

Inpatient family therapy: a multicenter study of families' and staff's experience of family climate

In Sweden, during the last couple of decades, family therapy has been often employed as a means of helping families in various problem situations (1,2). A multitude of treatment methods have arisen, including inpatient treatment of families, above all within child and adolescent psychiatry. It is often families with a wide range of problems who are treated in this way. These families have often received outpatient treatment without effect. As inpatient treatment is costly and resource-consuming, it is essential to follow up the results.

Hitherto, only the results of minor Swedish and Scandinavian studies of inpatient treatment have been published (3 - 7). Even internationally, relatively few studies have been published (8 - 14). The treatment form is rare both in Sweden and abroad, mainly due to the high cost involved. Roberts et al and Dydyk (8, 9) have, however, showed that despite of the high cost of treatment, society can benefit financially in the long run. However, because of the initial high cost, the treatment should be evaluated as to its effectiveness.

The purpose of this study is to present families' and staff's experiences of this form of inpatient treatment. The basic assumption, founded on constructivist theory, is that an individual's behavior is steered by their construction of the situation.

The study is a multi-center one in which several treatment units have participated, thus enabling the results from different units to be compared and at the same time providing a larger material. The article also summarises the previously reported results from three separate units (15 -17).

The following questions will be discussed in this article:

1. Does experienced family climate change during treatment?
2. How does experienced family climate change?
3. Are there similarities between the family climate as described by the families themselves and as described by the staff?
4. Are there differences between units and, if so, in what way?

Data collection and participating groups

In the preliminary stages, seven child and adolescent psychiatry units were interested in taking part in the study (Malmö, Lund, Växjö, Uddevalla, Karlstad, Falun and Umeå). Two of the units were excluded as the total material was either too small or incomplete. The data collection for all units took place during Autumn 1989 and Spring 1990.

Table 1 about here

In Lund, the length of treatment was, in principle, 4 weeks, but in one case the family stayed only 2 weeks in the unit (for evaluation) and in another two cases the length of treatment was 5 weeks. In Falun, all families spent 4 weeks in the unit. In the family unit in Lund, two patients with anorexia nervosa were also treated. These have been excluded from the study as the families of these patients were only sporadically there at the same time as the patients.

The non-response frequency in Lund and Uddevalla is explained by the fact that the families and/or staff failed to fill in the rating scales completely. There is an internal drop-out in all units due to the absence of families or staff on rating occasions.

All units have rated each scale at the same point in time.

As seen in table 1, the same rating scales were used for both family climate and group climate. In all units, families and staff have rated family climate and the staff have rated group climate in the staff group. In Lund, families also rated the staff group climate.

All the families admitted to the unit can be seen as having several difficult problems. Most of them had received outpatient treatment both in child psychiatric clinics and social welfare institutions. The majority came from lower social groups and from broken homes. As to the children's diagnoses, only a few of the units have used the DSM-III -R system. We have therefore attempted to divide the families into broader categories. As the units have mainly adhered to a family perspective, diagnosing was on a family level and all cases were diagnosed as "disturbed family relations". Each family manifested several psychiatric

problems in both children and parents. This renders it impossible to describe families on the basis of one specific problem. Internalized problems include anorexia nervosa, difficult to cope with diabetes, encopresis, school problems of somatic or anxiety nature: acting out comprises such problems as aggressiveness, difficult-to-manage children, limit setting problems, hierarchical problems etc. The group "other problems" includes obsessive/compulsive behavior, problems concerning visitation rights, evaluations of various kinds etc.

Method

In a study such as this one, where many people are involved, it is important to choose a simple and uniform way of collecting data. We have therefore restricted ourselves to a single questionnaire, namely **Family climate** (2) (other material has been collected in växjö and Uddevalla, but will not be included here.)

The instrument used is a self-report 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, the "family myth". Four factors emerged when the material was analysed.

Table 2 about here

Closeness

The factor which we have chosen to call **closeness** comprises 18 adjectives describing a climate where the members of the family appear to have a close relation to one another. The factor describes a positive climate characterised by harmony, security and warmth. The factor would seem to describe a functional family.

Distance

This factor includes 11 adjectives. The words appear to describe a family climate characterised by coldness and distance. In contrast to factor 1, which is a positive one, this factor expresses 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 (for a description of the test and the calculation of factor indices, see 2). The test has previously been used for the description of family climate in both clinical and normal groups. It has been used to rate family climate and also to rate the climate in staff groups. For the sake of comparison, the same factor structure has been used in spite of a somewhat different structure in group situations.

Description of treatment in the various family units.

All units focus on family therapy and work with the family as a unit. Systems theory and communication theory form the theoretical basis. However, the methodology in the units may vary according to content and length of inpatient care.

Växjö

The family unit started up in 1983 with five members of staff. The treatment period is Monday to Friday for two weeks. One family at a time is admitted either to live in or as day-patients. Treatment is based on systems theory (18-21). The childrens' symptoms are seen as a consequence of existing disturbances in the dialogue between the members of the family.

A detailed schedule is drawn up for the period. This includes therapeutic family discussions, milieu therapy in everyday situations and family activities. The goal is to make a transition from a problem focus to a solution focus (22). The milieu-therapeutic interventions take the form of informal talks and active support in various concrete situations. Family activities are a method

which has been developed from the start of the unit's existence. These activities place the emphasis on non-verbal aspects of therapy. Families may paint, write or play games together.

Falun

The family unit in the child and adolescent psychiatry clinic of Falun hospital, assumed its present form in 1985. The unit can admit two to three families at a time for a four week treatment period. During these weeks, the families are assigned a team consisting of a psychotherapist, two milieu therapists and a teacher. This team has intensive contact with the family. The team is given support by the those in charge of the unit in the form of case conferences, weekly supervision for the psychotherapist, team conferences and milieu therapeutic supervision.

Contact with the families is intensified already before their stay on the unit. It is essential that the problem is clearly formulated and that a working contract is drawn up between the family, the unit staff and others involved before admittance. There are established routines for this, including a visit to the unit by the family before admittance, a home visit, conferences with school etc and conferences with those who referred the family. Contracts are formulated as clearly as possible from the start even with a thought as to how they may be re-formulated during the course of treatment.

The aim of the treatment is to try to help family members regain an active, self-reflective and constructive position regarding their own situation. Together we try to "reverse the trend". Through these intensive efforts, a process of rehabilitation is started which can be further consolidated with the help of outpatient treatment from members of the unit and, possibly, later on with the support of others.

Lund

The family unit in Lund operates on a Monday to Friday basis admitting two or three families at a time. The treatment combines milieu therapy with continual family therapeutic sessions. The unit is run on a rather structured basis with scheduled activities during the day. The unit staff is

complemented by a psychiatrist, psychologist and psychiatric social worker and there is also a preschool, school and occupational therapy unit available.

The treatment period is usually four weeks, but in some cases can be shorter or longer.

Admittance follows a referral from outpatient clinics and a subsequent conference where the case is presented in more detail. As the families continue treatment at the outpatient clinic afterwards, the outpatient staff participate in discussions with the family and unit staff once a week. A follow-up conference takes place after six weeks.

Structural/strategic family therapy forms the theoretical basis for treatment, but other models may also be integrated in the treatment. Family therapy and milieu therapy are integrated in a way that themes focussed on in family therapy are integrated with milieu therapy and vice versa. Ward staff participate in family therapy sessions as participants behind a one-way screen.

Uddevalla

In 1985, the child and adolescent psychiatry clinic started the family treatment unit described in this study. From January 1, 1990, the unit operates on a day-care basis with a staff of 10. The staff consists of a psychiatrist, psychologist, psychiatric social worker and other staff, 20 in all. The unit has undergone considerable changes over the past 12 years. From an acute unit for the evaluation and treatment of individual children, it has developed into a family unit helping entire families find new solutions and attitudes towards their problems.

Families are admitted and sick-listed for a period of three weeks. A contract specifying the content and aim of their stay is drawn together with the family and in consultation with the referring outpatient team which will follow up the treatment. The families stay on the unit from Monday to Friday together with staff on duty all around the clock. The treatment team is made up of 2 family therapists and 2-3 milieu therapists per family. The schedule for the day includes school for the children, family therapy sessions one hour a day and some activity or other with the milieu therapists where problematic situations can be worked through. There is also time for the families' own activities.

Umeå

When the unit was started up 1985, it was strongly inspired by the work at Danderyd hospital's family unit. In the beginning, Satir and Minuchin were the most important family therapeutic sources of inspiration.

With a staff of 8 and two flats at their disposal, 2 family therapists and 2 milieu therapists each work with a family for a period of 4 weeks from Monday to Friday. The unit has no night staff. The yearly capacity of the unit is approximately 20 families and indications for admittance include sexual abuse, refugee problems or the evaluation of mental retardation, autism and even schoolphobia and anorexia nervosa.

The goal has been to respect and highlight the families' own wishes and to create a climate of openness and contact in order to encourage the families' own solutions to their problems. The possibilities of working with families before and after their stay on the ward are restricted because of the long travelling distances involved, but are possible to some extent.

Since the completion of this study, certain changes have taken place. The medical superintendent has been given more administrative responsibility and the quality of staff-training has been improved.

Results

The families' experience of treatment

In this study we were interested in finding out how families had experienced family climate at different stages in the treatment. Our first question was whether families had experienced any change in family climate during the observed treatment period. The first rating was made before intake, ratings 2 - 5 during the treatment period and rating 6, three months after treatment in the unit.

Here we will confine ourselves to presenting the results regarding the factors **closeness** and **chaos** as these, on analysis, seem to be the most interesting. In general, we can say that the families' experience of family climate changed during the observation period. We can also establish that the results differed between treatment units.

The results show that experience of family climate changed during the treatment period. Thus, **chaos** decreased and **closeness** increased.

The families' experience of these factors seems to be the most interesting. Comparisons were made between the average for each family on each rating occasion. Because each family has its own reference point for experience of climate, it is difficult to compare families. We have therefore taken a closer look at the families whose experience of family climate changed in a positive direction.

Table 4 shows changes in the families' experience (the average of all family members). Individual experience of family climate was also compared. The proportion of positive and negative experiences agrees in large with the family's collective description.

Table 3 about here

There are some interesting differences. Växjö and Falun consistently show the greatest changes during inpatient treatment. In Falun, families mainly change in relation to **closeness** and **distance**, whereas in Växjö it is mainly experienced **chaos** that changes.

No consistent treatment follow-up was carried out in Lund. The non-response rate for follow-up interviews was rather large and mainly concentrated to Uddevalla. In Falun, no follow-up interviews were conducted with the last four families as the family unit was to be closed down.

The positive results have prevailed, especially in Falun, whereas Växjö shows a poorer result on follow-up. It is interesting to note that, in Falun, the experience of **chaos** had diminished even further on follow-up.

Thus, the results show that a number of families describe positive changes. The changes described above are based on absolute values and can therefore be very small. We have looked for any significant values (via the Wilcoxon signed rank-test) between the different rating occasions for families reporting positive changes (see table and figure). The results in all cases where the families report positive changes in regard to **closeness**, **distance** and **chaos**, are statistically significant ($p < .001$).

During the families' stay on the unit, family climate was assessed by the therapists. It is interesting to take a look at the agreement between the families' experience and the therapists' ratings.

In the first place, we can conclude that the concordance between the two measurements was good. The factor **distance** shows least agreement. With the exception of Umeå where concordance was considerably lower, the different units were in fairly good agreement with each other. This can, of course, be a random finding as there were relatively few families from Umeå.

Figure 1 about here

Figure 2 about here

Summary and discussion

Family treatment in Sweden is conducted on either a day-treatment basis or by admitting the whole family as inpatients. This type of treatment is found in about 15 places and is conducted under the auspices of child and adolescent psychiatry. The study examines five (seven) of these units and comprises probably about 50% of all families admitted to the units during the period of the investigation.

The results show that 50% of the families experience a positive change in family climate during treatment, when ratings at the beginning and end of treatment are compared. The suitability of self-ratings can, of course, be discussed, but the families in the study were often negative to treatment and difficult to involve. It seemed natural to allow them to describe themselves the changes they felt the family underwent during treatment.

There are no greater differences between the units, except that Lund had a somewhat poorer result than the other units (table 3) regarding the total ratings of **closeness** and **chaos**. On the other hand, when changes in each index are seen separately, Lund does not differ from the other units. These results must be regarded as fairly satisfactory, as the families involved have usually suffered from many problems over a long space of time and many of them have been in treatment for a number of years without result.

If the initial ratings are compared with those made at the follow-up three months after treatment (table 1), we see some interesting results. Falun has clearly better results than the other units. Our interpretation is that the changes made via treatment in this unit seem to be longer-lasting. Växjö shows positive results concerning change in family climate during the actual treatment period, but these do not last in a long-term perspective. The 14 day treatment period may be too short to allow permanent changes to take place. The positive results in Falun, at least during the last year of the study, may be due to the longer experience of the unit staff who also have the best training. The Falun unit also has, by tradition, a very independent position in the organisation and has been able to steer intake and discharge from the unit. This independence was sorely tried at the end of the study period, when the unit was threatened with closure. This was reflected in the staff's rating of group climate, where **chaos** was described as being higher than at the beginning of the period. The unit in Växjö also had a privileged autonomous position. Perhaps this has a positive effect on results. A more detailed analysis of units' treatment ideology and method in would most likely yield some interesting information.

Table 4 about here

Table 5 about here

We found no differences between "internalising" and "externalising" families. A possible explanation is that treatment could be adapted to the needs of the individual family. It may also indicate that this classification is not very meaningful as the families often have a long list of problems which cannot be encompassed by these subgroups.

In the future, it would be desirable to evaluate treatment according to other criteria, for example, by measuring symptom reduction and ,indeed, we plan to do this. Previous reports show that positive changes in family climate regarding the factors **chaos** and **closeness** covary with a decreased need of future treatment (15).

Earlier follow-up studies of similar child psychiatric material in Sweden (3-7, 23, 25-28,31-33) and in the other Scandinavian countries (7, 28-30, 34) report varying results depending on treatment and symptomatology. Families who are admitted to a family unit probably have a poor prognosis as they have been the object of advanced measures for a long time before admittance. In this study, the individual psychopathology of the child or the family have not been the prime focus of interest. The reason is that we have based our work on constructivist theory where the experience of the individual is of prime interest. If the experience of the family has changed, it may be assumed to covary with changes in relations and, hopefully, with a feeling that symptoms have decreased. As none of the studies referred to have been focussed on how family members themselves have experienced treatment, this study is especially interesting. Comparisons with these studies must needs be lacking. If one, in spite of this, compares the results of the above studies, our results must be considered satisfactory.

Naturally a study with control groups would be desirable. An untreated control group would be especially interesting, but this, however, would be unethical. Other studies have also shown that such a group, in reality, would not be untreated. The problem of control groups is discussed at more length by Janson et al (3). One must also remember that the families who participated in this study would probably have deteriorated in health, if they had not been given the opportunity for

family treatment. One of the advantages with a multicenter study is that one can at least compare the units involved. In conclusion, at least 50% of both families and staff judge the family climate to have improved during the family's stay in the unit.

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