

Intensive Family Therapy – a way to treat multiproblem families.

A follow up study measuring individual psychopathology.

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Abstract

This article presents 109 heavily problem-loaded families in “Intensive Family Therapy“ (IFT) in a Swedish multi-centre project involving five Intensive Family Therapy Units (IFTUs). The purpose of the study is to present , compare and evaluate self-rated psychopathology before treatment in Intensive Family Therapy and six months after treatment .

The measurements distributed to the family members are: "Child Behaviour CheckList" (CBCL), “Symptom CheckList (SCL-90) and “Sense of Coherence“ (SOC). The results are reported for mothers, fathers and identified problem child before treatment and six months after start of treatment. Our results are compared to other comparable groups of families. Statistically significant changes towards a lower self-rated and parent-rated symptom-load and higher self-rated psychological health are reported especially by mothers. Measures of clinical significance based on respective mother’s results are presented. We conclude that clinically significant changes have occurred in these families over the period of treatment.

Keywords: Multi-Problem Family, Family Therapy, Milieu Therapy, Family Therapy Outcome, Child Behaviour CheckList (CBCL), Symptom CheckList -90 (SCL -90), Sense of Coherence (SOC).

Introduction

One of the most common ways to measure psychiatric treatment is to look at the individual symptom reduction. In this study we are looking at individual psychiatric symptom as an outcome of family therapy. In family therapy we work with the whole or parts of the family mainly to change family function. One of the questions is if working with the family in this way can also contribute to symptom reduction in individual family members. The interaction between family dynamics and individual psychiatric symptoms have been conceptually discussed. Kaslow (01) discusses a flexible system with four broad categories:

1. Well-delineated disorders of relationships. This category captures clinical problems where the clinician attends primarily to relational problems which lead to severe psychological distress.
2. Well-delineated relationship problems that are associated with individual disorders.
3. Disorders that require relational data for their validity. In this category an individual disorder is central in the presentation of the clinical problem to the clinician. However, a full clinical description of the disorder requires relational data.
4. Individual disorders whose evocation, course, and treatment are strongly influenced by relationship factors.

In our case it is the first, second and third category which are closest to the problems in our families.

Earlier studies

Applications of IFT from different parts of the world are described (02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15). None of these studies have evaluated the results by measuring individual psychiatric symptoms.

In several other studies we found examples of measuring results from family therapy by using individual psychiatric symptoms. In a Swedish, randomised and controlled study of a group of asthmatic children in treatment, family therapy resulted in a significant reduction of paediatric symptoms related to the illness (16). Svedin and Arvidsson (17) evaluated symptom load before and after family therapy for 56 children at a Swedish outpatient child psychiatric clinic. 65% of the parents reported improvement in the identified child's symptom load as a consequence of the treatment according to Cederblad's and Höök's symptom list (18). Gustavsson et al. (19) examined the patients' siblings in family therapy (n=10). 7 out of the 10 had fewer symptoms after therapy compared to before. Effects of different forms of family related treatment programs are evaluated through measures on individual symptomatology in different groups e.g. drug abuse (20, 21) and schizophrenia (22).

Aronen and Kurkela (23) evaluated for example the long-term effects of an early home-based intervention on the quantity and quality of psychiatric symptoms in adolescents (160 families). The mental state of the adolescents was assessed at age 14 to 15 years by the Child Behaviour Checklist and the Youth Self-Report. 80 families attended a 5-year long family counselling program (10 times/year). The adolescents in the counselled families had significantly fewer total symptoms on both the parent and the youth reports.

According to Antonovsky (24) Sense of Coherence is an important power of resistance to psychic stress. Good correlations between Sense of Coherence and total score on CBCL has been found among Swedish youngsters ($r = .61$) (25).

Aims

1. To present and compare self-rated psychopathology before treatment in Intensive Family Therapy and six months after treatment.
2. To discuss these results in relation to other groups, the treatment model and target-families.

Method

Treatment model

In treatment programs in intensive family therapy, described in detail in previous articles (26, 27) the work is done by a team-based combination of family therapeutic talks and closely related milieu work and social training in order to achieve a more effective treatment in a multi-systemic perspective (28). IFTUs (Intensive Family Therapy Units) 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 (29, 30). Models from group therapy and milieu therapy settings (31, 32) 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 (33, 34, 35). 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 (36). Family theory and practice from the structural family therapy, strategic family therapy and systemic family therapy were also frequently used both in family therapy and milieu therapy (37, 38, 39, 40).

Participating families

Participation in the study was voluntary. The criterion for inclusion in the study were all families going through the treatment program up to a certain number (the number varies among the different units) during 1993 - 1994. Of a total of 146 families 109 families participated in the intensive treatment program. Some families have been excluded (37 families) because they were at the treatment unit for investigation (n= 15), or did not know the Swedish language well enough, were not asked to participate or refused to participate . 86 of these 109 families (79% of the treatment families) were followed up and are the subjects of evaluation in this article. The participating treatment units (five different units) consists of established IFTUs in Sweden. The families in the study most likely give a representative picture of the families treated at these units. The pattern of exclusion is the same at all units.

When we compared the initial values on followed up families with the families that dropped out at follow up, we found no significant differences on any of the variables included in this report, We have also included a small waiting-list control group. These families were collected from three of the units after the main project had ended. In this group we managed to recruit 12 families demographically quite comparable with the families in the study group. They filled in the forms one to three months before entering the treatment and immediately before the start of the treatment. For these families, we did not find any changes in the variables included in this article during that time span.

Instruments

Child Behaviour Check List (CBCL) (41) is the parent form of Achenbach's checklist. The problem scale which we have used, consists of 113 items divided into eight sub-scales and three syndromes: Internalising, Externalising and a total problem score. The instrument has been validated in Sweden (42). In this study we have chosen to ask the mothers to rate the children.

Symptom Check List (SCL -90). The test is a questionnaire consisting of 90 statements describing different problems and symptoms . The test is often used as a general measure of psychiatric problems. Reliability studies were carried out: Cronbach's alpha .87 - .84, test - retest .75 - .84. (43, 44, 45, 46).

Sense of Coherence (SOC). Antonovsky developed the concept "the sense of coherence", with the following definition: "A global attitude which expresses to what extent you have a penetrating and lasting, but dynamic, feeling of confidence concerning comprehensibility, manageability and meaningfulness. It is an ability to make flexible choices among available alternatives specifically appropriate for the situation at hand" (24 pp 41). The questionnaire consists of 29 questions originally developed by Antonovsky (24). Every item is to be answered on a seven-point scale. Satisfactory reliability data were found (Cronbach's alpha .77 - .95, test - retest .80 - .91) (47, 48).

Clinical measures. To present measures of clinically significant changes for every family we decided to look for the size of change on each instrument for each family by developing three different measures. We decided to use $M \pm 1 Sd$ in a non-clinical group as a cutting score between a clinical and a non-clinical position. The cutting score for the instrument was set at, for SCL-90 to 42 ($M= 26, Sd= 16$), for SOC 134 ($M= 154, Sd= 20$) and for CBCL 29 ($M= 15, Sd= 14$) in accordance with Swedish norm groups (46, 25, 49). The second measure was to find out how many families changed more than 1 Sd 6 months after start of treatment (according to a non-clinical material). The third measure was to see how many families that changed significantly in the expected direction on more than one instrument.

Procedure

The families were asked to participate in the study at the introductory interview. All family members filled in the instruments at the beginning of the treatment period (if they were above 11 years) and six months after start of treatment.

Results

Boys (64 %) as IPs are more common than girls. There is no significant difference between the units in this respect. Regarding the age of the IP the units differ significantly (One factor Anova, F-test 4.55, $p = .002$). One unit has an average age as low as ($m=8,3$ years) while another unit has a significantly higher average age of the IP ($m=13,4$ years). There is no significant difference concerning the age of the mothers ($m = 37$ years). The families come to the IFTUs mainly because of a problem presented as behavioural-acting-out problem (60 %). The remaining 40 % are distributed equally among internalised problems and other problems such as self-destruction. The families are almost always considered as multi-problem families loaded with problems among several family members as well as socio-economic difficulties of different sorts.

Table 1: about here

The results show a significantly decreased symptom-load both for boys and girls. No significant differences are found between the different ages and sexes. There are no significant differences between the five units. No significant differences for the initial value were found between the follow-ups and those that were not followed up.

Table 2: about here

The results show clearly, for mothers and children who have filled in the form before and six months after treatment, that significantly reduced psychiatric problems are experienced after six months. No significant differences for the initial value were found between the follow-ups and those that were not followed up. Statistically significant differences were found between the different IFTUs on initial values ($F= 3.22$, $p= .02$, one factor anova) and on repeated measures (F -test 3.8 , $p = .001$, two-factor anova repeated measures).

Table 3: about here

A significant increase of "the sense of coherence" is seen for the mothers but not for the fathers. The fathers' initial value is close to a non-clinical group of men. No significant differences for the initial value were found between the follow-ups and those that were not followed up. We found no significant differences between the different units.

Table 4: about here

The values of the IFTU-group are, on all variables, higher than those for a group of children rated by their mothers with the same form at the beginning of a child psychiatric out-patient contact and 18 months after the start of treatment. The differences are particularly obvious regarding the externalising scale. The results of the IFTU-group on the externalising scale after treatment have

dropped close to the initial values for the outpatient treatment group. In comparison to a non-clinical group, the IFTU-group clearly scores much higher on symptom-load.

Table 5: about here

The mothers of the IFTU-group have, in several cases, comparatively high values as regards their self-rated mental ill health. In comparison to another Swedish clinical material consisting of parents of anorectic patients where the whole families were involved in the treatment (50), the IFTU-mothers show very obvious signs of greater mental ill health than the mothers of the former group. The values of the fathers are on the same level as those of the fathers in families with an anorectic child. A Swedish non-clinical group of women and men (25 - 40 years) (46), confirms that the IFTU-mothers rate themselves as being in very poor mental health.

IFTU-mothers' values on SOC are comparable to those of a group of 29 women in family counselling (IFTU group M = 133 (Sd 25.9), Family counselling group M= 131 (Sd 19.0)). The fathers' values are more comparable to a normal group (IFTU group M= 149 (Sd 21.6, Normal group M= 155 (Sd 18.3)) (25).

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 self-rated symptom loads for mothers nor in mothers' estimated symptom load for the children who were considered the identified patient. The results are statistically at the same level as the initial levels on the different tests for the treatment group (SCL-90: first occasion total M 100 (Sd 52), second occasion: total M 94 (Sd 54) $t = .79$, $p =$

.45, CBCL total first occasion M 54.4 (Sd 21.0), second occasion M 55.8 (Sd 24.0) $t = -.59$,
 $p = .56$.

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Clinical significance

Table 6: about here

From table 6 we see that 34 % of the mothers changed their number of symptoms on SCL-90 from a clinical to a non-clinical value. However, 41 % of the mothers have still very high values. On the sense of coherence scale we can see the same change but not as obviously,. Only 16 % moved from a clinical to a non-clinical position. The mothers' rating of the childrens' symptoms showed that 25 % have changed to a non-clinical position. On this scale quite many still had clinical values (52%).

We have also looked at the percent of mothers that moved more than 1 Sd (according to a non-clinical material) on the instruments SCL-90, SOC and CBCL in a non-clinical direction. We found that on SCL-90 63 % and on SOC 27 % of the mothers changed in a positive direction. From mothers' description of the children, 51 % have changed towards a non-clinical position. If we compare this with the results from table 6, we can conclude that quite a number change in a positive direction even though they do not reach a non-clinical position. We also find that if we combine the results from all three instruments mentioned above, 37 % changed more than one Sd on two or more of the instruments.

Discussion

The drop-out rate in this study is high (21%) but, compared to similar studies, it is not that remarkable (51). In many studies of multiproblem families drop-out rates between 25-50 % have been reported. It is worth mentioning that the drop-out concerns participation in the study, very few families broke off their engagement in the actual treatment.

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 these units are overall very similar (with exception of the initial values on SCL-90 at the different units). It needs to be discussed if a randomised control group in this situation is ethically acceptable. All the families in the study have undergone 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 the children into custody. We think that, in such a situation, it would be ethically incorrect to randomise families to either a non-treatment situation or another form for treatment that has not previously led to any improvements.

The single parent family is most common at all the units (53%). The difference between the units is not significant in this respect. If we compare this to the general population in Sweden we get quite a different picture. Most of the children in Sweden live with both their biological parents and if they have siblings these are whole brothers and sisters (75 %). 16 % of the children live with a single parent and 9 % of the children live in a stepfamily (52). The families in our group have somewhat more children than the average Swedish family. The families treated at Swedish IFTUs correspond with the group of families described by other researchers. The most frequent family is a single parent family (mother) with younger children who have out-acting problems, most

frequently a boy 8 - 10 years of age. The relation to the children's fathers or other important male persons is almost always complicated. The family is also socially strained in different ways. Often the family has had previous experiences of out-patient treatment without substantial recovery. The family's relations to social authorities and school are problematic.

Mothers' rating of their problem child's symptom load according to CBCL has improved during the time of treatment. The general psychiatric conditions according to SCL-90 for both mothers and children (> 13 years old) have improved notably. As regards the fathers the tendency is the same even if it is not significant. The lack of positive results from fathers may depend on lack of statistical power due to the small number of fathers in the study. The fathers also admit much fewer symptoms at start of treatment than the mothers which gives lesser possibilities for a significant change. It is also possible that the results are affected by the fact that the treatment model is more adjusted to mothers and children than fathers. We also know that the staff in all the units are mainly female which, of course influences the treatment climate. This treatment climate may seem a strange culture for the fathers with discussions in family sessions centering on emotions and relations. The results from SOC are similar to the results from SCL-90. We see a positive change for the mothers but not for the fathers. The fathers report values on SOC on the same level as non-clinical groups which means that there are no reasons for change. In several cases the fathers were less involved in the treatment.

As far as clinical significance is concerned we notice that about 50% of the families change considerably on each instrument, although the majority of them are still loaded with problems, compared to a non-clinical group six months after start of treatment. A little less than 40% of the families report change on two or more instruments. These results give on one hand information about the considerable difficulties of this group but also hope concerning available help for these families experienced in and disappointed by treatment. We can also note that 19 % of the children had non clinical values on CBCL on both measurement occasions. It is worth mentioning that CBCL as a instrument gives low values on the broader index even if there is a big problem with a

single symptom, like obsession, setting fire or severe aggression that may be very handicapping and needs treatment. In these cases a DSM diagnosis might be a better description. In some cases the psychopathology of the parents has been the main reason for the families being referred to treatment. In these cases IFTU-treatment often deals with parenting skills preventing problems for the children. It is also possible that the parents have denied the children's problems because of fear that the social agencies would take the children away from them. The study would have improved with perspectives on children's symptoms also from teachers or treatment staff.

There are many lessons to be learned on the way things should be more carefully planned and carried out with a higher degree of control regarding the method of gathering information.

However, experiences from participating units have been mainly positive regarding the evaluation process and the feedback of results to the units has stimulated them to increase the quality of their achievements. It is quite clear though that, in the future, fundamental conditions for clinically based research must be more explicit and that resources must be more distinctly available.

Research on clinical work must be discussed ideologically and become a more integrated part of the development of treatment methodology at clinical institutions.

A fundamental question is if the results are good or poor. If we look at the change in symptom-load the result is good, but often does not reach non-clinical level. Even after intensive and successful treatment the stress level of families seems to be high. We think that some of these families need continuous support through the growing up period of their children. Constructive achievements for this group of families seem to require more holding from the care-givers, elements of "practising in every day life with intensive coaching" and, not least, training in social competence etc., all in all that which an IFTU offers. The integrated elements of social training and social support within the IFTUs' treatment program obviously match the needs of this group. We also think that it is necessary to have continuity in treatment as these families are not easy to motivate and recurrently report problems. As a consequence of our results: The families in treatment improved but are still to a great extent problem loaded, we think it would be helpful for these families and, in the long

run, most economical to organise clinics with possibilities for continuous support from IFTU-
programs which include outpatient treatment.

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Table I: Mothers' report on CBCL before treatment and after six months (boys =47, girls =30)
(paired t-test).

	pre treatment	six months after treatment	t-value	p-value
	M (Sd)	M (Sd)		
Girls:				
Internalisation	15.2 (11.6)	9.1 (8.1)	3.9	.0006
Externalisation	20.6 (11.0)	13.2 (9.6)	4.2	.0002
Total symptoms	52.7 (27.0)	32.5 (21.0)	4.2	.0002
Boys:				
Internalisation	14.2 (9.2)	9.4 (7.6)	4.0	.0002
Externalisation	23.7 (12.0)	15.5 (10.2)	6.3	.0001
Total symptoms	54.6 (26.0)	35.7 (22.9)	6.5	.0001

Table II: Results from SCL -90 before treatment and six months after the start of treatment for mothers and fathers (paired t-test).

	pre treatment M (Sd)	six months after start of treatment M (Sd)	t-value	p-value
Mothers (n=78/86)	85.8 (59.8)	48.6 (45.1)	7.22	.0001
Fathers (n=41/62)	42.8 (37.5)	35.8 (38.5)	1.68	.10
Children >13 years (n=31/41)	83.6 (62.5)	64.6 (56.9)	2.41	.0224

(Internal drop -out is, for example, described as Mothers n=78/86.)

Table III: SOC total values and differences before – after six months concerning mothers and fathers in intensive family therapy, paired t-test.

	pre treatment	six months after start of treatment	t-value	p-value
	M (Sd)	M (Sd)		
Mothers (n=80)	133 (25.9)	141 (26.1)	-4.33	.0001
Fathers (n=35)	149 (21.6)	150 (21.1)	-0.77	.45

Table IV: Child Behavioural Check List (CBCL). Comparison between the values of the IFTU-Group for the factors and other relevant groups of boys and girls.

	IFTU-group		Outpatient-group		Norm-group
	pre treatment	six months after start of treatment	pre treatment	18 months after treatment	
	M (Sd)	M (Sd)	M (Sd)	M (Sd)	
Girls:					
Internalisation	15.2 (11.6)	9.1 (8.1)	13.0 (8.4)	9.8 (7.0)	4.4 (4.6)
Externalisation	20.6 (11.0)	13.2 (9.6)	13.5 (9.2)	10.8 (8.6)	5.5 (5.5)
Total symptoms	52.7 (27.0)	32.5 (21.0)	39.8 (23.3)	30.5 (21.5)	14.6 (13.0)
Boys:					
Internalisation	14.2 (9.2)	9.4 (7.6)	11.4 (7.6)	8.1 (6.4)	3.9 (4.4)
Externalisation	23.7 (12.0)	15.5 (10.2)	17.3 (10.5)	13.2 (9.0)	6.1 (6.1)
Total symptoms	54.6 (26.0)	35.7 (22.9)	44.15 (20.4)	33.2 (19.1)	14.9 (13.9)

IFTU- group (47 boys, 30 girls).

Child Psychiatric-out patient group (99 boys, 78 girls) (Botella, Hansen, Janze'n, Thunman , 1995).

Swedish norm group (654 boys, 701 girls) (Larsson 1998).

Table V: SCL-90. Comparison between the values for the parents in the IFTU-Group initially with two other relevant groups M (Sd).

	Mothers	Fathers
IFTU-families	(n= 78) 85.8 (59.8)	(n= 41) 42.8 (37.5)
Families with an anorectic child	(n= 18) 46.6 (22.5)	(n= 18) 35.1 (30.4)
Swedish norm group	(n= 157) 26.5 (16.1)	(n= 111) 23.3 (15.6)

Families with an anorectic child (Wallin, Röien and Hansson, 1996)

Swedish norm group (Malling-Andersen and Johansson, 1998)

Table VI: Percent mothers moving from clinical and non-clinical positions on the tests SCL-90, SOC and mothers rating of children on CBCL during a period of six months after start of IFTU-treatment.

Test	clinical values at both timemes	non-clinical values at both times	from non-clinical values to clinical	from clinical values to non- clinical
SCL-90	41 %	24 %	1 %	34 %
SOC	32 %	45 %	7 %	16 %
CBCL	52 %	19 %	4 %	25 %