

**A Systems Oriented Model for Description of Intensive Family  
Therapy Units.**

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Running head: Intensive Family Therapy

## Abstract

This article is the first of two articles presenting the development of a model for the description of Intensive Family Therapy. This work is carried out contextually in a national quasi-experimental multi-centre study in Sweden, concerning treatment results and follow-up results of 109 families undergoing Intensive Family Therapy. This form of family therapy is foremost employed within child psychiatric settings. Intensive Family Therapy can be described as a full day treatment program for families by a therapeutic team and including family interviews as well as family work in a therapeutic milieu, preceded by a planning and a preparational period and often followed by a shorter or a longer period of outpatient work. In this article the treatment ideology and supposed critical organisational elements of Intensive Family Therapy are introduced. A theoretical model for description of Intensive Family Therapy is presented. In a following article this model for description is empirically tested using newly developed instruments.

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

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This article has its starting point in a multi-center study in Sweden of Intensive Family Therapy and concerns treatment results for 109 families. In this perspective a description of the treatment model accomplishing this form of therapy is needed. In this multi-center study, 109 families are being investigated, using an extensive test-battery at different time intervals during a period of two years following treatment at Intensive Family Therapy Units (IFTU:s).

**The aim of this paper is:**

1. To describe and present Intensive Family Therapy
2. To develop a model to describe important dimensions in Intensive Family Therapy from a theoretical and clinical point of view.

In a following article, the seven IFTU:s composing the study group are presented and compared according to the model.

In the presentation, special consideration will be given to the specific treatment profile that the IFTU:s have in common, as well as the parts that are intrinsic to each unit. The common parts are seen as overriding and help to define the treatment model of the IFTU and the differing parts relate foremost to an analysis of the context in which the different IFTU:s are embedded.

The model describes some important dimensions chosen from 1) traditional organisational psychology, 2) relevant research concerning institutionally based treatment programs and 3) clinical experience. These dimensions are: commissions towards families and referrals, team resources of different kinds, outcome and conclusions concerning criteria for goal fulfilment.

The model is assumed to be able to differentiate the units. The usefulness of the model will be subsequently tested empirically.

The model may also be used later to support planning and development of this kind of unit as this form of treatment is resource demanding and costly and must be profiled and economised as far as possible.

### ***Development of Intensive Family Therapy.***

Family therapy became an important therapeutic approach within Scandinavian outpatient child and youth psychiatry during the 1970's. Several inpatient units for younger children within child psychiatry and social welfare in the Nordic countries, were also successively transformed into family treatment units during the 1970's and beginning of the 1980's (1). In the 1990's we have noticed a continuous increase of these kinds of units.

This development seems to be related to an increasing demand for methods which could deal with specially resistant problems experienced at that time and which were described as underorganisation in the family structure (2). The development of a perspective highlighting the family and its network as a significant unit for therapeutic work with children and the increase in family therapeutic knowledge inspired the development further.

Families were referred to these units for "Family Investigation" or for Intensive Family Therapy by social welfare authorities, the court or the outpatient units within the Child Guidance organisation, as the families were described as difficult to help on an out-patient basis.

IFTU:s have found theoretical and methodological inspiration from many sources over the years. In the beginning, there was a large variety of sources ranging from different kinds of milieu therapeutic settings for individuals, to general care and nursing programs (3,4).

Models from group therapy and milieu therapy settings (5,6) were adopted to fit families living together with other families in a meta-family for a period. The central idea was to use social feedback through mutual experiences of everyday situations in a therapeutic milieu between different family members, different families and milieu therapeutic staff in order to

relearn and train more adequate and constructive relational patterns within the family and between the family and the surrounding systems.

A family investigation/treatment model called Multiple Impact Family Therapy (MIT) was developed in Texas USA during the 1950's and 1960's (7, 8, 9).

Another source of inspiration were the "Flying Teams" in Norway. Due to long distances and difficulties with transportation, these teams went out to small towns and stayed for a couple of days intensive work (10).

Family theory and practice from the structural school were also frequently used both in family therapy and milieu therapy (11,12, 13).

### ***Earlier research and rationales for the model of description of IFTU's***

A summary of some significant theoretical considerations concerning this way of working has been published in Sweden (1).

There are no articles to be found describing research where systematic attempts have been made to relate operationalizations of central concepts of active processes in the treatment model to outcome data.

Reports from research on the model give an overall description of the treatment model and focus on some outcome measures. Despite that this research is sparse, these descriptions all contain presentations of central and important aspects of what may make these units meaningful therapeutic tools (14, 15, 16, 17, 18, 19). These aspects concern both the organisation and the content of the units' treatment programs and the mutuality between these factors. What is needed is a well structured model to describe these institutions in an ecological perspective, where specific, significant and critical parameters characterising organisation and treatment content of these units are identified and able to be related to outcome measures later on. Empirically based instruments need therefor to be developed.

#### **Concerning organisation:**

According to Schein (20) every effective organisation should possess:

1. *Adaptability* - the ability to solve problems and to react flexibly to changing environmental demands.
2. *A Sense of Identity* - knowledge and insight of what it is, what its goals are and what it is to do. To what extent are goals shared by members of the organisation and how is the coherence among members concerning the goals of the organisation ?



3. *Capacity for testing* - the ability to seek out, accurately perceive, and correctly interpret the real properties of the environment.

4. *"Integration"* as a part of the total organisation.

Ekvall (21) points out the importance of the integration of the ideological system, the decision-making system and the executive system within every member of an organisation irrespective of their role and position. He names such an organisation a humanocratic organisation.

Fridell (22) stresses the importance of making clear the outer and inner factors of the frame for the understanding and description of an institution for treatment. Outer factors are laws and regulations and attitudes among commissioners. Inner factors are competence and resources, selection of the staff group and their comfort at work, leadership philosophy, clients/patients and treatment goals. All this is mainly conceptualised within the treatment ideology which constitutes the rationale creating the stability and normative system for the institution. Fridell points to the importance of a description of the total treatment system (described through these outer and inner factors of frame) that all together affects the patients.

Sandberg (23) looks for factors within the child guidance organisation that inspire or hinder administrative goal-oriented efforts. He has developed a model for analysis containing the concepts external factors, internal factors, process and results. He concludes that "the main results underscore the importance of the three dimensions in child and youth psychiatric work i.e. personal competence, terms of co-operation and external conditions. It is the complex interaction of all these three dimensions that determines the quality of the work" (pp 201-202).

These four organisational descriptions accentuate aspects that seem to be important for institutions responsible for a treatment program. They stress a contextualized perspective when examining an institution. Furthermore, they point to the importance of a shared belief-

system or a rationale for the identity of the institution. They pinpoint a positive climate in the staff group. This is related to a style of leadership and a structure that underscores the importance, not just of shared beliefs but also of an experience of being a respected part of the decision making process and the formulation of plans and goals for the institution. Goal fulfilment should be constantly evaluated and fed back into the system for flexible accommodation. Shared beliefs in different aspects between the institution and other partners and within the institution are seen as important for the credibility of the institution. Of all these organisational and ideological factors together constitute the institutions "therapeutic effectiveness" or "therapeutic power".

From the clinical field, the concept of contextualization and a model for problem-solving has been developed by Petitt and Olson (24). The methodology of contextualization makes the user aware of mutual expectations in the process of finding meaningful commissions for a therapeutic contract among partners. The problem-solving model helps to formulate goals and goals-fulfilment.

### **Central assumptions concerning IFTU's therapeutic work:**

From a general systems perspective one looks for concepts that are helpful for a more precise understanding of mutually dependent processes within systems (25). More specific, it is important to look for central assumptions on how family and systems-oriented work are supposed to meaningfully relate to mental pain and psychiatric symptoms in children.

(Neurological and constitutional factors in children in interaction with family dynamics are of course also important aspects but outside our frame of presentation in this article). In order to supply a good therapeutic process we are looking for concepts from different family therapeutic schools to help us create alternative, constructive, system-based "understandings"

of perceived problems sometimes as starting-points for psychological challenge and social training.

A structural approach pinpoints the important inter-connectedness between family organisation and individual wellbeing (11). The systemic approach points to family myths and the system of meaning and its relation to the individual perception of reality (27). A contextual perspective stresses the relation between individual dilemmas and loyalty issues towards the family of origin (28). The narrative perspective focuses on the individual script (the story about oneself) imbedded within the family script (29).

It is of course of special interest to develop our understanding of the special circumstances which deem the IFTU model more advantageous than other treatment models. These concepts should cover "the special caring" of the family within the IFTU program, the combination of family therapy and milieu therapy (the dialogue between reflective therapeutic work and social skill training). Furthermore they should describe the very special and intense period in a family's life when going through an IFTU program as compared with ordinary ongoing life and at the same time undergoing an intense reorganising process towards its network (school, employer, social welfare authorities, neighbors).

We stress our deep concern for the creation of the "unconditional atmosphere" and the warmth within an IFTU from a psychodynamically oriented therapeutic tradition. This refers to an often used description of the IFTU from family members as "a house of helpers". "Containing" and "holding" are two concepts that give direction to the therapeutic activities within the therapeutic milieu at an IFTU (30). A period of four weeks or so at an IFTU is very often experienced as a very intense period for family members which is often described as a "turning point" in the life of the family or as a "rite de passage". Over the years, a special focus has been developed within the model with an emphasis on the continuous contact within the therapeutic team (family members, family therapists, milieu therapists,

teacher, referral persons). This focus on self-observation, especially with regard to the commission, team processes and countertransference interfering with good work, is one of the main characteristics of the model (31, 32, 33).

The conceptualisation about family therapy made by the structural family therapist Salvador Minuchin, plays a significant role in the development of thinking within the IFTU's. He (11) introduces the concept of "joining" (page 125) "The family moves only if the therapist has been able to enter the system in ways that are syntonic with it". The multi-dimensional approach (therapeutic activities within the same program from a family perspective and from a network perspective without forgetting the individual perspective) is a heritage from the structural tradition. The use of concrete metaphors from daily living create a number of opportunities to challenge and work with problems. Here, the key concept is that of "enactment". Minuchin writes (12, page 81) "Another advantage of enactment is that, since members of the therapeutic system are involved with each other instead of merely listening to each other, it offers them a context for experimentation in concrete situations." Minuchin stresses that this way of working is especially suitable when working therapeutically with families with younger children. Experience of therapeutic intensity, which is important in the structural tradition, comes in different ways such as staying at the unit for a row of days and meeting oneself and other significant persons in a structured therapeutic milieu as well as in conjoint and individual therapeutic conversations with a co-ordinated therapeutic team. Interactive training for a better mutual understanding of verbal and non-verbal signals (as well as of intentions and motives) between family members are often pursued through programs for social skill training developed within IFTU's and inspired from Marte Meo and BOF (34,35).

From the Milan systemic tradition we use therapeutic concepts as "Family Premise or Family Myths" "Interactive Time" and techniques such as "Circular and Reflexive questioning" for

systemic understanding of problems and symptoms, and thereby promoting alternative family systemic meanings of the experienced problems (27, 35, 36).

From the postsystemic or the constructionistic tradition in Scandinavia, foremost represented by the Norwegian Tom Andersen, we use the concept "the reflecting position". Another concept from him is the concept "just enough different" useful in creating contact between client and therapist as well as the optimal pre-requisite condition for new perspectives. The idea of sharing the responsibility with the clients concerning the meaningfulness of the treatment period at an IFTU is also supported by Tom Andersen's "democratic therapeutic ideology". The ever important question to be discussed with the family members is "what help is the best help for you at this point?"(37).

From the narrative tradition, we have been inspired by what could be named the "co-creating process of the story for change". Carlos Sluzki (38) describes therapy as a transformative process through which patients, families and therapists co-create qualitative changes in their stories about themselves and their problems and symptoms. The old stories containing the problem lose their dominance and are replaced by new ones which have no place for the problem. The problem either finds a new solution or is dissolved.

Michael White's technique of externalisation is often used in a playful manner within the IFTU context (29, 39).

De Shazer's solution-focused perspective has also added important tools to the units, helping to formulate achievable goals for the therapeutic work and emphasising a resource strengthening perspective (40).

"Parental training" as described by the coworkers at the Oregon Social Learning Institute is another key-concept within the IFTU:s. The ambition is to strengthen parents' competence in monitoring and disciplining their children and develop their skills in problem solving among the family members (41).

## ***“Common Denominator Perspective” versus “Aptitude by Treatment Interaction Perspective”***

Psychotherapeutic research history can be described according to two traditions or perspectives. One perspective, called "Common Denominator Perspective", looks for common denominators for successful psychotherapies, whatever their style and method (42, 43, 44). The other tradition is occupied with defining mediators between characteristics of different kind such as clients, therapists, problems, settings, commissions etc. and the most effective therapeutic performance; the so called Aptitude by Treatment Interaction tradition (45, 46). A model for description of the IFTU model needs to cover both these perspective. I prefer to organise these two perspectives in relation to each other as the first forms a foundation and the second refines and optimises the therapeutic efforts due to different "situational factors" defined through empirical research, clinical experience etc.

### **"Common Denominator Perspective"**

From the presentation above concerning the family therapeutic sources of inspiration for the IFTU ideology, the "trademarks" for an IFTU may at this moment be stated by help of the following definition. Every single IFTU builds its local version of this general frame.

By "Intensive Family Therapy" we refer to a way of working described by the following criteria:

**A.** A systemic-oriented program for investigating/exploring ways of dealing with an experienced difficult situation for a family and its helpers. A "family therapeutic program" consisting of family/individual interviews and milieu work in close collaboration over a

limited period of time usually three - four weeks, preceded by a period of planning and preparation and followed by a period of outpatient contact often through repeated home-visits and planned follow up conferences together with school, social welfare etc. (1).

**B.** The therapeutic work is organised and carried out by therapeutic teams. A team consists of family therapists, milieu therapists with different basic training as psychologists, psychiatrists, social workers, pre-school teachers, school teachers etc. These teams have a well-organised and detailed routine for internal and external co-operation.

**C.** Intensive family therapy programs are special investigation/treatment programs almost always starting from a crisis in the family or in the referring therapeutic system (family, social welfare/ outpatient unit together)

**D.** The weeks in intensive family therapy for the families involved, almost always have an extraordinary position in the ongoing life in the family and are often experienced as a useful ritual for "a new start or a turning point".

### **"Aptitude by treatment interaction perspective"**

Every IFTU has composed its profiled program from the therapeutic ingredients described above. The intensity and length of programs varies somewhat between the units. Some units seem to be more structural in their approach and offer a more generally structured training-oriented program, while others are more reflective and commissioner-oriented towards their families. Goals may be formulated more on behavioural change or more on experience and meaning.

### ***A System's Oriented Model for Description of IFTU:s***

One could argue at this point that a systems-oriented model for description of IFTU:s should consider the following:

1. The model must describe the IFTU in its context.
2. The model should give information about the feedback process between the IFTU and collaborating partners.
3. The model should describe the process for updating tasks for the IFTU on the basis of information about the relation between commission and outcome.
4. There should be a description of the identity of the IFTU (ideology), the available resources and how these resources relate to commission and outcome.

The model for description of IFTUs will be introduced using the following concepts: Context, Commission/Referral, Resources, Effects. A discussion will then be presented pointing to the importance of the interrelationship of commission, resources and effects and in relation to the macro and micro-context on which the analysis is made.

#### **Context**

The concept of "context" contains an understanding of how respective units are formally organised within the larger organisational structure (clinic and hospital etc.) and how they are internally organised (leadership and responsibility). This is called macro and micro organisation. Secondly, it contains an understanding to what degree the IFTU and the larger therapeutic context have reached a mutually confirmed understanding about the IFTUs treatment ideology and methods for defined significant therapeutic tasks. This is called Mutuality concerning treatment ideology.



#### a. Macro- and Micro Organisation

Positioning and contextualization of the unit is a significant factor in the sense that a clear commission and mandate from the "mother"- organisation should be given to the unit. This should be balanced with the allocated resources. Mandate for leadership and questions of mutually accepted responsibility between the "mother" organisation and the unit, as well as within the IFTU:s should also be quite clear (47). Routines for referrals, commission, methods and goals must be explicitly described.

#### b. Mutuality concerning Treatment Ideology

As partners in a living ecology of organisations, there should be a mutual acceptance and trust between those involved in the process of co-operation. Although units within such an organisational ecology do not always agree on everything, there must be mutual trust that other units do a "good enough job". Is there a functioning working alliance between partners concerning principles for indications for treatment at the unit, referrals routines etc.?

The task for a unit for intensive family therapy can differ in several respects. The unit may be used mainly for investigational purposes or for treatment purposes. Expectancies from families and other referring sources may differ both to extent and quality. The relation between the IFTU:s and the outpatient units can be regulated in different ways. The relation can be very close, only families referred from outpatient units being admitted, or the IFTU may be organised more independently as an alternative to outpatient work. These different circumstances require different competence and routines.

## **Commission**

In the specific case, the goal should be to create the best possible situation for the unit to do good work in the eyes of the family members under treatment, but also as far as referrals and others are concerned (24). The development of a perspective stressing the significant importance of an agreement about the commission between the partners in the therapeutic process should be accomplished. First and foremost, we are interested in finding out if there is a clearly defined process at the IFTU:s, for arriving at a mutually confirmed description of the situation to be worked with (e.g. intake routines) as we know from clinical experience how vital this is for a constructive therapeutic process.

## **Resources**

By "Resources" we mean the number and categories of personnel in relation to expectations concerning commissions as well as the total formal and informal knowledge, "the treatment culture", experience and training at a unit and different aspects of group climate in the staff group.

The preferred working profile for the IFTU:s can be described by five hypothetical dimensions along which each IFTU may position itself in relation to contract and commission from referral units, and to "theoretical conviction" and other aspects of resources in the staff group:

1. Organisational level: *Team style*: i.e. family therapy and milieu therapy in close collaboration - family therapy and milieu therapy separate from each other.
2. Commission level: *Time*: Short term - long term commissions
3. Ideological level: *Structure*: Generalised and predictable structure, program-directed treatment process - individualised, need-directed structure in treatment process.
4. Treatment level: *Style*:: supportive style - challenging style.

5. Treatment level: *Focus*: Problem/solution focused - process/growth and meaning focused.

Group climate is another important resource factor which covaries with the other factors mentioned.

Important aspects of group resources are:

1. *Sense of Coherence* when working with colleagues. Comprehensibility,

Meaningfulness and Manageability as far as tasks and roles at work are concerned

(48). This discussion relates to the humanocratic organisation mentioned earlier in this article.

It includes experiencing shared values concerning the unit's working profile. This is important as we know that high SOC-values counter burn-out phenomena among caregivers (49).

2. *Group Climate*. Functionality in a staff group can be described as a group profile consisting of the factors Solidarity, Split, Conflict Avoidance, Structure, Negativity (50).

3. *Curiosity, flexibility and openness for differences*, further training and change in style. A staff group can be described as more or less frightened, hostile or eager to further their knowledge and training (23). Differences in resources between units must be ecologically evaluated.

## **Effects**

It is logical to suppose that different contexts, commissions and resources within which IFTU:s operate, covary both with desired goals and with actually achieved treatment results.

For instance, different outcome criteria can be used both in relation to patient families and to other partners in the co-operative process. As far as families are concerned, it seems

reasonable to use a broad spectrum perspective concerning outcome, taking into consideration

such measures as symptom reduction, change in family organisation, social functioning, change in treatment consumption patterns and reported satisfaction with treatment.

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Figure 1 about here

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## Discussion

This model for the description of IFTU:s is one of many alternatives. It has chosen elements from traditional organisational psychology, relevant research concerning institutionally based treatment programs and from clinical experience in the field of intensive family therapy. The model of description is "systemic" in the sense that it gives hope that the "therapeutic power" of an IFTU may be described through the model by combined and interrelating elements from organisation, structure and commission as well as from aspects of content, methods and goals in the therapeutic work. The model may also already, at this stage, give hints concerning the relative weight of importance for these respective elements. It will hopefully provide a "fair" description of the state of an IFTU given the specific circumstances under which it operates i.e. commissions, goals, resources and results. This description may function as a foundation for debate and discussion for establishing plans and actions for the empowering of the treatment model for a specific IFTU given the specific circumstances for that IFTU. The model may also be useful in a more generalized perspective when considering developmental issues in different therapy or treatment programs within the mental health field.

The model will be empirically tested in two steps. In a following article it will be tested as to whether it can differentiate IFTU:s along the proposed relevant dimensions. In a second, more significant step, it will be empirically tested for its usefulness as an explanatory basis for similar and different outcomes between the IFTU:s in our multicenter study.

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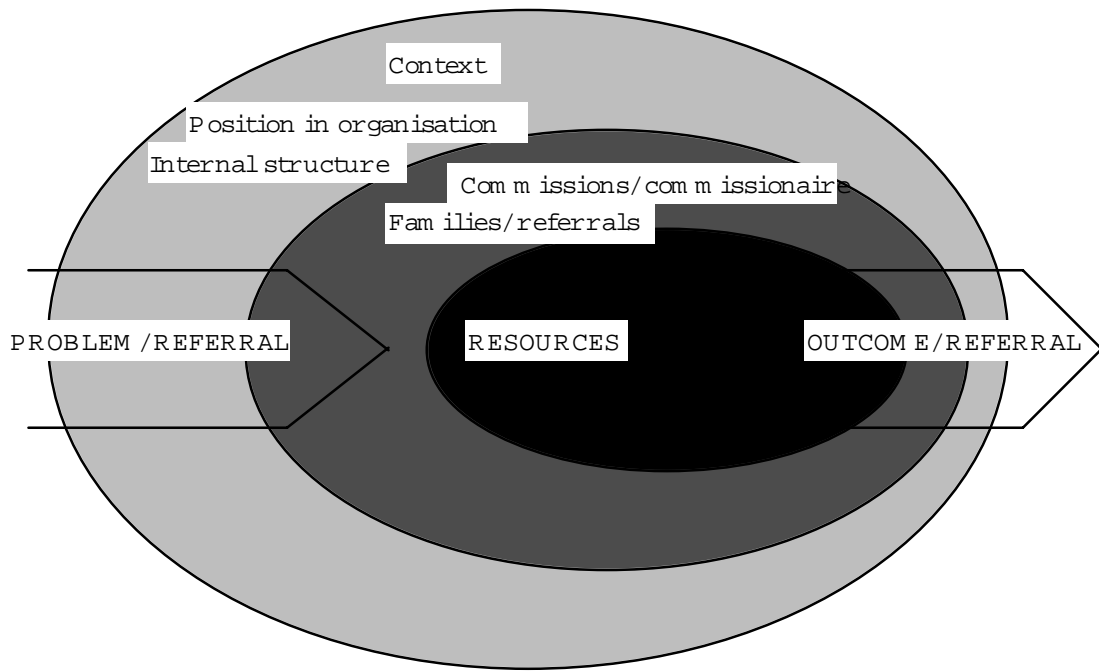


Figure 1: Graphic picture of the theoretical model presented for describing IFTU:s.