from the outcome group for example in such a way that only the most difficult families have dropped out of the study. Instead the drop-out is to be understood on the basis of several factors, for example, insufficient routine among the staff concerning the collection of information, resistance to participating in the project by some of the staff, more time pressure and stress during certain periods.

The study did not include a true randomised control group. We have therefore to be careful when interpreting the effectiveness of this treatment model. The study, however, gains strength by being regarded as replicated studies from five different units during the same period of time. The results from the different units are very similar. It is also worth discussing whether a randomised control group in this situation is ethical acceptable. All the families in the study have had different kinds of treatment in outpatient settings without positive results. A lot of the families live in a situation where the social welfare authorities have threatened to take over care of the children. We don´t consider it ethically correct in such a situation to randomise families to either a non-treatment situation or the kind of treatment that has not led to any previous improvements.

In this study we report on family function as it is experienced by family members and by independent observers. The results from these two perspectives harmonise and fortify each other. The families have gained considerably in functionality according to our measures.

Difficulties with self-report methods are obvious. In our study it has occurred to us that fathers and mothers have very different experiences of the family. This might be a gender specific finding. In this study the fathers´ views of the family are closer to non-clinical families. In that respect they have no reason to change! Maybe the fathers want to protect the family by reporting a non-clinical picture? It is also possible that the fathers knowledge of the family is limited to the unproblematic part of the families' life.

In conclusion the Intensive Family Therapy Treatment Model which was assessed in this study has been demonstrated to improve half of the families. Used on families difficult to successfully treat in less intensive out-patient settings it is a valuable model. Since half of the families were still considerably dysfunctional at the follow-up, the families should be offered continued support in a long term treatment chain including "booster doses" for example a new treatment week every half a year.

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TABLE 1 *Results from the self-rating scale Family Climate before and six months after the start of the treatment (paired t-test).*

	pre treatment		after 6 months		t-value	p-value
	M	(Sd)	M	(Sd)		
Closeness						
Mothers (n= 84)	1.06	(.93)	1.65	(1.03)	-4.67	.0001
Fathers (n= 40)	1.17	(.89)	1.49	(1.09)	-1.80	.08
Children (n= 47)	1.34	(1.08)	1.94	(1.08)	-4.14	.0001
Distance						
Mothers (n= 84)	.84	(.69)	.39	(.56)	4.40	.0001
Fathers (n= 40)	.71	(.54)	.43	(.58)	3.48	.001
Children (n= 47)	.68	(.75)	.42	(.58)	3.11	.003
Chaos						
Mothers (n= 84)	1.74	(1.33)	.80	(.95)	5.71	.0001
Fathers(n= 40)	1.61	(1.33)	.66	(1.03)	4.59	.0001
Children (n= 47)	1.29	(1.23)	.69	(1.17)	3.07	.004

(Internal drop out Mothers: n=84/86, fathers: n=40/63, children > 11: 47/82)

TABLE 2 *Results from the self-rating scale FARS. Mothers, fathers and identified patients,*
before treatment - six months after the start of treatment, paired t-test.

FARS	pre treatment		after 6 months		t-value	p-value
	M	(Sd)	M	(Sd)		
Attribution						
Mothers (81/86)	3.54	(1.88)	2.77	(1.97)	3.08	.003
Fathers (41/63)	2.81	(1.91)	2.30	(1.99)	1.57	.12
IP > 11 years (29/60)	2.68	(1.89)	1.80	(1.59)	2.42	.02
Interest						
Mothers (81/86)	5.47	(3.16)	4.52	(3.00)	2.27	.012
Fathers (41/63)	4.69	(3.30)	4.40	(3.25)	.80	.42
IP > 11 years (29/60)	5.41	(3.29)	4.00	(3.27)	2.27	.03
Isolation						
Mothers (81/86)	4.26	(3.85)	3.07	(3.24)	3.81	.001
Fathers (41/63)	2.64	(2.53)	2.52	(3.26)	. 61	.54
IP > 11 years (29/60)	4.32	(4.01)	2.97	(3.52)	2.48	.02
Chaos						
Mothers (81/86)	4.83	(3.46)	3.53	(2.92)	4.08	.0001
Fathers (41/63)	4.07	(3.32)	3.38	(3.48)	2.10	.04
IP > 11 years (29/60)	5.00	(2.95)	3.66	(2.70)	2.75	.01
Enmeshment						
Mothers (81/86)	5.65	(3.07)	4.17	(2.75	4.23	.0001
Fathers (41/63)	4.75	(3.19)	4.40	(3.50)	.48	.63
IP > 11 years (29/60)	5.15	(3.05)	3.28	(2.25)	3.66	.001
Total						
Mothers (81/86)	35.82	(17.89)	27.21	(16.94)	5.47	.0001

Fathers (41/63)	29.55 (16.64)	25.03 (19.22)	2.26	.03
IP > 11 years (29/60)	34.53 (18.69)	23.62 (16.18)	2.97	.001

TABLE 3 *Comparison of rated family function between pre-treatment and six months after start of the treatment on CRS-Turbo and on Beavers' Observational System Scales (n=42, paired t-test).*

Scales	pre treatment		after 6 months		t-value	p-value
	M	(Sd)	M	(Sd)		
CRS-Turbo:						
Adaptability	19.1	(4.8)	16.9	(4.4)	3.64	.0008
Cohesion	11.8	(5.0)	13.1	(4.3)	1.96	.06
Hierarchy	2.1	(1.2)	1.7	(1.4)	1.61	.11
Adaptability "-15"	5.6	(2.8)	3.7	(3.1)	3.64	.0008
Cohesion "-15"	5.3	(2.7)	3.7	(2.9)	1.38	.003
Beavers' Observational System Scales:						
Competence	25.1	(6.5)	29.5	(8.4)	-3.30	.002
Competence global	7.3	(1.9)	6.0	(2.5)	3.49	.001
Style total	28.8	(4.1)	27.4	(3.5)	2.29	.03
Style global	4.7	(1.6)	4.5	(1.4)	.75	.46
Style "-26"	3.5	(2.9)	2.8	(2.2)	1.82	.07

TABLE 4. *Percent mothers moving from clinical and non clinical positions on the tests FARS, Family Climate, CRS-Turbo and Beavers' Observational System Scales during a period of six months after start of IFTU-treatment.*

Test	clinical at both times	non clinical at both times	from non clinical to clinical	from clinical to non-clinical
FARS total	47%	20%	6%	27%
Family Climate				
Closeness	28%	23%	8%	41%
Distance	15%	35%	5%	45%
Chaos	43%	14%	8%	35%
CRS-Turbo				
Adaptability	50%	7%	5%	38%
Cohesion	55%	7%	9%	29%
Hierarchy	43%	15%	9%	33%
Beavers' Observational System Scales				
Competence	51%	10%	5%	34%
Style	40%	12%	10%	38%