INPATIENT FAMILY THERAPY

Evaluation of the work at a treatment unit at the clinic of child and adolescent psychiatry in Falun 1986-1990.

Figures 1-6 omitted. The article was originally published in Swedish in Fokus på Familien 4, 1991, 221-231.

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In Sweden today, there are about twenty units, mainly attached to child and adolescent psychiatry clinics, which admit whole families for treatment. So far their treatment programmes have not been evaluated to any great extent. In 1980, two studies were carried out at the Danderyd Hospital's child psychiatry clinic to evaluate the results of treatment in the family unit. One study was based on interviews with the families (n=49) and the therapists. In the other study, those who referred the families was interviewed. In 1981, the results of both these studies were compared. The interviews showed that the effectiveness of the treatment was rated similarly by families, therapists and remitters (Braaf et al., 1981).

The present evaluation concentrates exclusively on the patient's experience of family climate, rated with a standardised test administered at predetermined intervals. In accordance with constructivist theory, we presupposed that every family member lives in their own construction of reality, and on the basis of this, allots meanings to experiences, happenings and connections both inside and outside the family sphere (Segal, 1986). Thus, we considered that the measurement of family climate was relevant for evaluating the meaningfulness of a completed treatment period.

The idea of evaluating treatment outcome is not a new one. Our first effort was made in 1986 (Sundelin and Olsson, 1986) when we studied case notes for two comparable years. We compared the unit when it was organised as traditional child psychiatry unit, with a year when it was run as a family unit. We looked at the length of inpatient treatment, frequency, re-admittance, the clarity and patterns of indications for admittance etc. We also tried, by means of telephone interviews, to get some inkling of how families had experienced their time at the unit.

Presentation of the treatment unit

The family unit at the child and adolescent psychiatry clinic at Falun hospital took on its present form in 1985. The work of the unit is described in more detail elsewhere (Sundelin, 1987), but the following may be said briefly:

An intensive four-week treatment period is planned for two or three families at a time. During this period, the families have intensive contact with their own team consisting of a family therapist, two milieu therapists and a teacher. This team bases its work on painstakingly conducted preliminary work. After treatment, the family is followed up on an out-patient basis for at least three months, including meetings with others who support the family and the team. The team is supported by the unit supervisor through regular case conferences, weekly supervision for the family therapist, team conferences and milieu therapeutic supervision.

The intensive work that the family engages in, is based on a constructive dialogue between the reflective, systematically oriented family interviews and the milieu therapeutic work in the form of support, reflection and informal talks between the milieu therapists and the family or family member. In this process, we increasingly emphasise the family's unquestionable right to their own interpretation of the situation. We assume a conjectural tone when talking to the family in order to describe and clarify experienced problems, context and attempts at solution as richly as possible. We work with practical, concrete happenings, how these are experienced and their consequences, using a model for the integration of milieu and discussions (Goolishian et al., 1989).

Before the family is admitted to the unit, we place great importance on formulating, together with the family, the problem to be worked on and on

drawing up a working contract between the family, the unit and others involved, so that the aims are as clear as possible when the family is admitted to the unit. Nowadays, we have established routines for this, including a visit for the family to the unit, a home visit and possibly conferences with school or the remitter. The basic aim is for the contract to be formulated as clearly as possible from the start with regard to possible future reformulation.

Through good internal training during the past two years, the milieu therapists, or as we prefer to call them environmental family therapists, have developed their ability to be flexible towards the family members in order to be a resource for the family during their stay on the unit. This attitude has been inspired by the systemic/constructivistic influenced milieu work developed at the child and adolescent psychiatry clinic in Tönsberg, Norway (Vedeler at al., 1988). The ”tone” of the work has tended to be more and more conjectural, reflecting, dialogue-based, and focused more on the families' conditions as to experience pace and way of the therapy. During the past year, the families have lived in a flat outside the unit. This means that they have had their own ”territory” to retire to. Thus, co-operation and contact between the staff and the families has become more equal, differentiated and relaxed. The experienced responsibility for the treatment period has been more equally shared.

There are several prequisites for admittance to the unit. The most important is that the preparatory work has been thoroughly done. The families have often received outpatient treatment at our clinic without results. Furthermore, their situation is characterised by a multitude of complex problems, both social and psychological. The situation is often strained, those involved are exhausted and have lost hope that anything can ever be different.

The aim of the stay at the unit is to help families regain an active, self-reflecting, constructive position vis á vi their own situation. Together we try to ”reverse the trend”. By means of intensive treatment, a rehabilitation process is started which can be later consolidated by an outpatient contact with the unit and, a later stage, possibly with the support of others.

Together with the family, the assigned team strives to reflect the family’s situation. We work with a one way mirror and often with a reflecting team (Andersen, 1987). In dialogue with the family we exchange thoughts about how family members relate to one another and to the problem. Together, we make suggestions as to what the family can do themselves and what is required in the way of help in order to effect the desired future changes. The originally formulated problem often changes in this process and new challenges and needs emerge.

The investigated group

The investigated group consist of families treated in the family unit of Falun hospital during the years 1986-1987, 1988-1989 and 1989-1990.

Table 1. Description of the families in the study.

	1987		1989		1990
	Participating	Not particip.	Participating	Not particip.	Participating
Number of families	10	11	12	6	11
Number of individuals	10	24	19	9	24
Sex of the child:					
Male	11	17	15	8	16
Female	5	11	9	4	8
Age of the child:					
0-6	4	7	11	4	7
7-12	11	17	11	6	7
13-	2	3	2	2	10
Type of family:					
nuclear fami	3	1	1	1	4
stepfamily	3	5	2	2	3
single parent family	3	5	9	6	4
divorced nuclear fam	1	0	0	0	0
Type of problem:					
introvert	4	2	2	2	2
extrovert	4	7	5	2	6
other	2	2	5	2	3

The participants are those who completed the rating scales. During 1986-1987 we had an internal drop-out. Ten families totalling 34 individuals completed the rating scales on the first two occasions, but only 10 individuals from the 10 families completed the rating scales on all occasions. The reason for this drop-out was probably the pilot nature of the study and the insufficient motivation of the staff. Thus the comparison for 1987 made in table 5 is based on 10 individuals. The internal drop-out rate in subsequent years diminished.

The summary of families admitted during the three years of the study shows the participating families, the number of families who have participated each year and the number of drop-outs. The age and sex of the children and the family type is also shown. We have tentatively classed the families as either ”internalising” or ”externalising”. DSM-III diagnoses were available, but we chose to exclude these as they were made on the basis of grounds for treatment and were, therefore, very similar (ex relational problems 313 D) thus giving very little information. The social group of the families was also excluded as the majority of the families (c 85%) came from social group III.

All the families admitted to the unit had long-standing experience of treatment both from the child and adolescent psychiatry clinic and from other sources. All the families, both children and adults had several psychiatric problems. This makes it impossible to make a single diagnosis. Among psychosomatic problems we found anorexia nervosa, difficult-to-manage-diabetes, encopresis, school phobia of anxiety or somatic nature; externalising included problems such as aggressiveness, defiance, problems with limit-setting and hierarchical problems. Other problems were found, e g obsessive/compulsive symptoms, problems concerning visitation rights, evaluations of various kinds etc.

In table 1 we see that there is no great difference between the three years or between the investigated families and the non-response families. However,

during 1990, a greater number of the admitted children were somewhat older. However, these children largely come from two families having 4 and 2 children respectively over 13 years of age. Furthermore, in 1990 there was a larger proportion of intact families and in 1989 there was an unusual number of single-parent families.

Table 2. Number of evaluations on the different evaluation periods.

Period	Evaluations					Number of evaluations
1987		Week 1			Week 4	After 3 months	3
1989	Before admittance	Week 1			Week 4	After 3 months	4
1990	Before admittance	Week 1	Week 2	Week 3	Week 4	After 3 months	6

Table 2 shows that the procedures for data collection differed slightly each year. However, there were so many similarities that a comparison could be meaningfully made. The data collection on follow-up varied somewhat in time, but no follow-up was more than 4 months after treatment.

The unit's treatment method was judged to be similar during the three years of the study. Families mainly stayed in the unit from Monday to Friday. A few families were treated as day-patients. In the last year of the study, 1989-1990, the unit was housed in temporary premises and families lived in flats during the treatment period.

Method of investigation

Our aim with the study was to get feedback about our treatment results. In these times, we find ourselves more and more often in a situation where we are obliged to give a detailed description of the content of our work and our ”production figures” to the clinic administration and also to compete with other important fields for the financial resources to continue our work. We believe that solid, reliable measurements of treatment results will be decisive in the future for the continued existence and development of treatment models. These results of treatments will be more closely related to financial allocation and will also be required to by the caregiver to provide information about the meaningfulness of treatment and how it can be improved. Naturally, there are many questions as to how these evaluations should be carried out, what should be measured, the criteria for successful result, how can the results be related to the given assignment etc. Further, one wonders who has the right to give the answers? Who has the right to judge if anything constituting a constructive change has taken place?

During this first phase we decided to concentrate on a method of measurement which could be administered simply (each measurement taking c 10 minutes). We settled for the *Family Climate Test* (for a more detailed description see below)(Hansson, 1989). We refer to the experiences made at the treatment institution Sjövillan in Stockholm, where the measurement process in itself had obviously disturbed work (Andersson et al., 1989). We asked ourselves what information we were mostly interested in, and came to the conclusion that we would in the first instance, concentrate on measuring ”consumers satisfaction”, i e the clients’ experience of themselves before, during and after the treatment period. Similar studies have been carried out at, among other places, Åtvidaberg’s child and adolescent psychiatry clinic (Svedin et al., 1989).

We assumed that a family's climate rating covaries with their description of their problems and our treatment efforts. If a continuous evaluation procedure is to be introduced, much discussion is needed with the affected staff about the aim and value of the measurements. We discovered how difficult it was to find functioning routines for something new and untried. A whole year's measurement (1987-1988) had to be disqualified, because lack of administrative routines resulted in complete measurements being available for only 2 families during this year.

The entire study is based on a single instrument, the *Family Climate Test* (Hansson, 1989). The test is a self-response questionnaire consisting of 85 adjectives which each individual marks to correspond with their experience of the climate in their family at the time of answering the questionnaire. They are asked to mark at least 15 of the 85 adjectives. The test gives a picture of how the family sees itself, its ”family myth”. The test consists of four factors.

Closeness

The factor which has been named closeness comprises 18 adjectives describing a climate where the members of the family appear to have close relations to one another. The factor describes a positive climate characterised by harmony, security and warmth. The factor appears to describe a functional family. In general these words have been marked by many.

Distance

This factor includes 11 adjectives. The words describe a family climate characterised by coldness and distance. In contrast to factor 1, which is a positive one, this factor indicates a negative family climate.

Spontaneity

This factor includes 6 words describing spontaneity and richness of expressed emotions.

Chaos

This factor consists of 6 adjectives describing a family climate of confusion, anxiousness and instability, which immediately suggests that it be named *chaos.*

High values on each factor indicate that relatively many of the words included in it have been marked. This test has previously been used for the description of family climate in both clinical and normal groups (Hansson, 1989).

The team assigned to the family were responsible for administering the test according to the established routine.

The families in treatment were asked to complete the *Family Climate Test* at different points in time during the treatment period (see table 2).

Results

The results describe how the families themselves experienced their family climate. The ratings were made on several occasions in order to see if the experienced family climate changed. The families described an increasing closeness from the first rating to the last. The description was similar for the

last two years, whereas the first year showed less experience of closeness on the first rating occasion.

The results are, in principle, reversed when *distance* is compared with *closeness*. The individuals described a decreased experience of distance between the first and the last rating.

The factor *spontaneity* showed no clear pattern over the years. During the treatment period spontaneity decreased, mainly when compared with ratings made before the start of treatment. In two of years, spontaneity increased after the end of treatment in the unit, while it continued to decline during one year.

Measurement of *chaos* show a uniform pattern from high to low during the observational period. This pattern is similar for all the years. It is interesting to note that in 1990 there was an increase of *chaos* previous to discharge from the unit.

Table 3 shows statistical comparisons between the different measurements. The same cutting score (index 0-1, 1-1) was used in all comparisons.

Table 3. Significant differences between the different times of rating for the respective factor for the years 1986-1987, 1988-1989, 1989-1990.

Year	Closeness	Distance	Spontaneity	Chaos
1987	1-2			1-2
(n=10)	1-3	1-3		1-3
	2-3			
1989	1-3			1-3
(n=19)	1-4	1-4	1-4	1-4
				2-3
		2-4	2-4	2-4
		3-4	3-4	
1990	1-2			
(n=24)	1-3			
	1-4			1-4
	1-5			1-5
	1-6			1-6
				2-4
				3-4
				3-5

The calculations of significance are made through Fisher's exact test (Siegel 1956) for the year 1987, for the other years X2. Year 1990 n= 24 except for measurement 6 where n= 14.

There is a significant difference between measurements 1 and 3 for factors *closeness, distance and chaos.* All changes were in the expected direction towards a profile similar to that of a functional family (Hansson, 1989).

The other measurement is from September 1988 to June 1989. The results show that *closeness* increased and *distance* and *chaos* decreased, especially when the first and last ratings are compared.

The ratings carried out during 1989-1990 showed a recognisable pattern of change in the factors. Experience of closeness increased, experience if distance decreased and the experience of chaos decreased only to rise somewhat before discharge. The factor spontaneity showed a decrease similar to that of the previous years' ratings.

Table 4. The differences between factorindex for Distance and Chaos 1989-1990 using optimal median cutting score (n= 24 except measurement 6 n= 14.

Compari-son between measure-ments	**Distance** Index 0	>0	X^2-value p-value	Compari-son between measure-ments	**Chaos** Index 0	>0	X^2-value p-value
1*	7	17	5.37	2*	14	10	7.70
5	15	9	p=.021	6	12	2	p=.006
1*	7	17	6.39				
6	10	4	p=.012				

In table 4, we can see that the previous year's results are seen again in the final year of the study, when looking at some of the statistical calculations made on the basis of the best medians in the comparisons (table 3).

It is interesting to see how individuals and families respectively changed their experiences during the treatment period. The first and last ratings were used for comparison. When registering change, only absolute values were used, i e we have not taken into consideration the magnitude of change. For families, the average of the family member's ratings was calculated. In comparison to a normal group, family climate, as a consequence of treatment, should mostly show increased closeness and decreased distance and chaos.

Table 5. Family changes and individual changes between the treatment time for the factors Closeness, Distance and Chaos

	Closeness		Distance		Chaos	
Year	+	0/-	+	0/-	+	0/-
Families						
1987 (n=10)	9	1	2	8	2	8
1989 n=12	9	3	5	7	5	7
1990 (n=11)	11	0	2	9	4	7
Total	29	4	9	24	11	22
Individuals						
1987 (n=10)	9	1	2	8	2	8
1989 (n=19)	13	6	9	10	10	9
1990 (n=20)	17	3	7	13	9	11
Total	39	10	18	31	21	28

+ = higher value
0/- = unchanged or decreased value
+/0 = increased or unchanged value
- = decreased value

Spontaneity has not been included in table 5 as the results from this factor presented a mixed picture. The results showed that a large majority of the families (89%) and individual family members (80%) described an experience of increased closeness during the observation period. Decreased distance is reported by 71% of the families and 61% of the individual members. Decreased chaos is described by 64% of the families and 55% of individual members. In order to see how these figures correspond to whether or not

families sought child and adolescent psychiatric help in the future, we examined the children's case notes in 1990 to see if there was any indication of continued contact after the treatment period in the family unit. A more careful follow-up (e g by interview) would have been desirable, but was not possible due to lack of funding. However, it is our experience that if the families needed more help they would turn to the unit in the first instance, in which case it would be recorded in the case notes.

Table 6. Number of families who have applied and not applied for future treatment by the child and adolescent psychiatry (n= 33/39.

Year	1987	1989	1990	Total
Observ. time	more than 34 months	23-15 months	10-5 months	
Not applied for future treatment	6	9	6	21
Applied for future treatment	4	3	5	12

The results showed that the majority of the families did not seek further help after their stay in the unit, even though they were families with a massive problem complex. As the study was largely based on ratings of family climate, we were interested in seeing if there were differences between those who sought and those who did not seek continued help. Only the two last years of the study are reported.

In the initial measurements, those who sought further help reported greater closeness than the others. Furthermore, those who did not need further help had a clearly rising trend. This implies that those who did not seek continued help reported a lower initial degree of closeness and, thereafter, an increasing degree of closeness during the course of treatment, which also seemed to remain stable three months after the end of treatment. Those who sought

continued help showed a clearly rising degree of chaos after treatment, whereas those who did not seek further help remained on a low level.

Discussion

We can establish that the Family Climate Test seems to be sufficiently sensitive to reflect changes in family climate during treatment.

If the results of the study's three years are compared one can see parallels in climate test patterns. Experienced chaos decreased, the experience of closeness increased and the experience of distance decreased during the stay in the unit. In general, we conclude that, during the course of treatment, individuals rated their families more and more like normal families, i e families without psychiatric problems (Hansson 1989).

Treatment seemed to mean that changes towards greater closeness and decreased distance already took place in the initial stages. These dimensions seemed to establish themselves on a fairly stable level. However, changes in experienced chaos took place during the entire treatment period. The treatment was most successful in increasing closeness in the family climate and least successful in reducing chaos. When the three years are compared, the results from the first year appear to be just as good as those in later years, especially regarding reduction of chaos. The difference in results can be explained by the varying drop-out rate. Families who were difficult to motivate may be those who are who are also difficult to change. Another possible explanation is that the treatment focus changed to a more systemic one which was less directive and steering than the previous structural focus. During Spring 1990 there was a good deal of unrest in the unit, as its future was in question. This may have

led to a lessened capacity to deal with chaos in the family because of preoccupation with the chaos in the staff group and the clinic in general.

We have no measures of how the families fared after the conclusion of treatment in regard to symptom alleviation. According to a constructivist point of view, behaviour is steered by the family's own construction of itself which is why this method of evaluation is interesting. During the treatment period, the family's construction of family climate changed. The results are validated by our clients in their reports on the meaningfulness of their stay in the unit, when they had time to see it in perspective and also by the fact that most of the considered themselves to function on a higher level on follow-up and, thus, not in need of help from the child and adolescent psychiatric clinic to the same extent.

In the limited follow-up through the children's case notes, we were able to establish that two thirds of the families had not sought further help. Naturally, this is a coarse measure, as the families may have sought further help elsewhere. However, we cautiously interpret this positively, as the families would have probably contacted us if they had needed more help. We cannot be sure that the families are functioning well just because they have not sought help. We can, however, show that the two groups describe their family climate in different ways. Regarding closeness, those who sought continued help reported more initial closeness than the others. It may be that by giving an ideal picture of the family, they had not ”given the therapists access”. Alternatively, the families themselves may not have considered they needed any help, perhaps their resistance was high. It is interesting that the climate test may be used as a clinical instrument. It is also interesting that a high level of chaos covaries with families who have sought further help. This is validated by previous studies where dysfunctional families are often characterised as chaotic.

Further studies of a similar nature should, according to our beliefs, include a more long-term follow-up and a more structured validation of test results by comparing them with subjective reports from the families and with case notes. Conducting ongoing research like this, often involves problems with data collection. Even though we only used one rating schedule there was a large non-response figure during the first two years. Long-term motivation of the staff for research and allotting responsibility for data collection to some of the staff was one way of counteracting drop-outs.

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