Intensive family therapy - a context for hopes put into practice

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INTENSIVE FAMILY THERAPY

a context for hopes put into practice

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Contents

Abstract

This dissertation consists of four sections.

Section 1 deals with a presentation of a model for Intensive Family Therapy (IFT) and of the units practising this model. References to research in the field of Family Therapy as well as to relevant theories are made. A theoretical model for describing the functioning of these units is presented. Measuring instruments were developed on the basis of this model. Seven Swedish Units for Intensive Family Treatment (IFTUs) were evaluated. The analysis yielded two profile measures (structure and staff satisfaction) which were used to group the units into three clusters.

Section 2 deals with a multicenter study of treatment effectiveness (a pilot study and a main study). 109 families (86 in the follow-up) at a number of Swedish units for intensive family therapy took part in the main study. The families were investigated regarding symptom load and family function before and six months after the start of treatment. They were compared with other relevant groups of families with regard to symptom load before and six months after the start of treatment. The group of families treated with intensive family therapy showed clear statistical changes on follow-up. Half of the families reported notable clinical changes which must be considered satisfactory as the target group is composed of multiproblem families.

Section 3 presents a hypothetical model for family investigations called information-seeking work for change.

Section 4 weighs the profiles of the different units against the treatment results achieved. The conclusion is drawn that larger, more independent, more competent and more problem-focused units achieve better treatment results.

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The thesis is based on the following papers

Article 1:
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Article 2:
Hansson K., Davidsson-Gräns S., Milling M., Johansson P., Silvenius U., Sundelin J., Westlund M. Inpatient family therapy. A multicenter study of families´ and staff´s experience of family climate. Translated for this volume from: Nordisk Psykiatrisk tidskrift 1992; 46/5:336-343.

Article 3:
Sundelin J. A Systems-Oriented Model for Description of Intensive Family Therapy Units. Accepted Nordic Journal of Psychiatry, February 1998.

Article 4:
Sundelin J. A Systems-Oriented Model for Description of Intensive Family Therapy Units, a pilot study. Accepted Nordic Journal of Psychiatry, February 1998.

Article 5:
Sundelin J., Hansson K. Intensive Family Therapy – a way to treat multiproblem families. A follow-up study measuring individual psychopathology. Submitted, 1999.

Article 6:

Sundelin J., Hansson K. Intensive Family Therapy
- a way to change family functioning in multiproblem families. Accepted Journal of Family Therapy, March 1999.

Introduction

Background and procedure

This study was initiated as a phase in the development of treatment at the family treatment unit (a unit at the Falu hospital), in the middle 1980's in close co-operation with the Department of Child and Youth Psychiatry at Lund University. As in other parts of the country, the rationalisation efforts of the County Health Services in, what was then, Kopparberg county, meant increased demands for quality garantees from child and youth psychiatry in general, and especially from resource intensive and costly units providing in-patient care. A small pilot study entailing the evaluation of former patient-families' experience of their family climate was initiated by the family unit in Falun in order to test, on a small scale, the plausibility of a clinical evaluation project. The data was collected in the late 1980's. Eventually, this project was co-ordinated with comparable measurements from other intensive family treatment units throughout the country to form a multicenter study of a exploratory nature, mainly aimed at creating contacts between units and testing co-ordinating routines (Sundelin et al., 1991, Hansson et al., 1992).

A more thorough multicenter evaluation study of intensive family treatment was planned during 1992 and initiated in 1993 under the supervision of Ass. Professor Kjell Hansson and myself. In this study several criteria were set to judge the effectiveness and outcome of intensive family therapy criteria and for this purpose a number of different measuring instruments were used. The majority of the results are reported in this dissertation.

My task was to compile and analyse this material and also present a systematic description and examination of this special method of working. Formerly, the method was called in-patient care of families and/or milieu therapy with families, but, at this point in time, parallel to the theoretical development of the treatment model, we started talking about Intensive Family Therapy. The treatment form consisted of family work carried out by a well-coordinated team of family therapists working with family members for a limited, intensive period and included both therapy sessions and milieu work. From around this time, the units began to be called IFTUs (Intensive Family Therapy Units). The study was planned to include a comparative examination of the various family units regarding treatment results and, on the strength of this, attempt to draw some conclusions as to what makes these treatment units effective. In this context it seemed natural to include a description of the type of family most frequently treated at these units. My commission also included a critical examination of the treatment method in relation to this target group in the light of international research and clinical findings.

The purpose of the study

To present an internationally based theoretical and clinical frame of reference for Intensive Family Therapy.

To describe and define different aspects of Intensive Family Therapy.

To develop a descriptive model for Intensive Family Therapy which can be used in both research and clinical practice.

To develop methods of evaluation in accordance with this descriptive model with the purpose of testing the model empirically.

To describe and evaluate the units participating in the study.

To measure the total effectiveness of intensive family therapy and the effectiveness of the separate units.

To describe the group of families usually given this treatment and to compare them with other groups of families with regard to family function and symptom load.

To discuss the challenges facing clinically based research

Family Therapy Research; State of the Art

Before starting a large project regarding a special method for family treatment, it is natural to consider the various thoughts and ideas that have been put forward regarding family therapy in general. The following summary is based on research seminars with my supervisors and doctoral colleagues on critical questions and dilemmas in the field of family therapy research methods and on research results hitherto reported, mainly from work with children and adolescents. Guided by these discussions, I instituted data searches via the data bases Medline, Psych Litt and Eric. Examples of the keywords used are: family therapy, family therapy research, parental skill training, parental management, intensive family therapy, psychotherapy research.

I have chosen to discuss psychotherapy research in general and family therapy research in particular starting with Mardi Horowitz's model for the development of psychotherapy research, as presented by Armelius and Armelius (1985). Armelius and Armelius represent empirical psychotherapy research in Sweden. I shall then, with the help of this model, comment on the

current situation of family therapy research taking as my starting point the work of various established family therapy researchers. A presentation of family therapy research in general will be made with special focus on the group of patients mentioned in this dissertation, that is to say, families with children and adolescents who mainly present acting-out or externalised symptoms. One consequence of examining the present effectiveness of family therapy is the emergence and development of integrated treatment forms.

After a short presentation of the main ideas of the most important schools of family therapy, an integrated theoretical treatment perspective will be introduced. Finally, this section will end with a short description of what research shows to be the most successful integrated treatment models regarding externalised problems.

Horowitz's model according to Armelius and Armelius

According to Armelius and Armelius' model, psychotherapy research begins with:

1. A description and classification of the phenomena to be studied. An important task for psychotherapy research is to document the organisation of relations between various presumed psychological phenomena such as, for example, the relation between what the therapist says and what the patient does.

2. The second stage deals with associations. Associations between events form the grounds for our understanding of them. Armelius and Armelius see therapy as both art and science. In the same way that a musician is trained to perform his art, therapeutic competence can be described and developed through research by operationalising the components in effective treatment

programs and then consciously practising these. Just as musical proficiency largely rests on the musician's technical ability to handle his instrument, it is also possible with conscious training in therapeutical craftsmanship to raise the efficacy of interventions. It is also important to investigate whether therapeutic approaches differ in their degree of effectiveness depending on the situation and the nature of the problem.

3. The third level of research concerns an attempt to determine causal relations, to confirm the hypothesis that psychotherapy can alleviate certain mental problems.

To do this, the relation between aim and criteria must be considered. The closer these are to each other, the more likely it is that measurements will confirm a positive outcome.

The criteria of change (the measurements measuring change) must be sensitive to the phenomena to be measured and not to other irrelevant phenomena in the situation.

The reliability of associations must be discussed. It is thought that this can best be established by repeated studies using new patients and new therapists. The authors raise a number of points which must be taken into consideration when drawing conclusions from the associations found: Does the design include a control group? Is the change measured affected by other factors than therapeutic effect? An example of this is a maturational process which would have occurred irrespective of any therapeutic intervention. Does the measuring procedure in itself have effects that yield false information about change?

For example, the actual measuring procedure may influence the client's answers or the observer's interpretations in a way that decreases the reliability

of the measurement. How does the selection of the sample to be studied (the group of clients to be studied) and the drop-out rate during the investigation affect conclusions which can be drawn about the treatment model? How do statistical procedures such as regression effects (floor and ceiling effects) affect the picture given by the results? Finally, the authors mention ethical aspects such as whether research work at a clinic disturbs the therapy under study. They discuss how these effects may be minimised. Regarding the integrity of the research process, they discuss the importance of the research contract, clarity about the confidentiality of results and the autonomy of the research procedure, so that the individual therapeutic process and the information gleaned from the research results are separated from each other in a clear and controlled manner.

1. Description and classification.

The field of family therapy is extremely complex and heterogeneous. Formulation of theory is not especially sophisticated as working methods have emerged from a pragmatic tradition. A reasonable requirement regarding the description and classification of a research field is, however, that the field itself be defined. Therefore, I have chosen to present D. Station's definition of family therapy (Stanton 1988, p 9):

"Family Therapy - perhaps more appropriately Systems therapy - is an approach in which a therapist (or a team of therapists) working with various combinations and configurations of people, devises and introduces interventions designed to alter the interaction (process, workings) of the interpersonal system and context within which one or more psychiatric/behavioral/human problems are embedded, and thereby also alters the functioning of the individuals within that system, with the goal of alleviating or eliminating the problems."

Like his research colleague Ryder (1988), Stanton shows the current complexity of the research field by demonstrating how the established research tradition of logical causal relations (the search for simple, pure, linear associations) is not functional in a field of research dealing with mutual, so-called recursive, associations. Stanton also points out the question of the objectivity of research and comes to the sole conclusion that it is important to accept that the starting point for both therapist and researcher in the study of family therapy is a complicated one. One works as both participating observer and, in this respect, also as a constructor of one's own research field. Further, he sheds light on the complex interchange of sensitive feed-back processes, that, for better or for worse, steer the therapeutic process and points out how a constructive perspective on this complex field requires a thoroughly worked through theory to start from; this is essential for the generation of hypotheses which can lead to a number of manageable variables. The family therapy researcher is also faced with the dilemma of either concentrating on purely manualised models of family therapy and attempting to hone them to even further precision or to recognise the value of studying clinical practice, i e integrated, complex working models of family therapy which have been developed pragmatically. These, although more difficult to describe, are probably more potent and synergetic (Stanton, 1988, Pinsof, 1995).

2. The second step deals with associations.

David Reiss (1988) argues that the progress of development in family therapy research has come to a halt with outcome studies. Two main factors have caused this. The first has to do with financial resources and the importance of demonstrating tactically and politically to a wide public, the effectiveness of family therapeutic models. The other reason is that family therapeutic theories of change are too poorly developed to stimulate the next step of research, namely, the development of research on the associations between the active agents in the family therapeutic process and treatment outcome. Reiss outlines

two such theories of change, namely the Deconstruction-Reconstruction theory and the theory of projection-rejection-conversion. The initiated reader will recognise these theories of change as representing the structural school of family therapy and the systemic school respectively. Neither of these models of change are more than an outline of a useful model to explain the active agents in the family therapeutic process. However, they could form starting-points for an interesting and intensified development of family therapy research.

Lambert and Hill (1996) comment on the same aspects as Armelius and Armelius, but also include an interesting discussion on measures of outcome and process. They ask, what are relevant measures of outcome? They describe the historical development from generally formulated evaluations to the current use of more concrete and operationalised variables. In their opinion, the multitude of possible measurements mirrors the complexity of the field of psychotherapy research. The various therapeutic approaches rest on different theoretical bases and different areas of treatment with different clients and different problems. It is, thus, extremely difficult to find simple, acceptable measures of this complex process. Throughout the years, attempts have been made to find models for individualised therapeutic goals. The GAS-measure (Goal Attaining Scale) is mentioned, but the conclusion drawn is that individualised goals remain more of an ideal than a reality. Instead, attempts have been made to discover models to categorise different outcome measures such as intrapersonal measures, interpersonal measures and level of social function. In the ideal outcome study, one would hope to tap all possible aspects of change. Another aspect of outcome measures is the durability of the change. How lasting is it and what measures are suited for use on repeated occasions? Sigafoos et al. (1995) suggest that regarding reactivity when completing self-answer questionnaires, one should take into consideration the context in which the questionnaire is completed and the social relation that the client has to the investigator (to check reactivity, a note should be made of the context when the

questionnaire is completed (author's note, Petitt and Olson, 1992). Questions can be formulated to measure internal matters in the family or the family's relation to the outside world. They can also be phrased so that the persons answering experience themselves as a member of the family or as a critical outside observer. All of these factors must be taken into consideration when interpreting responses to different questionnaires.

The general opinion is that it is essential to have a broad perspective and that many different criteria are required to measure change via family therapy (family measures and individual measures from all family members, self-ratings and observer ratings, the ratings of others such as therapists and researchers, other types of psychiatric, psychotherapeutic, social and socio-economic measures etc.). Further, the importance of extreme sensitivity to the context in which the work of change is going on is stressed, as well as a connection to the outcome measure both in regard to the "presented problem" and to well-developed theories of change via family therapy. The above report mirrors the established position in the field of family therapy research (Olson, 1988, Anderson, 1988, Wynne, 1988).

A highly relevant topic for discussion concerns clinical versus statistical significance. Lambert and Hill (1994) discuss various ways of making pronouncements about a change signifying a difference by deciding in advance critical changes in a number of variables which, taken together, constitute a multiple measure of clinical difference. The risks involved in retrospective studies and what is really measured when one asks clients, after the termination of treatment, to describe their situation before treatment, are discussed. The recommendations they make are in accordance with those of the majority of established researchers: the importance of a prospective research design with a comparable control group.

3. The third stage is, then, to refine the analyses of therapy process variables and their outcome. There is some research showing how process variables can be coupled to outcome variables (Alexander, 1973, Alexander et al., 1976). Lambert and Hill (1996) say that it is now time to examine the association between therapy process variables and different clients. This is called "Aptitude by Treatment Interaction". Some reflections on this subject are found in another section of this work (Sundelin, 1998 a).

As far as the reported research on therapy variables goes, it is said that, in general, the age of the therapist does not seem to covary with the outcome of therapy. On the other hand, it seems to be important that the therapist is not younger than the client. Regarding the gender of the therapist, it would seem that female therapists suit female clients better. Nor does there seems to be convincing empirical support for the fact that the socio-economic standing of therapist and client has any influence on the outcome of therapy (Lambert and Hill, 1994).

Hansson (1996) describes clinical research with different ambitions in the form of a ladder where the lowest rung concerns "evaluation of care", "consumers' satisfaction". The next step is "evaluation by following up treatment". The third step is a prospective study with measurements both before and after treatment. The fourth step supplements the third step by comparing measurements with those of a control group. The fifth step concerns process studies to establish the active agents in treatment and how these covary with outcome.

Alternative perspectives and criticism of empirical psychotherapy research.

Quantitative research has often been criticised from the perspective of qualitative research. Criticism has often been of the nature that quantitative research through its methodology often provides answers that are uninteresting from an information point of view, it is pseudo-exact and difficult to apply for the individual clinician. However, there are strivings to describe a dialectic relationship between psychotherapy and other adjacent disciplines, between quantitative and qualitative research traditions.

A qualitative analysis must be regarded as an analysis of phenomena, characteristics and meaning (Starrin, 1994). Its aim is to identify a) the variation, b) the structure and/or c) the process in the identified phenomenon, characteristic or meaning. The goal of a quantitative analysis is to investigate a) how previously defined phenomena, characteristics and meanings are distributed among different groups in a population or are distributed with regard to different events or situations and b)if there are any associations between two or more phenomena, characteristics or meanings and, if so, whether any possible conclusions about causal relationships can be drawn. The suggested distinction between qualitative and quantitative analyses results in the, not altogether controversial, conclusion that in order to measure phenomena we must know a great deal about what we want to measure, if a measurement is to have any significance at all. This knowledge can only be obtained through a qualitative analysis. To put it another way, it is by means of a qualitative analysis that we can achieve knowledge about the internal relations of a phenomenon, i e knowledge as to what is typical of a special characteristic and which properties this characteristic exhibits. According to Starrin's views, questions of analysis should be given precedence to questions of method and statistical analysis. Sells et al.(1995) present an integrated

research model where qualitative and quantitative methods are alternated in an ascending movement within the same project in order to verify theoretical findings generated by the qualitative model. They call it a "Multi-method, Bi-directional Research Model". The antagonism between methods has been supplanted by a fruitful interchange as exemplified in one of the author's proposed research project about which criteria should be studied in the reflecting-process. The model is presented as a number of stages beginning with the identification of the research question, choice of theory and qualitative method by means of a generative working method. The next step is to gather data, analyse and categorise them in accordance with quantitative research designs. Concepts are validated by qualitative methods and hypotheses are formulated. A transition is then made to a quantitative perspective, the research population and sample identified, methods chosen and developed and data collected. Theoretical concepts are then documented and expanded in a qualitative analysis. Complementary aspects of qualitative and quantitative research have also been described by Bryman (1993).

Therapists and therapy research.

Newmark and Beels (1994) are two clinicians who represent the critical views often heard from therapists on psychotherapy research. In an article, they write that it is difficult to be rid of scientific ideas, even if they don't work, as they represent "the truth". Therapeutic competence is not founded on research, but on experience and sessions in everyday clinical work. How one knows what to do as a therapist in different situations is based on experience from clinical work. Family therapy is not first and foremost a science, but rather a ceremony to heal families. The therapeutic process between therapist and families where the mutual creation of a metaphor enables change, is extremely complex. The greatest risks run by science are over-generalisation and over-simplification. Why cling to Bateson? Why use Maturana to emphasise the

importance of "local knowledge"? The concept of "expressed emotion" is certainly useful in research, but not clinically. Science, they say, restrict the clinician's outlook. A scientific idea can be misinterpreted as something which actually exists. Theories generated in the therapeutic setting are, by definition, an expression of desires and fantasies, otherwise they would not function as a therapeutic instrument within the framework of the therapeutic reality of change. The clinician can use science by following the scientific literature regarding the long-term effects of therapy. The clinician should exercise self-criticism as to how he/she applies scientific theories in therapeutic reality. The clinician should always be open for new ideas.

The relationship between the family therapy clinician and the family therapy researcher.

In an attempt to shed light on the somewhat strained relations between the family therapist and the family therapy researcher, Liddle (1991) takes up a number of points that should be focused on in order to better this relation in the long run and, at the same time, allow the development of family therapy to be influenced to a greater degree by scientific feedback:

The reciprocal expectations of the role of the researcher in a clinical context must be defined in order to gradually disperse a number of mutual prejudices and misconceptions. The tasks for clinical research must be defined and the expected outcome described from a consumer perspective. In this way, the clinicians' need for research more closely related to clinical reality can be met.

The development of schools of family therapy has often taken place by defining an opposite position or anti-position. This tendency must be combatted by using a multi-dimensional perspective of change. The barrier can be broken down, for example, by developing more functional channels for

contact and communication, such as periodicals with interesting articles in a language comprehensible for the clinician and by integrating research and effective models of family therapy within the frame of family therapy training schemes.

Pragmatic, constructive consequences of this are the development of efficient research-based multidimensional models of family therapy treatment.

Family therapy's culture as a non-scientific activity with charismatic leaders and a "confessional" basis must be opposed.

Criticism of the traditional scientific society by social contructionists.

Gergen (1994) takes a social constructionistic stand. He argues that objectivity is a rhetorical phenomenon. Science is anything but objective and he questions the basic ontological assumption that an independent world corresponds to the words, language and expressions of this world. Our convictions as to what is good and true are created by the social process, above all, as is it formed by our foremost form of communication, language. He criticises efforts to find a "single voice" and idea about what is privileged knowledge. On the contrary, knowledge is gained by increasing the dialogic spectrum, that is to say, by describing as many alternative theories as possible regarding a phenomenon and its inner and outer associations.

A story comes to be regarded as true through skilful narrative art. (My own comments pointing out the similarity to the different sections of a research report follow to give a provocative example of Gergen's main line of thought.)

1. Establishing a valued endpoint.
   (goals and aims of the report)
2. Selecting events relevant to the endpoint.
   (description of research variables and research population)
3. The ordering of events.
   (description of procedure and method for carrying out the project)
4. Stability of identity.
   (reporting of results)
5. Causal linkages.
   (discussion of results)
6. Demarcation signs.
   (conclusions and suggestions for further research)

The debate on family therapy research in Scandinavia during the 1990's.

An interesting debate on family therapy can be found in the leading Norwegian family therapy periodical "Fokus på Familien". Questions about the basic assumptions of research are discussed. Hansson (1993) stresses that criteria of effectiveness must be established by others than the researcher himself and that methods must be described carefully and the generalisibility of methods of work investigated. Andersen (1994) considers that a central issue is the discussion of the ideological assumptions behind every research effort. Andersen questions the viability of seeking general conclusions about psychotherapy in the average values of client group data. Further, he says that a dialogue between living subjects - people - can easily be objectified by trying to standardise methods. He objects to the use of such words as "interventions" and "therapy" considering them poor metaphors to describe the actual dialogue.

Jaakko Seikula (1996) says that it is most essential to find words for and create a language for difficult experiences in a social community. Therapists are co-authors rather than authors. The therapist's most important task is to be able to follow the language stream in order to adapt to the language of the network and to develop the dialogic conversation within the network and between the network and the therapeutic team, thus widening the perspectives of the participants.

Questions concerning psychotherapy research on children and adolescents and their families.

When planning a large multicenter project which includes the evaluation of a family therapy model for the treatment of families with children and adolescents, there is every reason to consult the established expertise in the field. In the following, we will discuss a number of problems and dilemmas confronted by our project. We also present recommendations for the planning of treatment models and research projects which can constitute desirable goals in our development both as clinicians and clinical researchers.

Kazdin (1994) formulates the following (much abbreviated) challenges in therapeutic work with children and adolescents:

Problems are a common occurrence and often part of normal development. How does one differentiate between these and problems that are not normal?

Every problem during childhood and adolescent years must be seen in relation to age and developmental level in order to be correctly evaluated.

Rapid natural development and the co-variation between many different areas of life are unique for childhood and pose a challenge for treatment.

Motivation to seek help does not always stem from the child or young person. The drop-out rate from treatment programs is high, especially for young people. Premature conclusion of treatment is more common among young mothers, single parents, families from minority groups, socio-economically burdened families, families with a high level of stress and prone to crises, families with strict methods of upbringing, families with children who have serious problems, families with a history of antisocial behavior, families with children who have learning difficulties and families where the child has several diagnoses (co-morbidity).

Concerning questions of evaluation, Kazdin concludes that:

Parents are the most important source of information but this information must be seen as biased. Mothers' answers to check-lists are often influenced by their own problems. Several sources of information should be used to establish the child's situation and status. Many studies report low consensus between reports from parents, teachers and the child's own estimation of its difficulties.

Extremely disturbed children have often several types of symptoms and perhaps several diagnoses. Kazdin sees this as a methodological problem regarding the grouping of symptoms and diagnoses when making comparisons.

He sketches a number of future tasks for psychotherapy research regarding children and adolescents.

The scope of research questions should be broadened in accordance with the following:

- The effect of treatment contra lack of treatment.
- Identification and categorising of the components in the treatment that contribute to change (e g length) and influence outcome.
- The relative effects of alternative methods.
- Combinations of treatments that can better the outcome.
- The roles of different treatment processes in therapy.
- The influence of patient, family and therapeutic characteristics singly or in combination with alternative treatments.
- Developmental aspects on the carrying out of treatment and its effectiveness.

Alexander et al. (1994) discuss effect goals. They stress that family therapy research should think in linear-systemic and quantitative-qualitative terms. They launch the concept "matching to sample" which implies the setting up of meaningful contextualised aims for the group under study which also decide methodology and sub-goals on the lines of what has previously been said about Goal-Attainment Scaling.

Both Kazdin and Alexander et al. describe very clear frameworks for how "research possible" treatment programs should be organised.

The authors make the following recommendations for future research (summary of Kazdin, 1994, p 576 and Alexander et al., 1994, p 613):

- Attention-placebo effects must be monitored by using control groups.
- Treatment models must be defined, verified and better described empirically.

It is important that the research world comes to an agreement on a number of "core outcome batteries", which can then be supplemented by context and problem-specific instruments.

Clinicians and researcher must develop, test and compare programs for both short-term and long-term treatments.

Family therapy research must be steered by better differentiated clinical theory specifying the interaction between treatment models, disturbances/problems and patient systems. The ideas on "Aptitude by treatment interaction" (ATI) ought to be developed. Pinsof's concept of appropriate therapeutic contributions "problem maintenance structure" is a constructive starting point for future work (this concept is presented below).

Family therapy research must incorporate cost-benefit measures.

"Family therapy" is too narrow a name for the research field. Most research in this area is not called family therapy but is given other names such as, for example, "parental management".

Thoughts on family therapy research in this project.

How should a research based program for family treatment be designed? Which therapeutic factors should apply to all families offered treatment at IFTUs and which factors should to be tailored to the need of the individual family? How should such a program be planned? How is one to know that the units, in their different ways, represent this sort of framework and how are similarities and differences in the phenomenon called IFTU to be measured?

In accordance with Armelius and Armelius' views on psychotherapy, family therapy can be described a complex phenomenon - both art and science. Like Armelius and Armelius however, we approach the phenomenon from a scientific perspective. How does one find a balance between essential therapeutic measures of change, their therapeutic conditions and the precision of the measures? How is an essential therapeutic change to be established? If such a change has occurred, is it to be established by the client, the therapist or a non-involved person? Should criteria for change be open or should prior standards or criteria for change be set for the client, therapist or observer to choose from when making an evaluation? Should there be several criteria for change and criteria on different levels, for example social cost-benefit goals? How are these to be weighed against each other?

How should the association between the therapeutic process and effectiveness measures be linked?

How is a statistical significance to be evaluated? How are a number of measured differences before and after treatment to be interpreted? Does the measure indicate a clinically noticeable difference for the individual family?

One of the problems in the clinical world is finding a control group whose results can be compared with the group under study. Without a control group reported differences remain unexplained. The active agent behind the change is a mystery. How can one ethically defend a randomised design when families with an extremely heavy symptom-load have already experienced all too many unsuccessful treatments? What conclusions dare one draw from results of a clinical study which does not have a prospective randomised design and where results are not compared to data from other relevant groups of families? The representativity of the units and families participating in the study must be discussed and evaluated. What conclusions can be drawn from such a study?

What value does it possess? A question related to the above is how to deal with the expected relatively large drop-out rate in a clinical study.

How does the measuring procedure itself affect the results? With regard to the self- answer questionnaires, the information is mainly based on parental ratings. What does this imply? Can filling in the same questionnaire repeatedly explain change? A related question is whether the questionnaire as a form of measurement is equally suited to mothers, fathers and children. Do gender-based attitudes to one's own life situation as father or mother influence the way the questionnaires are completed?

Regarding observer's ratings, it cannot be ignored that these may be prone to unwanted observer effects.

Possible statistical regression effects, i e floor and ceiling effects in the measurements, should also be commented on.

The present multicenter study has therefore attempted to work with several outcome measures by using a large battery of tests. This dissertation includes an attempt to relate the outcome results with the therapeutic process, above all, on an organisational level. Possible undesirable statistical effects affecting the measures of change are discussed, especially when comparing measures from different units. Measures of clinical significance are constructed. Measures from comparable groups are presented as well as from a small group of families on the waiting-list.

The representativity of the reported results is discussed, not least in connection with how these may have been affected by the relatively large, but expected, drop-out from the study. We have attempted to handle the influence of the measuring procedures by using various kinds of measures (self-ratings and

observer ratings). The question is also discussed from the point of the chosen time intervals between measurements and from the perspective of age and gender.

Towards an integrated treatment perspective

The emergence of the IFTU family treatment model must be seen from three angles and contexts: 1. The total picture of family therapy's present, fairly concordant, views on successful treatment models for difficult family conditions. More about this will be said below. 2. The experiences of the different schools of family therapy regarding work with complicated family situations and families with foremost externalised problems and heavy symptom loads. The most well-known schools of family therapy are briefly presented. 3. A workable theoretical model of integration for achieving a concordant treatment concept for an IFTU which has "plenty of breathing space", Pinsof's model (1995), is presented.

Research recommendations regarding integrated working models

Kazdin (1994) and Alexander et al. (1994) draw the following, largely identical, conclusions when summing up the collective state of research on different forms of psychotherapy for children and adolescents. Three comprehensive meta-studies of family therapy were examined: Gurman et al. (1986), Hazelrigg et al. (1987) and Shadish et al. (1993):

Any psychotherapy would appear to be better than no therapy at all. The effects on children and adolescents are, in the main, equivalent to those achieved when psychotherapy with adults is evaluated. Family therapy works

and is more effective than standard treatment and/or individual treatment for, among others, the following patients: adolescents with behavior problems, ADHD children with aggressiveness and "non-compliance", autistic children, children with chronic physical illnesses, obese children where the child is at cardio-vascular risk.

Family therapy is not harmful: None of these studies of family treatment show less advantageous results for those who have received treatment than those who have not.

There is no available data giving support to any one particular form of family therapy. (This regards almost exclusively the American schools of thought, which are mainly different variations of the strategic and structural traditions of family therapy (author's comment)).

Family therapy by itself is not effective when it comes to what are defined as serious problems. By these are meant conditions of psychotic confusion and severe anti-social behavior involving extreme acting-out, criminality and heavy drug abuse. In these cases family therapy must be integrated in a broader treatment plan which includes individual treatment, group treatment, medication and various educational programs to train social competence, impulse control etc.

In general, Kazdin and Alexander conclude that parental and family influence are important ingredients in the treatment of children and adolescents. The degree of parent and family influence varies depending on the type of problem that the child suffers from. It is therefore important to try to clarify this influence when planning different types of treatment involving children with various problems. "Parent management training" is considered very successful in regard to behavioral problems. Many of the studies include a supplementary

package consisting of child therapy and therapy with couples. These studies had often even better results. It must be pointed out, however, that all studies had good results.

Guiding factors for development in the field should be corrective feedback for research on process and effect and not charismatic leaders.

Recently, Diamond et al. (1996) reviewed the current state of family therapy. Rather than speak of family therapy, they prefer to talk about family-based treatment, where behavior treatment, psycho-educative treatment and systems-oriented treatment are integrated. Behavioral treatment most often includes training in "parental management" and parenting skills and "behavioral contingencies programs" for the family. Psycho-educative programs strive to change negative attributions regarding the patient's illness, training in coping skills, social support for the patient and family. Systems-oriented treatment works with restructuring non-functional patterns of relating in family interaction. The authors arrive at similar conclusions regarding the current state of family therapy and its implications to those already mentioned above. Family-based therapies try to establish or re-establish a context for positive development in order to help handle or dissolve the child's symptoms. Family treatment promotes normal family processes which support the healthy development of children and adolescents. Medication and supplementary treatment (e g admittance to an in-patient clinic) are used when necessary. However, all interventions are judged from the viewpoint of promoting family competence and growth. The therapeutic value of this "corrective developmental experience" is supported by extensive research from the field of developmental psychology showing that positive parent-child relations have a positive effect on child and adolescent development in many life aspects. The authors stress the importance of promoting integrative treatment programs based on a family perspective such as the multi-systemic programs of

Henggeler et al. (1995), and Liddle et al. (1995). These programs will be presented in more detail later on.

At the request of "Marriage and Family Therapy", William Pinsof and Lyman Wynne compiled a review of the state of research on family therapy in the form of a monography published as a separate number of the periodical (1995). The monography has separate chapters on important problem areas where the outcome of family therapy is evaluated. The chapter on different behavioral problems in children is compiled by Ana Ulloa Estrada and William Pinsof. The results from other reviews presented above are confirmed through careful presentations of the results of other studies for each of the problem areas. It is interesting for a Scandinavian reader to note their descriptions of Lovaas successful therapeutic work with parents and autistic children (Estrada and Pinsof, 1995). In the chapter on family-oriented therapies with adolescents, an excellent and clear presentation emphasises that the more complicated the problem, the more essential it is that an effective treatment deals with several goals for change on different levels using a combined battery of therapeutic and other methods for change (Chamberlain and Rosicky, 1995).

A consequence of this evaluation of the effectiveness of family therapy is the development of integrated treatment models, despite warnings about the risks involved when using them (Lebow, 1997). An integrated treatment program requires a broad institutional basis, a number of team-members with both specialist competence and the ability and will to cooperate in a context which is "greater than each one of them". One wonders if an integrated perspective is possible to uphold for the majority of active therapists. It places heavy demands on training for all concerned. Furthermore, there is the risk of a diluted eclecticism and lack of overall ideology unless the team see an integrated perspective as something worth striving for (Lebow, 1997).

Regarding multi-dimensional integrated, research-based treatment programs, Chamberlain and Rosicky (1995) conclude that family therapeutic interventions seem to ameliorate behavioral problems and problems of criminality among adolescents better than individual psychotherapy. However, they also confirm a high drop-out rate. In their review of the effects of family therapy, Pinsof and Wynne (1995) find that family therapy with adolescents and their families on an out-patient basis seems to help in the case of moderate behavioral disturbances. The more severe the disturbance, the more obvious it becomes that family therapy must be supplemented by other efforts. The role of family therapy must be synergetic with other methods within the framework of an integrated treatment package. Therefore, a presentation of four models, all of them integrating different treatment efforts now follows. With the exception of the last model, all of them have been given a positive report in the overviews of research mentioned here.

Functional family therapy (FFT) (Alexander et al., 1997), the work at the Oregon Social Learning Center (OSLC) (Patterson, 1997), multi-systemic therapy (MST) (Henggeler et al., 1994, 1996,1997) and multi-dimensional family therapy (Liddle et al., 1992, Liddle, 1994) have under a long period showed a mixture of scientific cautiousness, clinical and field-focused sensitivity and a continual production of outcome data which have mutually influenced each other. All four programs are laudably open to input from different clinical and research-based sources. All four have been also strong enough to adhere to their theoretical emphasis and, in consequence, their suppositions, techniques and results have retained an internal consistency over a long period of time.

Functional family therapy.

In functional family therapy (FFT), the child is often described as the identified patient in a dysfunctional family system (Barton and Alexander, 1981, Alexander et al., 1997). The supposition is that problem behavior as expressed by the identified patient is the only way for the family to express and satisfy their interpersonal needs for proximity, distance, support etc. Treatment focuses on directly changing interactional and communicative patterns so that interpersonal needs at different ages and for different temperaments can be expressed in a way that enables the family to function adaptively. Theoretically, therapy is divided into different phases. The first phase concentrates on connecting to and motivating therapy, by confirming each person's needs and trying to balance these with the needs of the other family members. The second phase consists of an evaluation of the family's resources, the difficulties between family members and between the family and the environment which impede a movement towards change. The third phase consists of working on long-term motivation. The fourth phase introduces various types of programs for change and the fifth phase concentrates on generalising experiences. The model integrates knowledge from the entire family therapeutic field and includes cognitive and behavior-oriented techniques. The main goal of treatment is to increase mutual understanding and positive feedback between the members of the family, to establish a clear and unambiguous mode of communicating, to help describe in concrete terms what behaviors family members want from each other, to learn to negotiate in a constructive manner and to help each other identify solutions to interpersonal problems. Effect studies of FFT have shown clearly positive results (Klein, Alexander and Parson, 1997). There are also a number of process studies which show differences in communication patterns between normal and dysfunctional families (Alexander, 1973) and the association between therapist

characteristics, the family's behavior and treatment outcome (Alexander et al., 1976).

Oregon Social Learning Center OSLC.

The Oregon Social Learning Center's model for work with anti-social behavior in young people is of long-standing and well documented by research (Patterson et al., 1993). Since its start in the 1960's, the institute has been lead by G.R.Patterson. The work has comprised both a preventive project and a treatment program. A theoretical model of critical factors in the development of criminal behavior has been developed. OSLC's theoretical standpoint is both behaviorally and cognitively oriented. Anti-social behavior is mainly learned and based on the interaction between individual and context (family and environment). It can be un-learned by alternative patterns for reinforcement of adequate pro-social behavior, competence training and training in problem-solving (so-called social training). The training is directed at parents, children and other representatives in the everyday life of these children and their families (day-care centers, school, peer group etc.). It is interesting that, in accordance with the theoretical model for the development of anti-social behavior, a program for intervention at different phases in this career has also been drawn up. In latter years, this has led to among other things: a prevention program for families who have recently gone through a divorce (Forgatch and DeGarmo, 1997), a prevention program for children in the equivalent to Swedish grades 1 through 6 (Reid, 1997, Reid et al., 1997, Reid and Eddy, 1997), models for treatment programs for advanced anti-social behavior and juvenile delinquency (Chamberlain and Reid, 1991, Chamberlain and Rosicky, 1995, Chamberlain and Moore, 1997).

Multisystemic therapy.

Multisystemic therapy is a method developed primarily to effectively treat serious anti-social adolescent behavior. The research team have documented good results in their effect-research on both a short-term and long-term basis (Henggeler et al., 1995,1996,1997, Schoenwald and Henggeler, 1997). The term "multisystemic approach" indicates how several contributing aspects are focused on when treating critical factors in the emergence of criminality, such as individual treatment, family treatment, work with peer groups and the school environment. This model is theoretically based on structural and strategic family therapy (Minuchin, 1974, Haley, 1976) and on ecological ideas of behavior and behavioral change (Munger, 1993). The principal idea is that all work takes place in the natural environment, that is to say in the home environment.

The starting point is an initial evaluation of the strengths and weaknesses of the actual family and the interaction between the young person and the family, between the family and other important systems such the young person's peer group, family friends, school and the parents' place of work. Work with the family often entails dealing with a high level of conflict and a low level of emotional closeness. There are often conflicts between parents or caregivers over upbringing and their own personal problems diminish their parenting ability. Family work often incorporates sessions aimed at increasing parents' ability to help each other relate in a constructive manner and take measures to increase family structure and feeling of belonging. The treatment strives to remove obstacles in the way of change, such as parental drug-abuse, a high stress level and poor social support.

With regard to the peer group, it is above all necessary to cut back on the young person's contact with deviant friends and increase the time spent with

"well-adjusted" friends via clubs and organised participation in sport. This work is largely carried out by the parents with the guidance of a counsellor.

Work in school includes support for the parents to help them develop and intensify efforts to follow up how the child functions and achieves at school, as well as helping them organise and structure homework and recreational time.

Individual work is carried out with the young person and his parents largely through social training, self-confidence training and analysing cognitive representations which prevent positive development, or make it more difficult.

An overall aim is to create resources and give parents strength to deal with the most pressing problems in the family, in relation to the peer group and at school. The counsellor's role is mainly to motivate and teach.

A vital aspect of treatment is co-ordinating work with that done by other " help instances". Work is mainly conducted in the families' home environment in order to increase the effect of generalisation.

The treatment team for each family consists of three counsellors who are supported by highly competent professional therapists. Each team works with 50 families a year. The various applications of the work are continually evaluated. Criteria used in comparison to other treatment forms, mostly individual ones, are the adolescents' symptom load, the parents' psychiatric status, the general level of stress in the family, future criminal behavior, arrest because of possession of drugs and arrest for sexual crimes.

Another program developed under the leadership of J. Szapocznik, has a long history of research, theoretical development and a successful program for the treatment of behavioral problems in children and adolescents from a Latin-

American dominated culture. The method of working is based on structural family therapy. In a study comparing results with those of individual therapy, no immediate differences were found, but the two conditions were clearly better than the results in a placebo group. Follow-up results, however, were clearly better for the boys treated in the family program (Szapocznik et al., 1989).

Multi-dimensional therapy.

Liddle and his associates' Multi-Dimensional Therapy also deserves mention (Liddle et al., 1992, Liddle, 1994). This method was especially developed for work with adolescents with behavior problems and drug-abuse. Like the other models, it was developed in relation to research findings. The intervention model is integrative, based on an interactionistic model of the relations between cognition, affects, behavior and the influence and feedback from the environment. Different behavioral problems are described in terms of a network with multi-faceted influences. A consequence of this, is that interventions must be broad and directed at several different important functional goals. The approach assumes that change occurs via multiple pathways (cognitive restructuring, affective clarification and expression), in different contexts (individual, familial and extra-familial) and through different mechanisms (e g development of a new cognitive framework and the acquisition of new skills). The model emphasises that special contexts for special aims must be "tailored to order". The importance of integrating developmental psychological aspects in the young person with the total interactionistic concept of treatment is especially emphasised.

The Center for Research on Aggression, University of Syracuse, New York.

The Center for Research on Aggression, University of Syracuse, New York, has, under the leadership of Professor Arnold P. Goldstein, developed a number of methods for group work with young people with acting-out problems. The content of the work is somewhat of a side-issue to the other models presented as it does not have the same clear family theoretical base. Still, it is interesting because it has developed methods for the concrete training of skills which are also used in family-oriented programs. ART (Aggressive Replacement Training) is composed of three intertwined parts: training of social skills, training in the control of aggression and moral development. There are some interesting ideas on how paranoid/aggressive thoughts develop in the anti-social child and how they are amplified in a negative circle in an anti-social career. The cognitive aspects of the treatment program focus on this. A. Goldstein is the author of several books such as Aggressive Replacement Training: A Comprehensive Intervention for Aggressive Youth (1987), The Gang Intervention Handbook (1987). An evaluation of the method has also been published (Goldstein and Glick, 1994).

Different clinical perspectives on work in difficult family situations and with problems of acting-out.

Structural family therapy

Structural family therapy was developed in the 1960's by Minuchin when working with families and adolescents in the slums of New York (Minuchin et al., 1967). The structural method is described in the book Families and Family Therapy (Minuchin, 1974). The method has, above all, been employed in work with families with a low degree of structure and where family circumstances

are described as chaotic and poorly integrated; when externalised problems are present co-operation with other care authorities is clearly indicated. In their book "Family Therapy Techniques" (Minuchin and Fishman, 1981, p 58), the authors write that "in families where one of the members presents symptoms related to control, the therapist assumes that there are problems in one or all of certain areas: The hierarchical organisation of the family, the implementation of executive functions in the parental subsystem and the proximity of family members". Jorge Colapino who has worked for many years within the structural tradition, presents (1995) some interesting ideas in regard to work with families with ineffective parents who neglect their children. He describes the spontaneous process in these families' association with social welfare authorities as a process which dilutes responsibility, and where parents, who already are weak, easily fall into a process which makes them even weaker. The structural analysis before commencing work with these families must take into consideration a wider context, where the family and those involved in helping them should together constitute the system offered help by the structural therapist. Therapeutic work with the family, to increase the competence of the parents and help them create a more adequate structure in the family's interaction, must be supplemented with efforts to break down the complementary pattern between the under-functioning parents and the "over-functioning" social welfare services. One must be prepared to constructively and together confront the completely adequate aims of the social services to "save a child" with the need to support a family by taking stock of resources and efforts to develop these resources in family work with a view to helping them delineate clearer boundaries between themselves and the environment and to take adequate responsibility for their future.

Strategic family therapy

According to strategic theory (Haley, 1980, Madanes, 1981), disturbed or disruptive behavior in a child is the result of incongruence in the family's

hierarchical organisation. Parents are in a superior position to the child through the very fact that they are parents, yet the child is in a superior position in relation to the parent/parents by protecting them through symptomatic behavior which often metaphorically expresses the parent/parents' difficulties. The child's problems give the parents a reason to avoid dealing with their own difficulties. The planning of strategic therapy includes helping the child retain the interpersonal gains of symptom development in a different way than via the symptom. In a case study of a five year old boy with violent outbursts of aggression, the incongruity in the hierarchical position between mother and son was solved by means of a ritual where the boy was told to pretend to have a violent outburst every morning and afternoon which the mother was instructed to meet with hugs and kisses. Then the mother was told to have a similar outburst and the boy was directed to help mother "calm down" in the same way with hugs and kisses (Madanes, 1981).

Appertaining to adolescent problems, there is the classical strategical description of how the family hierarchy is rendered instable in connection with the problem of "leaving home". This period activates conflicts between the parents and the young person is caught up in a triangle drama in order to stabilise the family at the expense of their own adequate development. The therapeutic strategy is to first take control and then see to it that the parents regain control and retain it by co-operating with each other (Haley, 1980)

Solution-focused therapy

Solution-focused therapy was developed at the Brief Family Therapy Center, Milwaukee, USA, foremost by Steve de Shazer (1985, 1988). It, also, emanates from an interactionist perspective where the individual is preferably described in context. Representatives of this school wish, however, to mark a clearly different position to that of established schools of family therapy on a decisive

point: namely, in their view of change. They consider everything to be in a constant state of change and the key to solving experienced "hangups" are the exceptions i e those occasions when one feels that one has actually solved a problem one is faced with and usually not been able to handle. Therapeutic measures are built on the already existing change. Instead of solving the problem, solutions are constructed together with the clients. The perspective on planning the family treatment is very pragmatic and is steered by two rules:

1. If something is not broken, don't mend it. 2. If you know what works, do more of it. 3. If something doesn't work, don't repeat it, do something different. This applies to both the therapist's work and to the message he/she conveys to the family.

When working with socially burdened families, Insoo Kim Berg (1992) describes how, in this tradition, these three rules can be put into practice, preferably in the families' own homes. Much energy goes into establishing a mutually experienced, trusting partnership. The work revolves round questions of commissions, goals and contracts. The family members are stimulated to participate actively and to take responsibility. The therapist tries to respectfully understand and learn about the specific way of living and functioning in the family in question. Strengths and resources are explored. The therapist's work of making contact with and merging with the family in order to arrive at a mutual formulation of what is to be done, forms the basis of the subsequent work towards change. This is brought about by identifying the exceptions where constructive solutions have taken place, by goal formulation with the "miracle question", by checking up sub-goals and injecting the family with the hope of finding future possibilities.

Narrative family therapy

Michael White (1991) writes that people's life stories do not only determine the meaning that they give to their experiences, but also what part of these experiences they choose to give meaning to their lives. What we actually experience in life is, however, richer than each story about life. The structure in each story arranges and gives meaning to experiences. However, there are always feelings and experiences that are not totally encompassed by the accepted story. White says that people need professional help when they feel that the stories they have about their own experiences and/or others' stories about the same experiences a) do not agree with the experience, b) when there are important contradictions between a person's own experience and story and between one's own story and the current opinion of the environment. Externalisation, which is the central method in White's narrative therapy gives people an opportunity to step out of their own and others' story about themselves and thus catch a glimpse of experiences which can create new, extended stories. This is done by finding the unique occasions which support and form these new stories. The "ritual" is an important instrument in narrative therapy for creating new mutual experiences which form the basis of creating new interactive stories. Methods are described for how family members of different ages and with different problems individually or together can "glimpse and find strategies to counteract their problems". These rituals for new experiences may look different, but all strive to create new life stories which give scope for more activity and increase self-esteem and greater competence for those involved. Regarding his work with families with acting-out behavior, White describes the "closing ritual" where parents develop the controlling function and also their closeness to the child who acts out (White, 1991, Freeman et al., 1997)

Systemic family therapy

A systemic perspective on ideas about externalised problems is described by two Danish psychologists with long experience of work with families where acting-out is the presented problem (Jörgensen and Schreiner, 1987). Their working model for how a child's acting-out may be experienced, consists of a relational analysis of the contexts in which the problematic behavior is found and includes hypotheses on how the context can be understood from the perspective of both child and adult. In their book, they start from an interactive model or "system of meanings" in the interplay of child and parents, where the problematic context triggers destructive ideas and activities which then interweave with and strengthen each other. The authors sketch ideas for discussions, mainly with the adults, about the children in order to break the negative interaction. This is done in hypothesis generating talks about how the problem can be experienced from the child's perspective and how the child, in this situation, expresses important needs which can perhaps be seen and met with in a better manner. However, ideas are also given as to how parents are helped by discussions where they can formulate for themselves how they interpret the meaning of the context where the problem arises. Why is the child the way it is and why does it do what it does? What is it trying to say? How does this provoke me? How do I interpret the child? What is my automatic response? What response is right? The book reports experiences of parents' hypotheses and the activities these trigger. It describes how parents' hypotheses are not only formulated on the basis of ideas as to what is best for the child, but how they are also coloured by ideas on parenthood in general and their own parenthood in particular. This part of the book could well be described under the title of "parent self-esteem and how it can be increased". One can also see how the creation of a psychological distance and the parents' reflectiveness establish conditions for a new start from a clearer perspective. In their discussions with the therapist, the adults in the fighter relationship get a chance to work with and extend their ideas and

hypotheses on how the present situation can be described. New light is shed on the situation. This enables parents to evaluate their own and the child's actions differently. The adult also gets in touch with his/her own vulnerability which has previously enabled the child to "set him/her going". The adult also sees the situational context in perspective and can do further work on this rather than solely focusing on burdening the child with all the responsibility for the difficulties.

Similarities and dissimilarities in different family therapy models.

The structural and strategic traditions as described by Minuchin and Haley and Madanes respectively, emphasise unambiguity in family structure with the parents in a hierarchically superior position. Both these schools have a clear, normative idea of a functional family when dealing with problems of acting out. The therapeutic process of both schools combines practical exercises, home tasks and rituals with talks during which a new understanding is reached. The family therapist is a leader with a clear therapeutic strategy. Practical phases are also found in both the solution-based and narrative traditions. In these latter approaches there is not such a strong emphasis on the normative perspective on what constitutes a functional family. Instead, the emphasis is on a constructive solution for the family's particular case which they seek to find with the help of the therapist. The therapist's role is that of a partner in a dialogue, a guide, a consultant. In the narrative tradition, the solution is based on understanding and meaning, whereas the solution-focused tradition is more eager to see that things actually work in practice. The systemic tradition bases its work almost exclusively on discussion and the meaning elements in the system which define understanding of the interaction between and within participants. In the systemic tradition, rituals become meaningful by adding alternative ways of understanding. In the structural tradition, they, above all,

increase the possibility for the development and use of hitherto concealed assets, competencies and resources within the family and for social training.

As previously mentioned, the majority of the evaluation studies presented are based on family therapy in the strategic or structural traditions.

William M. Pinsof's model (Pinsof, 1995) for an integrated psychotherapeutic treatment program.

I now present an integrated treatment model which can be used by those working with a family-oriented or system-theoretical approach to children and adolescents and their families. The model gives possibilities for the flexible use of different, mainly family therapeutic, approaches depending on the nature of the presenting problem.

The model is developed by William M. Pinsof, psychologist and professor at Northwestern University School of Education and Social Policy and head of the university's family institute. The author is a well-established researcher and clinician in the field of family therapy.

Pinsof starts with the concept Problem-Centered Psychotherapy which he contrasts to Value-Centered Therapy which is not organised around the presented problem to such a high degree, but around an accepted definition of health, normality or ideal functioning.

Problem-Centered Therapy integrates biological, individual and family therapeutic models. The problem-centered model treats the "patient system" which is defined as containing all the human systems which are, or can become, involved in the fact that the presented problem remains or will be

solved. Human systems can be biological, psychological, social or combinations of these.

The critical question for the problem-centered therapist is: What hinders the patient system from resolving the presented problem? The answer lies in what Pinsof calls the Problem Maintenance Structure which includes all the members of the patient system including their actions, biology, cognitions, affects, object relations and self-structures. The therapist formulates hypotheses about the problem maintenance structure from the working perspective which is assumed to be active. The basic supposition is that a health perspective is assumed as long as nothing to the contrary is proved. This means that one tries to treat the problem maintaining structure first on an educational and organisational level within the total patient system. If this proves unsuccessful, one works with an increasingly deeper psychological and individual perspective until the problem maintaining structure is dissolved. The aim of the therapeutic work is not total achievement but a good enough achievement which can be defended from a cost efficiency point of view.

Pinsof defines different levels of constraint: **1. An organisational level,** which deals with an analysis of the rules applying between the members in the patient system. **2. A biological level** dealing with constraints in key members such as reading and writing difficulties, physiological handicaps, illness, biologically determined depression etc. **3. A meaning level** which includes cognitive and affective components regarding the importance and roles that the different members in the patient system assign to themselves and others and the behavior of themselves and others. Which culture, in the broad sense of the word, experiences the problem most? **4. A transgenerational level**, where constraints are associated with invisible loyalties to the social network and "psychological obligations" to families of origin etc. Constraints for previous levels can sometimes be described as anchored in and explainable

at this level. The fifth level for analysis is the **object relations level**, where the constraints according to Pinsof can, for example, be described from the point of concepts such as projective identification in a pair-relationship. Pinsof calls the sixth level the **self-system**. His point of departure is Kohut's self-psychology where the self is described as a triangular structure consisting of the poles ambition, ideal and effectiveness. Adequate development is attained by supplying these poles with adequate supplies of good self-objects throughout life. The author further describes contexts in which treatment can be carried out: in a family/network context, in pair therapy and in an individual context.

The complicated interplay of the dependent working alliances which arise between the therapist and the members in the patient system, are described in the model as phases and transitional phases between the different foci in treatment work. The model also describes how different treatment contexts can be used alternately and how questions of loyalty and integrity between the therapist and the patient-system and within the patient-system can be handled.

The adaptive solution is defined by Pinsof as the simplest, most direct and most cost-effective solution that the "key-patient" can produce. This task identifies what must happen in order to solve the present problem (the process aim of therapy). The adaptive solution is found in and formulated from five sources: 1. The therapist's knowledge of the problem cycle. 2. The picture of the patient system, its structure, human and economic resources, developmental level and culture. 3. The therapist's knowledge of the accumulated professional and scientific knowledge/wisdom regarding the presented problem and effective measures. 5. The "key patient's" understanding of what needs to be changed in order to solve the presented problem.

Research plan

Incitement for developing methods for IFTUs; emergence and development.

Family therapy became an important therapeutic approach within Scandinavian outpatient child and youth psychiatry during the 1970's. Several inpatient units for younger children in child psychiatry and social welfare in the Nordic countries, were successively transformed into family treatment units during the 1970´s and beginning of the 1980´s (Sundelin, 1995). In the 1990´s we have seen a continuous increase of these kinds of units. This development seemed to be related to an increasing demand for methods which could deal with specially resistant problems experienced at that time, which were described as underorganisation in the family structure, chaotic family situations, acting out behavior and other behavioral problems difficult to get a grip on with the methods used in outpatient child psychiatric clinics (Aponte, 1976). 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 further the development. Families described as difficult to help on an out-patient basis were referred to these units for "Family Investigation" or for Intensive Family Therapy by social welfare authorities, the courts or outpatient units within the Child Guidance organisation.

IFTUs have found theoretical and methodological inspiration from many sources over the years. The therapeutic content and performance are largely built on an integrative approach and are in a constant state of development. 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 (Nakhla et al., 1969, Kennedy et al., 1987, Gillis et al., 1989). Models from group therapy and milieu therapy settings (Jones, 1970, Feldman, 1970) were adapted to fit families living together with other families in a meta-family for a period. The central idea was to use social feedback from mutual experiences of everyday situations in a therapeutic milieu with 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 (MacGregor, 1962, Hallström, 1991, 1992). Another source of inspiration was 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 (Haugsgjerd, 1973). 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 (Minuchin 1974, Minuchin and Fishman, 1981, Haley, 1980, Boscolo et al., 1987). As early as 1959, there are descriptions of how mothers in need of psychiatric care were admitted to a psychiatric clinic together with their small children (Main, 1959). Institutions working in this manner are described in a number of articles. The treatment was carried out by letting the families live in the institutions during the period of treatment, sometimes as day patients and sometimes by working therapeutically in the families' homes. Aspects of the working model from the viewpoint of practice, theory and the specific need for care and treatment of the target group are penetrated (Johnson and Savage, 1967, Nakhla et al., 1969, Lynch et al., 1975, Ney and Mills, 1976, Riddle, 1978, Goren, 1979, Harbin, 1979, Combrink-Graham et al., 1982, Dydyk et al., 1982, Churven and Cintio, 1983, Cooklin et al., 1983).

Intensive Family Therapy; one definition.

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 sessions 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. (Sundelin, 1995).

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).

D. The weeks of 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".

The plan of the study

As already mentioned, collaboration with the Institute for Child and Youth Psychiatry at Lund University was initiated as a step towards developing the work of the Family Unit at Falu Hospital (a unit for intensive family treatment at the child and adolescent psychiatry clinic). A small pilot study to evaluate how families who had received treatment experienced their family climate was started at the Family Unit at the Child and Adolescent Psychiatry Clinic in Falun to test the feasibility of a clinical evaluation project. Gradually, this study was co-ordinated with similar studies at other units for intensive family treatment throughout the country into a multi-center study of a pilot nature, mainly to establish contact between the units and to test co-operation routines (Sundelin et al., 1991, Hansson et al., 1992).

A more thorough multicenter evaluation study of intensive family treatment was planned during 1992 and started in 1993 under the leadership of Ass. Prof. Kjell Hansson and myself. It was decided that I compile and analyse this material and at the same time describe and map out this special method of working more systematically. This work was also to include a comparative review of the various units for intensive family treatment with regard to treatment outcome and thus draw conclusions from the information which could answer questions about what makes this sort of treatment unit effective. A natural consequence of the study was to look at the type of family which was most often treated at these units. The commission also included a critical review of the treatment method from the point of international research and treatment findings. Table 1 below illustrates the research plan as it is presented in this dissertation.

Table 1: The research plan

1986-1990	Pilotstudy 1: Sundelin J., Hansson K., Westlund M. Inpatient family therapy. Evaluation of the work at a treatment unit at the clinic of child and adolescent psychiatry in Falun 1986-1990. Fokus på Familien, 1991;4: 221-231. Pilotstudy 2, Small multicenter study: Hansson K, Davidsson-Gräns S., Milling M., Johansson P., Silvenius U., Sundelin J., Westlund M. Inpatient family therapy. A multicenter study of families´ and staff's experience of family climate. Nordic Journal of Psychiatry, 1992; 46/5:336-343.
1992-1998	Two articles addressing description of the treatment model: 1. Sundelin J. A Systems Oriented Model for Description of Intensive Family Therapy Units. Accepted Nordic Journal of Psychiatry, February 1998. 2.Sundelin J. A Systems Oriented Model for Description of Intensive Family Therapy Units. a pilot study. Accepted Nordic Journal of Psychiatry, February 1998. Two articles addressing multicenter-effects of intensive family Therapy: Sundelin J., Hansson K. Intensive Family Therapy - a way to treat multi- problem families. A follow up study measuring individual psychopathology, submitted, 1999. Sundelin J., Hansson K. Intensive Family Therapy. - a way to change family function in multiproblem families, accepted Journal of Family Therapy, March 1999.
1996-1998	Two special chapters in the dissertation addressing special issues: 1. Informationsseeking work for change with families. 2. IFTU-organisation and effectiveness as a treatment unit.
For the future	A prospective randomised study on heavy problem-loaded families comparing an integrative therapeutic perspective with traditional outpatient design for therapy.

Study group 1

Units for intensive family treatment included in the study

The study group studied in the first part of this dissertation consists of the various IFTUs. These are the family unit at the Clinic of Child and Youth Psychiatry in Lund, the family unit Rullegården at the Clinic of Child and Youth Psychiatry in Karlshamn, the family unit at the Clinic of Child and Youth Psychiatry in Uddevalla, the family unit at the Clinic of Child and Youth Psychiatry in Helsingborg, the family institute at the Clinic of Child and Youth Psychiatry in Falun, the family unit at the Clinic of Child and Youth Psychiatry in Växjö and the Skutan family treatment home, social services department, Gothenburg.

All these units collectively and compared with each other comprise study group 1. All of them accepted an invitation from the Institution for Child and Youth Psychiatry at Lund University to participate in the study. Even though they are not randomised from the total population of IFTUs, they represent clear examples of the treatment model. Unit 3 is excluded from the outcome part of the study because of a large drop-out of families. The unit is included in the measures comparing the different organisations of the units and their relation to treatment results. Unit 4 mainly worked with commissions for family investigation and is therefore also excluded from the treatment part of the study. The response frequency for the questionnaires distributed to the staff concerning the working profile of the units was over 90%.

Table 2: Some significant characteristics for the IFTUs involved in the study.

	Karlshamn	Lund	Helsingborg	Skutan	Uddevalla	Växjö	Falun[1]
Day care (x) 24 hours care (xx)	x	xx	x	xx	xx	xx	xx
Referrals from	Own outpatient	Own outpatient region	Own outpatient	Soc welfare bureaus	Own outpatient	Own outpatient	Own outpatie 35% region, other sources 65%
Intensive fam . ther.tasks in %	65%	87%	90%	50%	100%	85%	55%
Other tasks	35%	23%	10%	50%		15%	45%
Estimated duration of tot contact with fam intens+extens.	1 month	3 months	2 months	2 months	5 months	6 months	8 months
Number of staff with dipl. in psychotherapy	0	0	1	7	0	3	4
Number of staff	10 + 6 aff. ther.	12 + 6 aff. ther.	6 + 0 aff. ther.	10 + 0	10 + 2 aff. ther.	7 + 0	15 + 0
Further training Milieu and Family therapy	internal	internal high	internal	internal external high	internal	internal external high	internal external high
Unit starting year	1981	1985	1982	1981	1990	1983	1981
Employed staff N working years at unit (1995)	8.5	9	9	10	5	7	11
N Intens Family cases per year	30	40	17	17	27	12	25

Day-care (x) 24 hour care (xx) differentiates the units as to whether they meet their families for treatment during daytime or if the families stay in the institution Monday through Friday. Referrals from describes whether the units

[1] The order of presentation is different from the numerical order in which the units are presented elsewhere in this article

get their referrals only from outpatient units in the same organisation or if referrals come from different sources. Different solutions indicate different therapeutic tasks, different degrees of autonomy and considered competence. Intensive Family Therapy tasks in % other tasks indicates to what degree the different units focus on intensive family therapy compared with other forms for therapeutic and investigative work. Estimated duration of total contact with the families indicates length of time that the therapeutic responsibility rests more or less solely on the unit. Number of staff with diploma in psychotherapy gives information concerning the formal level of competence in the staff group. Number of staff describes the size of the unit. The "+" means number of affiliated therapists with a looser connection to the unit's teamwork. Further training milieu and family therapy means my classification of reported accomplished further educational programs at the units. Starting year and employed staff N working years at the unit (1995) give an idea of the unit's collective experience as an intensive family therapy unit and an idea of the stability of the staff group. N intensive family therapy cases per year indicates how many families per year go through an intensive program.

All units within child and youth psychiatry except Falun, have a child psychiatrist in charge of treatment. Falun has a social worker who is responsible for treatment, as has Skutan which is organised within social services. All units are family-oriented and have obvious similarities which can be defined within this treatment model. All of them work with families in a daily intensive program over a period of time. The work is carried out by a team of milieu therapists and family therapists working together. There are some differences in the capacity to provide night accommodation for families. The duration of the therapeutic work with families differs considerably. The units differ in size and available resources as well as flexibility in the unit's program. Differences are also seen concerning organisational affiliation, tasks and commissions. The basic training profile among milieu staff is very similar,

consisting of nurses, psychiatric nurses, children's nurses, teachers of different kinds, pre-school teachers etc. Formal further training of staff groups differs quite a bit. The units are of different ages but none of them is entirely new. A noticeable characteristic is the stability of the staff groups. The method Intensive Family Therapy is the common denominator for all the units and is presented in the following "vignettes" or clinically angled stories in order to give the reader more information about the "study object". The content can be seen as expressing central ideas for clinicians working at an IFTU. Most of all, the aim of the text is to give those who are interested, more food for thought by presenting "soft data" on the world of the IFTU, and thus background for a deeper understanding of the treatment method.

"Vignette 1" Thoughts developing over a period of 20 years.

How can a family therapist describe the language of symptoms and suffering? How can one motivate the relevance of a family perspective when treating serious individual mental symptoms, especially in children? How can one motivate the relevance of IFTU's working method for the families treated there? How can one argue that the IFTU method should be given priority when working with the group of families which comes to these units for treatment?

Information from family therapy research and the introduction of different schools of family therapy which to a greater or lesser degree lack scientific verification regarding their effectiveness must be seen on a time scale spanning more than 30 years. During this period, the knowledge about family therapy has grown enormously and the perspective has changed. New family therapeutic approaches have been founded on the assumptions from earlier schools of thought. Some perspectives have been completely forgotten while others have experienced a renaissance.

In the beginning of the 1980's, our analysis of an acting-out problem's relation to the family's problem was simple. Forceful work was undertaken without hesitation with the aim of strengthening the parent or parents' executive function by affirming their position as the parent/parents of their child (Minuchin et al., 1967, Minuchin, 1974). Efforts to help parents create a more structured family situation which would help children out of a chaotic world and into more orderly furrows were considered successful. Symptoms receded and the majority of those involved were satisfied.

The working method was blunt, demanding and created conflicts. By dramatising key situations in the family's way of functioning and training new functional patterns of transaction, we helped families develop new competencies. At the beginning of treatment we were involved in a power game with the parents as to which perspective of change was to be the privileged one. Then, together with the parents, we were in a fight with the child and its confusion in the new, clearer family structure. Then we and the family were in conflict with those who were to continue our work in out-patient clinics and schools until they were convinced as to the excellency of the new perspective. After this new families arrived and we began all over again (Anderson and Steward, 1983).

Although we were successful, we got weary. We started to be more careful in our analyses of the family condition to be treated. We showed more respect for just how difficult these conflicts were. The strength of the conflicts was seen more and more in the light of the dynamics behind them, both on a systems level and on an individual level (Wrangsjö and Runfors, 1984). We became more open for the process which possibly, but not necessarily, led up to the point where we formulated a contract that we were the ones who were going to help the family. The therapeutic theme based on systemic thinking must be firmly established among all involved and we began to understand that

the only way was for everyone to see to it that no-one got left behind and that everything proceeded at a reasonable pace. We became more open, gentler, perhaps more uncertain and absolutely more humble and realistic as to our possibilities to help. We regarded ourselves as co-workers going from one point to another in a process that had begun long before we came on the scene and which would continue long after the conclusion of our work together. We described ourselves more as benevolent experts who distributed our pearls of wisdom for the family and its members to accept or reject. At this point, our commission reached its conclusion (Selvini Palazolli et al., 1984, Papp, 1983). We formulated systemic hypotheses about the deficiencies in the family dynamics and how the child, as symptom bearer, loyally took its share of the load. We now described in positive terms how deeply impressed we were over the extent to which the family members assumed mutual responsibility and co-operated with each other. If an adolescent was acting out in the family, at school or after school, it was done to protect family members from coming into contact with even more painful experiences and the adolescent's choice was one to be respected at that point in time. However, we offered to accompany the family on their journey towards finding alternative ways of action.

Gradually, we started to think about what being an expert entailed. Why didn't we ask our clients about their hypotheses as to why the situation was as it was and what they thought was a wise way of solving the problem. The responsibility for how the treatment period should be used became a problem shared by us and our clients (Boscolo et al., 1987, Tomm, 1989). The questions about the identified patient's symptoms and their function in the family system were no longer the most important ones. Instead, we were more interested in hearing what the different family members thought about themselves and the way they functioned together. We shared our thoughts with the family from a reflecting position (Andersen, 1991). The problem's relation

to the family members became a question of understanding the signals that were sent between family members and how each one silently interpreted these signals. It became important to put this into words and express "the circle of the unexpressed" (Andersen, 1992, Anderson and Goolishian, 1992). Instead of influencing clients, we started to be partners in a therapeutic conversation (Inger and Inger, 1992). Should therapy have a clear goal other than sensitivity to the dialogue and the conversation? The self evident standard hypotheses were regarded with caution. Instead we listened like anthropologists looking for a local cultural variation (Paré, 1995).

We discussed male and female language and also male and female values and how a patriarchal society represses the female values (Silverstein and Rashbaum, 1994)

We were surprised that so many different logical explanations to the contexts could exist simultaneously. We found that openness on this point made our talks freer and gave the family the possibility of choosing their own way out of the problem.

Did we become far too open and sophisticated? Did the stress and confusion increase for some families when they heard all these different voices talking about how things could connect (Boscolo et al., 1987)? Were we constructive together regarding the families' possibilities of finding solutions to their problems? Perhaps we should have taken responsibility for the fact that we met families with different backgrounds, life experiences, resources and difficulties and paid more consideration to their needs (Pinsof, 1995)? Perhaps a sensible decision would be to meet one family with constructive reflections, whereas another family would be helped by being offered more elements of practical training and coaching in their treatment. We started to be more disrespectful to the fashion of the times and freer to use our collected experience in certain

situations (Cecchin et al., 1992). The place and role of the symptom could be given different categorical explanations. Sometimes in order to get rid of the symptom it was necessary to increase family competence regarding structure and closeness. Sometimes it was obvious that the symptom was an expression of stress which could be described as triangulation in a parental conflict in a generational perspective. Sometimes we were forced to conclude that it was a blessing that a child had his particular family around him, as they managed to function passably well despite the child's functional difficulties. Sometimes, however, the picture was more tragic with a traumatised child or one who lacked resources, living in a family with poor resources. Family work could sometimes be extended to include help to relatives who could support overburdened, but basically capable families, to survive repeated catastrophes and pick up the pieces again (Pittman, 1987, Hetherington and Blechman, 1996). Sometimes the problem was the interplay of the symptom with deep loyalties to the traditions, history and dramatic life choices of the family (Boszormenyi-Nagy and Krasner, 1986). Sometimes the symptom told of current injustices or abuse (Bentowim, 1992). Sometimes it cautiously pointed at family secrets such as abuse. Sometimes there was total role confusion with an unclear delegation of responsibility and therapy was one long emphasis on context in order to bring about some semblance of order and stability to the child's experiences (Petitt and Olson, 1992).

In later years, in phase with our change of perspective on the responsibility of family members, ascribing them more participation, competence and responsibility for their situation, we have come into collision with our fellow carers who often wish to confer without the participation of the family (Mason, 1992). More and more, we have come to the conclusion that child and adolescent out-patient care should expand their method of working with the families who are often found in IFTU treatment, both by working on a team basis with therapeutic sessions and milieu work and by working more in the

families' homes and in the everyday life environment, including school, day-care and neighbourhood.

We have now almost come a full circle, but even so, we perhaps find ourselves at a different point than where we started. There are now clear research-based impulses regarding therapeutic work with these families. The message is unambiguous. The families should be met multimodally in co-ordinated treatment programs. This means that, in our arsenal, we must have the tools to work on all levels from medical treatment, individual therapy and family therapy to social collaboration and in joint effort with the network. Competence will lie in the analysis behind the short-term as well as long-term choices of the therapeutic system, the cost-effective combination of a treatment form that results in constructive change (Pinsof, 1995). The resource perspective is still strongly emphasised. Assisting the liberation of salutogenic forces in the family and the network will be an important task. If this force increases, the survival ability of the children will increase, despite the difficulties which come their way (Antonowsky, 1991).

"Vignette 2": Why family therapy, when a referral describes a child with symptoms?

An important question one must ask and seek to answer as a family therapist is how to motivate treatment of the primary group (family) when one is asked to assist in the solution of a problem expressed by or about an individual. To dally with this extensive question and express opinions on it may seem far too ambitious a task for this restricted space and can lead to other possible subjects for a dissertation. In spite of this, I have chosen to reflect somewhat on this dilemma as it is highly central for a family therapist in an IFTU context.

Above all, working as a family therapist in families with children one is struck by the fluidity of the boundaries between the child's identity and the formative forces for its cognition, affects and actions in the here and now. The older the child, the more history it bears with it in its dialogue with the people currently close to it. However, the "here and now influence" of the identities of all those involved is extremely obvious from the view of the family therapist, despite increasing knowledge on temperament and constitutional factors, as explanations for the development of an individual's person and character.

Problems, symptoms and disturbances are often described by family therapists as a mismatch between the needs of the young family member as an individual, of stimulation for development and the environment's attempt to have the child where it wants, hopes or wishes it to be. In this way, the experience of myself in the most important context will be placed side by side with another experience of who I am or hope to be (this expression is found in actions rather than conscious reflections). Family therapy treatment programs all try in one way or another to achieve a more flexible field, a larger "play area" so that this mismatch decreases. The process in the language and activities of the family and the individual's experience of himself will hopefully become more concordant. The suit which is too small can be exchanged for one which fits better and the individual can express himself without it "straining at the seams". The picture of a "mismatch" also includes the times when an individual feels lonely, deserted and abandoned in this context. This includes not least individual developmental difficulties which have not been discovered or accepted. If a child on a given occasion was to attempt to answer the questions: "Who am I and how am I?" (if we now look at how these answers would be translated into cognitive, emotional and behavioral strategies in the child's way of functioning in everyday life both in calm and in stressful situations), the child's position can be described as a meeting-place or a cross-roads. At this point, a number of pictures or sketches of the self as it acted in earlier similar

situations to the current one meet. The current situation exerts its influence on the total picture which is now taking form and determines the answer to the questions of who I am and what I am doing in this particular situation. The self-image, especially that of children, can be described as fluent and changeable, influenced by its defined context and its current relations.

The problem for the child is that the total sum of all these pictures for some reason does not give adequate advice or does not work at all once it has been obstructed (Nathanson, 1992). Treatment must aim at making the interactive process constructive again; perhaps by simply re-starting the process and helping the child to re-establish a dialogue between itself and the most important others in its environment. In his newly published book, the Norwegian psychologist Övereide (1998) stresses how important it is for adults and parents to develop their ability to provide communicative support by consciously helping the child with identity and context-marking and by meeting it's desire for contact with positive attention when it seeks the help and support of important adults. Children with specific difficulties are in extra need of this support.

The self of the child is, at every moment, formed by its experience of the dialogue of activities in which it is placed or places itself. The self can be described as generalised representations of interpersonal actions. When the context changes, the self changes. The self is a continuously changing process. A child does not **have** a problem, a child **is** its problem in its context.

One can therefore maintain that the self, per se, is empty and that it is completely attached to the immediate experience of the context within which it is defined. The child's self is echo-systemic. Just as the boundaries between the child and its immediate and important contexts are fluid, so are the boundaries between the child's previous and present experiences of itself also fluid. The

present is built on previous experiences, but it is also clear that what the child experiences in the present activates a selection of the previous experiences which constitute its history. These help (or hinder) the child to understand the situation in which it finds itself and to know what to do.

It is, thus, clear to the family therapist that a good family process is an outer framework for the child which is absolutely necessary if its developing and growing forces are to come to fruition and mature. A functioning self is a self in a good context (Rosenbaum and Dyckman, 1995, Diamond et al., 1996)

"Vignette 3": A typical IFTU family (an imaginary case)

Eva is a 36 year old mother of three children. She has only basic education, but is regarded by many, if not all, in her vicinity as capable. She has had several jobs in the check-out at grocery stores etc., but has been out of work for the last two years. Her economy is strained and she is dependent on social welfare. She is in contact with a social worker regarding her situation with the children. She is helped by having the small children in day care for a few hours each day, despite her being unemployed. This, however, has now been questioned. For the most part, co-operation with social services is constructive, but can become somewhat more tense when her obligations as a parent are discussed. She and her three children (Anna 16, Erik 5 and Sara 3) live in a rented four-roomed apartment in a high rise suburb in her home town. She has no contact nowadays with Anna's father, Bertil. He is said to be an alcoholic and lives some distance away. Erik and Sara have the same father, Olle. Olle and Eva separated two years ago, but the children have fairly regular contact with their father who lives in the same town. He has a temporary job just now and, according to Eva, gives her some support by having the children to stay every other weekend. He also supports Eva in other ways regarding the two children. There are, however serious conflicts between Eva and Olle about the

way the children should be brought up. The parents have frequent discussions about shared responsibility, limit-setting etc. Eva now has a relationship with Per who is 29 years old and works as a motor mechanic with his father's company. He visits Eva often, but officially has his own home in the same town. Per and Eva agree that the children are Eva's problem and Per does not interfere much. The younger children accept Per, but Anna does not like him. Eva's mother lives 20 kms away. Eva describes their relationship as "so-so". Her mother has her own problems in the form of alcohol abuse and always looks to Eva for support, rather than being a resource for her daughter. Eva has contact with the psychiatric outpatient clinic and is on medication for depression and mental instability. Eva has two younger siblings with whom she is in close contact. They sometimes help each other with their respective children, but Eva says that she cannot really rely on help as her sister is often over-burdened by her own situation and her brother usually hands over the care of both his and her children to his partner. Eva smokes, although she thinks it costs too much. She is worried about her own and the children's health and tries to smoke near the kitchen extractor fan or on the balcony.

On the advice of her social worker, Eva seeks help at the child and adolescent psychiatric clinic and after that at an IFTU, mainly on account of her difficulties in managing parenthood because of the circumstances. The referral names Erik, 5 years old who is hyperactive, oppositional, aggressive with his playmates at the day-care center and stubborn. His little sister is also hyperactive, quarrelsome and has a poor appetite. The children often bicker with each other and on a couple of occasions the neighbours have contacted social services when the situation, according to them, was chaotic with raised voices and screaming. Eva denies that she hits the children. In a preliminary talk, Eva says that she is completely worn out and does not know how to cope with the situation. She mentions that Anna has thought about moving away from home since Per came into the picture and Eva does not want this to

happen. The girl is only 16 years old. Eva wonders just how long Per will put up with the situation. The parental conflict with Olle has escalated since he found out that she sees Per regularly. Her mother is negative to the idea of seeking child psychiatric help. A child psychiatrist's suggestion for DSM-IV diagnoses for those involved are for mother Eva: Major Depressive Disorder 296.3, for Anna: Parent Child Relational Problem V61.20, for Erik: Oppositional Defiant Disorder 313.81, for Sara: Attention Deficit Hyperactivity Disorder, not otherwise specified 314.9.

"Vignette" 4: An IFTU member of staff (not so imaginary)

Britta is 49 years old. She has worked in child and adolescent psychiatry since the late 1960's. She was employed as a children's nurse in what was then the inpatient ward for children under the age of 12. When the clinic was reorganised and a family unit was to be opened, Britta was very interested in getting a job there. It felt more natural for her to have closer contact with the children's parents and to work through them to a greater extent. Britta remembers, however, the overwhelming change she underwent from being on the staff of a children's ward to being a team member in a family treatment unit. Her new job involved giving much more support to the children's parents and playing a more indirect role in relation to the child.

Since then, over the years, Britta has trained as a pre-school teacher and gone on to do a two year systemic training course and a course in Marte-Meo technique to become the competent family therapist that she is now.

Nowadays Britta lives alone. She has a grown-up daughter. The girl's father has good contact with both his daughter and Britta and they are now good friends. Britta considers that the work at an IFTU has always been demanding but extremely meaningful. She cannot imagine any other job that would be so

rewarding. She gets on well with her colleagues. They meet privately on birthdays and other special occasions. She considers that the County Health Authorities have been unfair and mean in their evaluation of the work she does and the wage she earns. Sometimes it is hard to accept that she has devoted most of her working-life to a meaningful yet underpaid job. She is, however, grateful that her employer has financed part of the further education she has participated in. Her main interest outside work is horses. She breeds riding horses and has always had horses and people interested in horses around her. She has also often used her experience to make contact with both parents and children in the families she has worked with. She has noticed how much easier it is to build up a confidential contact during a riding outing. It makes a positive starting point and contact is much more informal when one can talk "on horseback".

Britta worries about the future as there is a rumour that her place of work might not be there much longer. She feels deeply about the meaningful treatment method she has contributed towards developing and cannot understand who, if the unit is closed down, will be able to take over the important treatment method which has been given priority at her place of work. The supportive work she has done over the years has been an important part of treatment in difficult life-situations for these over-burdened mothers. She has also seen her work as prophylactic for the development of these children who, even in the future, must rely on their, for various reasons, over-burdened parents. Throughout the years, she has often felt gratefulness radiate back from families previously in treatment when she happens to meet them in different circumstances.

"Vignette 5: Some central thoughts in an IFTU

Now follows a description of the core in the treatment philosophy of an IFTU. It deals with the method's "turbo-force" which makes it meaningful. This force is an oscillating movement between the interpersonal actions in a family and the therapeutic conversations the family has about these actions at an IFTU. The force also deals with the forming of the space within which help is given and the form of this help in terms of the two-way process between the family and the therapeutic team and their mutual aims. The "space" must been seen, in both concrete and abstract terms, as the cognitive and affective sphere within which it is possible to create a reality encompassing both hope of possible change for the better and the actual resources to accomplish this change.

Time-out - rerun is a way of describing in five steps a common everyday sequence in the treatment of a family at an IFTU. First I shall describe this IFTU method. After that I shall use this framework or "microprogram" in order to describe in a more concrete manner a central treatment perspective for an IFTU in all its different facets.

Let us imagine a normal treatment day at an IFTU. The family which we briefly sketched above have been in treatment for a week and have now decided with their treatment team to go into town and buy clothes for the two younger children. This choice of task goes back to the agreed upon theme of their stay; to work with questions of limit-setting especially in certain critical situations such as when shopping together. The contact between the family and the treatment team is now one of trust. The team have told the family about their way of working with, among other things, "time-out - rerun". The method has also been tested by the family in earlier therapeutic work in a milieu with a lower stress level.

The five steps in "Time-out - rerun" are

1. Identification of the therapeutic field: when mother, the two youngest children and a team-member are going to try on a pair of jeans for Erik, he protests violently, becomes angry and loudly screams that he doesn't want to. Mother is completely helpless and finds the whole situation extremely embarrassing. She wants to give up the whole undertaking immediately and leave the scene with her children. The therapist identifies the situation as a potential therapeutic possibility in line with what has previously been agreed upon. The therapeutic field is identified by the therapist.

2. Observation of the "spontaneous" process: The therapist waits a while to see if the mother finds a spontaneous solution. It is soon obvious that in this situation, she is steered by helplessness and begins to prepare her exit from the shop. The little boy acts out even more. The mother now begins to look frightened.

3. Time-out: The therapist intervenes and says to the mother: "No, we won't go. Let's see if we can solve this in another way this time!" The mother nods doubtfully. She now associates the situation to the agreement between her and the team regarding the therapeutic theme (granted, with anxiety about how the situation is going to develop). Mother and therapist have a mutual picture of the situation to be challenged. The little boy goes and sits down in the play corner. The little girl holds the therapist's hand. Mother and therapist confer. The therapist confirms that she saw that a difficult situation had arisen for the mother. She asks the mother if she recognises the situation from earlier. The mother says that it is always like this. The therapist then asks if she can remember any similar occasion when she managed to solve the situation in such a way that both she and the boy were happy about. The mother answers no. The therapist then asks if she can think now of any way to handle the situation. Hesitantly, the mother says that she can go and talk to Erik. The

therapist does not leave it at that, but wonders, "What will you say to him and how will you say it?" After a short while, mother and therapist agree that she should formulate the message thus, that a pair of jeans must be tried on, but that Erik can have a say in the matter as to whether he likes the jeans or not, once he has tried them on. If they do not suit, they can try another shop.

4: Re-run: The therapist assures the mother that she is certain she will do a good job with Erik however things are going at the moment. The mother goes over to Erik who is sitting in the play corner looking sulky. She bends down, strokes his hair and tells him about her plan. Erik accepts the idea and tries on the jeans, but immediately says that he doesn't want a pair of jeans for girls. He thinks the pockets are cut in a girlish fashion and therefore doesn't want the trousers. Mother and Erik talk about this and mother say that she understands Erik's protests much better now. The therapist is supportive towards mother because she found a very competent solution to this difficult situation. They are satisfied with this and leave the store relatively calmly.

5. Evaluation, Reflection: later in the afternoon, the family and the team gather together for a talk which, among other things, contains a summing-up of the day's work. With the help of the therapist, the mother relates for the others what happened in the clothes shop. All those involved were pleased over the outcome and wondered what the mother had done this time to make it turn out so satisfactorily. Mother is given a chance to reflect upon the feelings that overwhelmed her when she was about to give up and give in to thoughts that the little boy had a serious problem, that she herself was weak and incompetent and that her mother always criticised her for this. She gets help to reflect over the picture she got of herself and Erik after the "re-run" and sees then her more competent sides as a problem-solver, above all from her timer as a shopgirl. The team talks about how she can use these pictures of herself next time a similar situation occurs. Plans are made to continue therapeutic talks

about her relations to her "inner critics" so that these voices can be dampened in critical situations to allow the "encouragers" to take over and tell her she is competent. The mother sees how she could help herself if she was able to define these situations as ones which challenge her competence, but which she stands a good chance of handling, rather than situations that are doomed to fail from the very start.

6. Conclusion/new theme: The talk ends with identifying other similar situations where there is reason to train further together as they are high risk situations for the old destructive game between her and Erik. A complementary theme is formulated around how Sara experiences the mother's conflicts with Erik and how the mother can be available for her and give her the support she demands while at the same time helping Erik to grow in this situation. The method of giving feedback in the critical situation is also discussed. The mother thought that it had worked well and felt that she had been given support this time. However, everyone agrees that the therapist should keep more in the background next time and allow the mother to carry out her plan on her own. The therapist can share her views afterwards.

Time-out - re-run as a cognitive model

The "Time-out - re-run" model can be also used to describe in a more general way how a week in intensive family treatment or an entire intensive treatment process at an IFTU develops. The active work in the therapeutic milieu identifies, initiates and arranges situations containing examples where central interactive processes are dramatised. These are described, generalised, understood and mirrored in reflective talks from the point of everyday happenings, together with the family and the therapeutic team. The therapeutic questions focus on developing new social strategies to handle these challenges in the milieu. They are also extended to questions about general life themes which constitute important subjects for therapeutic sessions and which go hand

in hand with successful solutions of the former. Often, questions about obstructions to possible solutions on a social and/or economic level arise. These, in their turn, are a reason to take the initiative to meeting with other parts of the social and professional network around the family, for example, relatives, school, neighbours, paediatrician, psychiatrist etc. The "turbo" in the method refers to this dialogue between different foci where tasks in different contexts, on different levels, in varying time perspectives etc., are formulated in a mutually influencing process.

Thus, in the way described above, the focus oscillates between the concrete and the abstract, between action and thought, between example and generalisation, the small world and the larger world, between the trivial and everyday and the strange and overwhelming. The "surface" for possible learning is thus wide and the work of integrating new experiences is solid. There are good possibilities for transferring the therapeutic experiences from talks and milieu therapy to the everyday home situation.

This learning and new orientation process rests on the supposition that interactive processes in the family are isomorphic, i e that central patterns for regulating the balance between the members of the family repeat themselves in different contexts. This experience on a meta-learning level aims at bringing a higher degree of structure to existence. It creates, to use Antonowsky's (1991) terms, a higher degree of comprehensibility, manageability and meaningfulness, by gradually categorising a tangle of stressors on a higher level of abstraction as the same stressors in different garbs and in different contexts. Above all, the increased experience of more room for thought and more alternatives for action (increased social and communicative ability, increased capacity for conflict solution, increased ability to constructively solve problems) contributes to a feeling of increased competence and,

consequently, a lower level of anxiety when faced with challenges in family life.

However, none of this would be possible without establishing and maintaining an atmosphere of trust between the family members and the therapeutic team. To put everyday life temporarily on one side and allow the therapeutic experience to become a "core experience" for one's family, demands established and maintained trust for the "pilots" and a reliance on the fact that they wish the family well. Talks about the mutual therapeutic process are a central feature of treatment work starting from the question as to whether today's help was efficient. To risk letting go of what feels secure in order to begin exploring one's self, one's habits and those of others, demands that helpers can be trusted. The need for help and support becomes clearest in situations where the outcome is never an obvious success but, rather, filled with uncertainty and perhaps, above all, the fear of betrayal. Trust makes it possible to mobilise the courage to try new things. The work of an IFTU during this parenthesis in life has sometimes been called "the experimental workshop of life" or a "moratorium" in life. Both these terms are an attempt to describe a space which is both separated and sheltered from the hard reality of everyday life, but at the same time in touch with it. We describe a space where one can experiment with oneself and others. A holding space where one can temporarily step out of oneself and put words to mutual experiences in order to begin building new realities in which to live.

However, the work would not be meaningful if the experiences could not be transferred to life outside treatment. It is therefore extremely important to continuously go out and test them. Good and bad experiences are then digested, or if you like, broken down into matter which is nourishing and meaningful in the compost of "the therapeutic space". This more sophisticated strategy of facing life means that one must pause, formulate possible alternatives, choose

one of them and feel that the solution was good enough, given the circumstances. Gradually we hope that it will more and more find its place in the family's life and that the "social bandage" supplied by the IFTU will eventually become superfluous in the life of the family.

Study Group 2

Related DSM-IV diagnoses.

A family therapy approach coupled with scientific ambitions confronts one with the question of how to best describe this group of families and their identified problem-children. During the planning period there was much doubtfulness about diagnosing family members according to the usual DSM IV procedure before treatment because it was considered that the process of diagnosing would confuse and de-focus the prospective treatment which was largely based on systemic principles. Therefore, we who were responsible for planning the project, chose not to set a DSM IV diagnosis as this routine was seldom carried out at the units involved.

However today, in 1999, I agree with Gottlieb (1996) that attempts to describe a problematic situation solely by using relational terms will never and should not preclude individual descriptions/diagnoses. They should instead be used to complement individual descriptions and thus increase the possibility of a conceptualisation which helps one think in terms of a context based understanding of the problem and the measures needed to solve it. This opinion is supported by current research in the field which suggests, though it is not yet proven, covariation between a number of factors on different levels regarding the origin of the problem we have tried to describe. In this context, it is relevant to mention Kaslow's (1996) grouping of diagnoses into four

categories and to conclude that, categories 2, 3 and 4 are most often applicable to our group.

Category 1: Well-Delineated Disorders of Relationships. Focus on relational disturbances which are in themselves important as they lead to mental distress for one or more members of the family.

Category 2: Well-Delineated Relationship Problems That Are Associated with Individual Disorders. Here, the relationship is still the prime focus for treatment. The relationship problem in all probability arouses or influences serious disturbances in one or more family members.

Category 3: Disturbances which demand relationship data for their validity. An individual disturbance is central. A complete description of the problem requires relationship data (e g behavioral disturbances).

Category 4: Individual disturbances whose appearance, development and treatment are strongly influenced by relationship factors (e g children with life-threatening diseases, psychoses).

In order to place IFTU families and IFTU treatment in their context, we must now take stock of family therapy oriented, research based information regarding relevant diagnostic groups and their treatment.

Attention-Deficit Hyperactivity Disorder (ADHD)

Family therapy is effective regarding the aggressivity and "non-compliance" features of this syndrome. Concentration, impulsivity and hyperactivity are not so easily affected. Combined programs with family therapy and behavior/cognitive therapy at home and in school have been found to be effective in a long-term perspective. Cognitive behavior therapy treatment is

primarily employed to come to terms with impulsivity and deficits in concentration. Regarding hyperactivity, the best results are attained by medication (methylphenidate and d-amphetamine, Kazdin, 1994, Alexander, 1994).

Oppositional Defiant Disorder (ODD) and Conduct Disorder(CD)

Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) are DSM IV's categories for the classification of acting-out behavior which is disruptive to others. Alexander and Pugh (1996) argue that the behavior criteria which according to DSM IV must be present for this diagnosis are solely based on the symptoms presented by the child. They are therefore too limited if they do not take into consideration the child's environment. The problem will unfortunately be presented as if it were of a non-contextual nature and solely emanated from a state of mental ill-health in the individual. This is neither in line with research results nor clinical reality regarding ODD and CD. Current research presents a collection of facts that include both family and socio-economic factors in which the child's problem is embedded and between which there is mutual interaction.

Alexander and Pugh recommend a developmental perspective in order to understand how these problems originate, change and develop. They describe two possible paths of development: 1. Early onset path and 2. Late onset path. In spite of the fact that the "early onset path" is not as prevalent as the other, there is reason to pay attention to it, above all because of the severity and stability of these children's problems. They constitute the majority of the group of children and youths who later commit crimes. These children are also probably more aggressive, have clearer educational problems and even co-morbid problems such as hyperactivity and impulsive behavior. The problems of this group are also more likely to prevail in adulthood than the problems of the late-onset group. The problems of this group start in early

adolescence. The behaviors include more concealed, non-aggressive problem behaviors such as shop-lifting and adolescent criminality. A large proportion of this group are girls and the group does not exhibit disturbed family relations to the same extent as the first group. The problem behaviors can be caused by a number of factors in a multitude of different combinations. These factors can be e g inadequate parenting including drug and alcohol abuse, neglect, foster home placement. Research has identified potential mechanisms such as non-adaptive family patterns of interaction between children and parents which cause and/or maintain these problems. The most important finding, however, is that these disruptive behaviors can be dispersed without individual treatment, by parent-training or family therapy. This does not exclude the fact of biological/genetic factors in the aetiology. Parent-training comprises three main phases; "monitoring", "disciplining" and "problem-solving". The rationale for parent-training is that the child's problem behavior provokes the surrounding environment and that it can be counteracted by parent-training programs. One can also, on the grounds of this research, maintain that relational processes are closely connected with the origin, retention and development of behavioral patterns. Herein lies the main criticism of DSM IV as a diagnostic system in regard to these problems, as the system does not describe interactional processes of significant relevance for the development and retention of these problem behaviors.

A broader perspective is therefore recommended for these two diagnoses. Besides an evaluation of the child from the point of the diagnosis criteria, the following should also be taken into consideration: 1. The nature of the child's parenting. 2. Whether or not aggressive behavior is present (in order to differentiate between early and late onset) and 3. How much the child suffers from trauma caused by abuse or neglect (the latter in order to perhaps complement measures taken, with individual support for family members).

"The IFTU-family"

The concept of the IFTU family as used here needs to be clarified. Well-deserved criticism has been directed over the years at terms such as "the asthmatic family", "the diabetic family" and "the anorectic family" on several counts. The concept gives a false representation of these families as having a homogenous structure and function on the grounds of specific symptoms in an individual family member. The concept is also criticised for implying that this structure or function automatically generates specific symptoms. The concept also suggests that the "family" as a phenomenon exists as an independent unit outside or above the family members' consciousness. A current family therapeutic perspective based on established theory and research takes a much more advanced view on the relations between processes on a family and an individual level and is unable to accept concepts such as "the diabetic family" (Kaslow, 1996).

In this dissertation, I regard "the IFTU family" as those who have undergone IFT. The families are, in the main, homogenous regarding certain demographic data, symptom load and family function. A common denominator is that the group has a pronounced need of help and requires a lot of work in order to produce change. The IFTU model is understandable and acceptable to these families. Another common factor is that the families themselves have not felt that they have been given adequate help in the current adolescent and child psychiatry treatment context and that others have also come to the conclusion that these families cannot receive the help they need within the existing out-patient system. Thus, the group of IFTU families have several of their common denominators in a care context which excludes them because their needs do not match the priorities and restricted resources and competencies of the system.

From a traditional scientific point of view, there is an obvious weakness in comparing treatment programs using a group of families which is not completely homogenous or uniform regarding critical variables. Homogeneity in such a complex phenomenon as a person or a family is an abstract construct where the question of the purity of variables will always be subject to certain provisoes. We know that many variables always co-vary in complex systems in general and that making any aspect of this complex organism a starting point for investigation will always involve a pseudo-scientific choice. We know especially that the families we call IFTU families are often regarded as burdened with problems on many different levels. The concept "multi-problem family" is an established term although even this concept can be criticised from different aspects.

The strength of this perspective is that we are dealing with a practical treatment reality where clinical knowledge and experience have led to the emergence, description and evaluation of a treatment program for a group of families who have not been helped by other methods. The argument in favour of context-based similarities is also strengthened by available accounts of other successful treatment programs for families with psychosocial problems. A clearly common factor for the success of these treatment programs is their multifactorial design (Pinsof and Wynne, 1995).

How can the information gleaned from a treatment study of a group as described above be of interest? In my opinion the strength of the study lies in its context in an existing clinical treatment reality for a clinically selected group of families. One can see how the treatment program works for this particular group and then use this information in order to refine criteria for the selection of families who will benefit most from an improved version of the treatment model. The ultimate aim is to optimise the use of the publicly funded health care resources available at any given time.

Method

Study group 1

From the starting point of organisation theory, family therapy theory and clinical experience from the work of an IFTU, a model for describing IFTU's was devised. This gave a basis for constructing tentative scales for measuring the profiles of the IFTU's. These scales and their place in the theoretical model are shown below in table 3.

Table 3: An overview of the connections between the model of description and the different questionnaires and scales.

Questionnaires and scales	Location in model	Theoretical reference
Referral Attitude (RA)	Context/Commissions	Contextualisation (Petitt, Olson 1992)
Form Background (FB)	Context/structure	Organisation/Leadership (Fridell 1996)
Working Profile (WP)	Resources	Ideology Fridell 1996, Ekvall 1988)
Salutogenic Group (SG)	Resources	Sense of coherence/ Antonowsky (1991)
Group Climate (GC)	Resources	Group Climate (Hansson, Olsson 1991)
Attitude Working profile (AWP)	Resources	Sense of sharing (Ekvall 1988)
Attitude new Knowledge (ANK)	Resources	Ideology, Flexibility (Schein 1965, Fridell 1996)
Different measures of outcome	Outcome	Effect (Lambert & Hill 1996)

Data collection took place during Autumn 1993 by asking all colleagues at each IFTU to fill in the devised questionnaire.

A brief presentation of the "profile test" now follows. For more detailed information, the reader is referred to Sundelin, 1998 b.

RA (Referral Attitude)

The questionnaire RA is administered to the directors of the referring units and belongs to the "context" dimension in the model of description. The questionnaire refers to the theoretical model and the importance of a clear and mutually accepted relation between the commissioner and the performer. The questionnaire consists of two sections: The descriptive section consists of 10 open questions concerning the local IFTU from the perspective of the referring units about, for instance, experienced climate of co-operation. The other section consists of twelve 10-point attitude items. This scale is supposed to mirror a general measure of knowledge of and confidence in the local IFTU on the part of the directors of referring units, by asking them to judge the degree of agreement, from their point of view, on the local IFTU's treatment ideology.

The second section of RA, the attitude form, is homogeneous. Every single item correlates highly with the total score (M .69 range .52-.86). Internal consistency (Cronbach's Alpha) is .84.

FB (Form Background)

The questionnaire FB is administered to head of the IFTU. It consists of four broad open category questions concerning inner and outer organisation such as structure of leadership, number of staff, organisational relations for the IFTU, types of commissions, etc.. The information is analysed and categorised by the author.

WP (Working Profile)

This test is constructed to address staff members experience of the unit's treatment ideology. The test was filled in by every member of the respective staff, including resource personnel and addressed 5 hypothetical aspects:

1. Team style 2. Time 3. Structure 4. Style 5. Focus.

1. Organisational level: *Team style*. I.e. do family therapy sessions and milieu therapy activities function in close collaboration or are they separate from each other?

2. Commissional level: *Time*. Does the unit work with short or long-term commissions?

3. Ideological level: *Structure*. Does the unit operate in a generalised and predictable structure with a program-directed treatment process or is the treatment process individualised, need-directed?

4. Treatment level: *Style*. Supportive style or challenging style?

5. Treatment level: *Focus*. Problem/solution and behavior oriented or process/growth and meaning focused?

Factor analysis yielded a two-factor solution. Factor 1 included 7 items and was named "Profile concerning Structure, Directiveness and Responsibility". Lower values on these scales mirror a tendency towards a high and predictable structure in the unit, a directive therapeutic style and assuming responsibility for change, while higher values mirror a differentiated structure, a non-directive reflective therapeutic style and shared responsibility with the family. Internal Consistency (Cronbach's Alpha) was .73.

Six items make up factor 2 named "Profile concerning Length of Time for Treatment Process, Locus of Change, Degree of Problem/Solution Focus". Lower values on these scales mirror a tendency towards short term-focus, focus on external behavioral change and a problem/solution oriented style

while higher values mirror a tendency towards the perspective of a longer therapeutic process, focus on experience rather than behavioral change and on growth rather than on problem/solution. Internal consistency (Cronbach's Alpha) was .74.

SG (Salutogenic Group)

The significant importance of staff groups' comfort and well-being for successful therapeutic programs has been stressed by several researchers.

Well-being at work and Sense of Coherence were measured by a form named SG. The form was tested for homogeneity and a two-factor solution was chosen for 16 of these items. Factor 1 was named "Job Satisfaction - me and my job" (9 items). Internal Consistency (Cronbach's Alpha) was .87. Factor 2 was named Comprehensibility, Meaningfulness and Manageability (7 items). Internal Consistency (Cronbach's Alpha) was .90.

GC (Group Climate)

GC was filled in by the staff at the IFTU's, including resource personnel. GC consists of a list of 85 words from which one has to choose at least 15 words describing characteristics of a group's climate. Through factor analysis five factors are described: Solidarity, Split, Conflict Avoidance, Structure/Control, Negativism. Criteria for chosen words were > .50 corr. with it's factor and < .25 corr. with the other factors (Hansson and Olsson , 1991). This test was chosen because it is an established instrument for measuring group climate constructed from the perspective of experienced group processes, whereas SG is constructed more from existential hypotheses.

AWP (Attitude Working Profile)

The importance of a clear and reliable ideological frame together with the experience of every staff member that they are part of and share this ideology are considered very important for good outcomes in therapeutic programs.

AWP is concerned with staff attitude to the unit's working profile and is filled in by the staff at the IFTU's, including resource personnel. The staff are first asked to estimate the usual profile (WP) at work and then asked for their personal opinion, item by item, about that profile. This attitude schedule consists of ten 10-point rating scales. Each item correlates with total score M .80 range .87 - .71. Internal Consistency (Cronbach's Alpha) .93.

ANK (Attitude to New Knowledge)

The importance of openness to feedback and flexibility towards change and development in accordance with a constant flow of new challenges from theoretical and empirical perspectives, are considered very important for a staff group. A scale was constructed on this issue. However it did not work at this stage and is therefore excluded from further presentation.

The items constituting the newly constructed tentative scales are found in the appendix.

Study group 2, Families treated at an IFTU

The pilot-studies

Table 4: Some data of the families participating in the two pilot-studies.

Pilot-studies	Drop -out %	M age of IP	Sex of IP %	Type of Family %	Internalised Externalised problems %
Study 1 n families = 33	34%	9 years	Boys 64 % Girls 36%	Nuclear 21% Step 28% S parent 51%	Intern. 24% Extern. 48% Other 28%
Study 2 n families = 59	8 %	9 years	-	Nuclear 52% Step 24% S parent 24%	Intern. 37% Extern 44% Other 19%

The main study

Participation in the study was voluntary. The criterion for inclusion to the study was all families up to a certain number (the number varies among the different units) during 1993 - 1994. The criteria of exclusion were difficulties with the Swedish language to such an extent that it was not considered meaningful for the families to fill in the questionnaires (n = 8) and families who felt extremely insecure or threatened by participation in the study (n = 5). A few families were excluded as they broke up in the course of events. In some cases the family or family members moved from the district or other changes occurred that made further contact with the project impossible (n = 4) . A total of 109 families participated in an intensive treatment program. 86 families were followed up. The commission for 15 other families was family investigation. Composition of the

families in the study probably gives a representative picture of the families treated at these units. These families are presented in tables 5 - 7.

Table 5: The numbers of treated families from the different units in the multi-center study. The number of excluded families and treated families not followed up and families in investigation.

Unit	All families		Excluded families		Families in treatment followed up		Families in treatment not followed up		Families in investigation	
	n	%	n	%	n	%	n	%	n	%
1	30	100	10	33	11	37	2	7	7	23
2	40	100	3	7	26	65	7	18	4	10
(3	40	100	3	8	17	42	8	45	2	5)
(4	31	100	5	16	7	23	5	16	14	45)
5	18	100	0	0	11	61	7	39	0	0
6	28	100	4	14	19	68	5	18	0	0
7	30	100	5	17	19	63	2	7	4	13
Total	146	100	22	15	86	59	23	16	15*	10
(Total	217	100	30	14	110	52	46	21	31	14)
Total					86/109	79	23/109	21		

* 11 were followed up.

A dominance of treatment commissions is obvious. It should be observed that the person in charge of the research function at unit number 1 left the unit suddenly and unexpectedly, which had the effect of delaying the collection of information for a time until a replacement could be found (n = 5).

Unit 3 is not included in the evaluation phase as the data collection was not carried out consistently. Similarly, the group from unit 4 is excluded as there were too few families treatment. The main emphasis was on family investigations commissioned by the social

welfare department. The unit's work at that time was largely that which is described in chapter on information-seeking work of change.

Table 6: Families participating in the study in numbers and in percentage.

Unit	Single parent families n	Nuclear families n	Step families n	Total n	Family size M
1	9	2	2	13	3.0
2	14	14	5	33	3.7
(3	11	10	1	22	3.5)
(4	19	2	1	21	2.7)
5	11	5	2	18	3.5
6	9	10	5	24	3.5
7	15	3	3	21	3.0
Tot	58(53%)	34(31%)	17(16%)	109 (100%)	3.3
(Tot	88(58%)	46(30%)	19(12%)	152 (100%)	3.3)

The single-parent family is definitely the dominating type of family at all units (53%). The difference between the units is not significant in this respect. If we compare this to the general pattern of family life in Sweden we get an entirely 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 step-family (National Statistics, 1996).

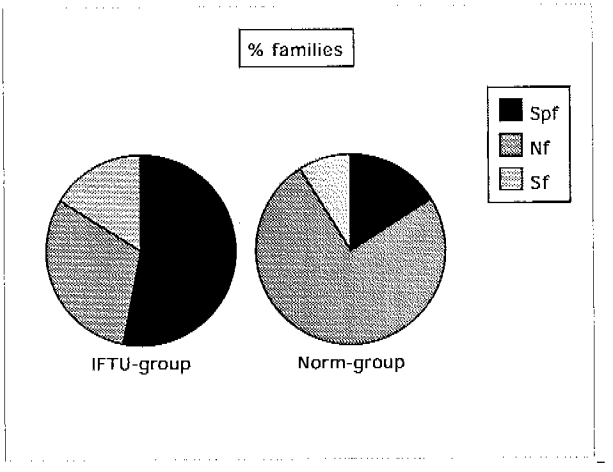

Figure 1. Distribution of family types in the IFTU group and in a Swedish norm material, (Spf = Single parent families, Nf = Nuclear families, Sf = Step families.

The sizes of the families in our study correspond on the whole with what is common in Sweden, but must be understood in the light of the relatively high number of single-parent families seen at IFTUs. This means that the families in our group have somewhat more children than the average Swedish family.

In general, the families are socioeconomically underprivileged with a high degree of unemployment and dependency on social welfare and a low educational level. They have often a complex picture of problems of a psychological, social and economic nature. The problem of the identified patient is often co-morbid. Often several family members are described as problem or symptom-bearers. Family function tends to have a low degree of structure. (From a short description of every family taking part in the study.)

Table 7: Distribution of the number of boys/girls regarding identified patient, IP's age and mother's age.

Unit	Boys IP	Girls IP	Age IP		Mothers age	
	n	n	M	(Sd)	M	(Sd)
1	9	4	8.3	(2.8)	36	(8.0)
2	22	11	11.2	(2.9)	39	(6.6)
3	14	8	8.0	(3.3)	36	(9.0)
4	***	***			32	(6.4)
5	8	10	13.4	(2.6)	40	(5.5)
6	19	5	11.1	(4.3)	36	(7.4)
7	12	9	9.9	(3.9)	36	(8.4)
Tot.	64%	36%	10.8 years		37years	

*** Parents considered the IP

Boys as IPs are definitely more common than girls. There is no significant difference between units in this respect. Regarding the age of the IP, the units differ significantly (One factor Anova, F-test 4.55, p = .002). Unit 1 has the lowest average age (somewhat over 8 years) while unit 5 has a significantly higher average IP age (somewhat over 13 years) than all the other units. There is no significant difference regarding the age of the mothers (One factor Anova F-test 1.1, p = .37).

The families come to the IFTU's mainly because of a problem presented as an externalised problem i.e. an acting-out problem or a conduct problem (60 %). The remaining 40 % are distributed equally among internalised problems and other problems such as anxiety and self-destructive behavior, which are not easily categorised as either acting-out or internalisation (classification made by the author from the primary presenting problem in the family description). One sees a significant difference between the units inasmuch as that the units 2

and 5 have a clearer tendency to work with more internalised problems than units 1, 6 and 7 (F-test 3.2, p = .02).

Tables 8 and 9 below present comparisons of the initial values between the families in the different units, by using the mothers' initial ratings of family function and symptom load at all six units.

Table 8: Comparison between all mothers' initial values at six units on different scales for family function and for symptom load (n= 134, (one factor, factorial anova).

Test	F-value	P-value	Sign diff between
Family Climate			
Closeness	.25	.94	-
Distance	.30	.91	-
Chaos	1.99	.08	unit 3 - unit 5, 3 - 6, 3 - 7
3 significant differences out of 45 unipolar comparisons	7%		
FARS			
Attribution	1.13	.35	unit 1 - unit 2
Interest	1.09	.37	unit 6 - unit 7
Isolation	.70	.63	-
Chaos	.78	.57	-
Enmeshment	.46	.80	-
Total	.98	.43	unit 2 - unit 7
3 significant differences out of 90 unipolar comparisons	3%		
KASAM	1.34	.26	-

Continuation table 8.

CBCL			
Withdrawn	.58	.72	-
Som. compl.	.69	.63	-
Anx./Depr.	.46	.80	-
Social probl.	1.73	.14	unit 6 - 7, 5 - 6
Thought probl.	.97	.44	-
Att. Probl	.27	.93	-
Delinq. Probl.	.34	.89	-
Aggr. probl.	1.41	.23	unit 5 - unit 6
Intern.	1.35	.25	unit 2 - unit 7
Extern.	1.40	.23	unit 2 - unit 6
Total	1.09	.37	unit 2 - unit 6
6 significant differences out of165 unipolar comparisons = 4%			
SCL-90	n= 134		
Somatization	1.23	.30	unit 2 - unit 7
Obsess.-comp. probl.	1.64	.15	unit 2 - unit 7, 6 - 7
Social self-esteem	1.73	.13	unit 2 - unit 7, 6 - 7
Depression	1.83	.11	unit 2 - unit 7, 6 - 7
Anxiety	1.97	.09	unit 2 - unit 7, 6 - 7
Hostility	2.34	.05	unit 1 - unit 7, 2 - 7, 5 - 7
Phobic Anxiety	2.14	.07	unit 1 - unit 7, 2 - 7, 3 -7, 5 - 7, 6 - 7
Paranoid Ideation	2.40	.04	unit 1 - unit 7, 2 -7, 5 - 7, 6 - 7
Psychoticism	2.71	.02	unit 1 - unit 7, 2 - 7, 5 - 7, 6 - 7
Other problems	3.44	.01	unit 2 - unit 7, 6 - 7
Sum	2.70	.02	unit 2 - unit 7, 6 - 7
29 significant differences out of 165 unipolar comparisons = 18%			
Total 41 significant differences out of 465 unipolar comparisons = 9%			

One can establish that the majority of unipolar comparisons between units (initial values for mothers' ratings) are not significant regarding family function and symptom load. Despite differences in, above all, mothers' own symptom load, I would like to maintain that the group of families is sufficiently homogenous to allow a meaningful interpretation of both the total results and a comparison between the treatment results at the different units.

Table 9: Comparison between initial values for the mothers, not followed up and those followed up on the different scales for family function and symptom load, (one factor, factorial anova).

Test	M (Sd) not followed up	M (Sd) followed up	F-value	P-value
Family Climate	n= 25	n= 84		
Closeness	.85 (.89)	1.11 (.93)	2.0	.16
Distance	1.00 (.73)	.81 (.67)	1.85	.18
Chaos	1.92 (1.21)	1.69 (1.27)	.79	.37
FARS	n= 28	n=81		
Attribution	4.22 (1.72)	3.38 (1.93)	4.79	.03
Interest	6.29 (3.71)	5.26 (3.02)	2.43	.12
Isolation	5.60 (4.12)	4.15 (3.67)	3.47	.06
Chaos	6.68 (3.94)	4.60 (3.40)	8.21	.005
Enmeshment	7.09 (3.52)	5.50 (3.01)	6.04	.02
Total	43.5 (21.6)	34.1 (17.4)	6.12	.02
SOC	n= 21	n= 80		
	117 (26.4)	134 (26.3)	5.51	.02
CBCL	n= 31	n= 77		
Withdrawn	3.87 (3.09)	4.23 (2.95)	.19	.66
Som. compl.	2.53 (2.59)	3.13 (3.18)	.47	.49
Anx./Depr.	10.0 (5.14)	9.22 (6.23)	.21	.65
Social probl.	4.67 (2.99)	4.64 (3.23)	.001	.98
Thought probl.	1.60 (1.68)	1.57 (1.88)	.003	.95
Att. Probl	8.40 (5.05)	7.60 (4.35)	.39	.53
Delinq. Probl.	6.00 (4.93)	4.83 (3.70)	1.16	.28
Aggr. probl.	17.73 (12.73)	18.13 (9.74)	.02	.89
Intern.	14.32 (15.17)	14.57 (9.99)	.14	.91
Extern.	23.55 (15.81)	22.47 (11.75)	1.57	.69
Total	53.42 (33.23)	53.83 (26.14)	.005	.95

Continuation table 9.

SCL-90	n= 31	n= 78		
Somatization	12.73 (10.95)	11.49 (9.85)	.38	.54
Obsess.-comp. probl.	9.83 (7.68)	10.38 (7.58)	.14	.71
Social self-esteem	10.13 (7.17)	8.81 (7.05)	.14	.71
Depression	19.63 (11.01)	17.80 (11.10)	.72	.40
Anxiety	11.78 (7.39)	10.71 (7.39)	.54	.46
Hostility	5.25 (4.31)	5.71 (4.78)	.27	.60
Phobic Anxiety	4.08 (4.66)	2.90 (3.55)	2.33	.13
Paranoid Ideation	6.45 (4.91)	5.51 (5.31)	.88	.35
Psychoticism	5.60 (5.88)	5.21 (6.09)	.11	.74
Other problems	8.75 (5.55)	7.16 (5.35)	2.28	.13
Sum	89.70 (57.41)	86.33 (58.90)	.09	.77

Total n sign 5/32=
15%

A comparison of the initial values of the group of families followed up and the group of families only measured initially shows that on the majority of variables the groups do not differ significantly. Differences are found in FARS. Mothers in the families not followed up score higher degree of dysfunction.

Control group

There is no control group in the real sense of the word in this study. I would maintain however, that the different units' results as repeated measures of roughly the same working methods although with different client families and different staff groups can be regarded as a type of control.

We have compared some of the measurements with those of a small group of families on the waiting-list for treatment at an IFTU. Waiting-list control is an

established form for clinical control (Bergin and Garfield, 1994). We measured these families twice with an interval of at least a month. The first measurement was made during the planning of treatment and the second when treatment was about to commence. This group is interesting because it was chosen on the same principles as the group of families who were later measured during treatment and had comparable demographic data. Thus we have comparative material regarding problem and symptom levels on two occasions without any treatment inbetween. The interval is, however, not entirely comparable with the investigated group's six months. We also get some indication regarding the clients' reactions to completing the questionnaires on repeated occasions, as one might suspect that the very fact of repeating the same questionnaire can in itself induce change. It can also be said to constitute a measure of the instrument's stability. This data will be reported in the section on results.

The values of our families compared to other comparable clinical groups are also presented to give some perspective on the problems of our groups and the symptom-load as shown by our instruments.

Instruments study group 2

Family climate

The Family Climate Test consists of 85 adjectives from which family members choose and underline at least 15 words that they think are applicable to their family's current emotional climate. The Family Climate Test was homogenised by factor analysis into four factors: Closeness, Distance, Spontaneity and Chaos. These dimensions explained 40 % of the total variance and they were fairly constant. The test - retest reliability is satisfactory (three weeks r = .95, 5 months r = .89). The correlation with other comparable instruments is also

acceptable. The Family Climate Test seems to be able to describe changes within the family achieved by therapeutic interventions (Hansson, 1989).

FARS

FARS (Family Relations Scale) is developed from the instrument FACES and emanates from Olson's circumplex model (Olson et al., 1983).

It is intended to measure family function in an easy way. The rating scale consists of 46 statements about "my family" that the person filling out the test has to decide whether they fit or not. Factor analysis gave five factors: Attribution, Interest, Isolation, Chaos and Enmeshment.

Attribution:. One member of the family has become the scapegoat or an experienced problem with one family member is reported. A higher score on this scale indicates more attribution.

Interest: The scale measures the extent to which family members share mutual interests. High scores on this scale indicate fewer mutual interests.

Isolation. The scale measures experience of coherence and emotional solidarity within the family. High scores state experience of less coherence and solidarity.

Chaos: The scale measures experienced difficulty in predicting what will happen between the family members. Clinical experience says this measurement of chaos is more stable over time and less sensitive to special current events than the chaos dimension on the Family Climate Test. High values indicate a high degree of chaos.

Enmeshment:. This scale measures pressure on the family members to spend a lot of time together. High values indicate a higher grade of enmeshment.

FARS has high reliability (internal consistency: .94 for mothers and .92 for fathers). Covariance between this measurement of family function and other family measurements and the differences of the results on this instrument between the clinical and non-clinical samples show that validity is satisfying.

The results for Family Climate as well as for FARS before treatment (at the introduction of the treatment) and six months after the start of treatment are reported totally as well as separately for the families at the different units.

Results from measurements with these instruments in other relevant comparable groups are presented (Cederblad and Höök, 1992).

CRS-Turbo

CRS-Turbo is theoretically developed in accordance with Olson's circumplex model. Olson's circumplex model describes two orthogonal axes, Coherence and Adaptability.

A family can be described by a combination of points giving a certain position on these axes.

The test consists of three scales: Adaptability, Cohesion and Hierarchical organisation. Low rated values indicate rigidity while high rated values indicate a chaotic family milieu. Low values indicate disengagement while high values indicate enmeshment. 0 - 1 indicates clear clarity Generation borders while 2 states unclear Generation borders. Inter-rater-reliability is regarded as good. Adaptability r = .88, Coherence r = .87, Hierarchical organisation r =

.92. In order to get a high degree of reliability, it is obviously important that the raters are trained and co-trained. For the purpose of validation it has been proved that raters, with the help of this instrument, can separate so called "normal families" from families that have sought child psychiatric help.

Beavers' Observational System Scale

The observer-rated schedule Beavers' Observational System Scale is designed by Beavers and emanates from Beavers' Timberlawn's family model (Beavers, 1982). This is a two dimensional model where the horizontal axis relates to structure, available information and flexibility of the system. The positioning of a family along this axis gives a measure of family competence. This is why this scale is called "The Competence Scale". The more competent the family, the higher the rated value. The vertical axis relates to the family's way of interaction. This variable is not meant to be seen as a continuum from dysfunctional to functional interaction but rather as a u-formed scale with the most adaptive pattern of interaction in the midrange of a scale going from a centripetal tendency (satisfaction is seeked within the family) to a centrifugal tendency (satisfaction is sought in the world outside the family). A global rating measurement for each scale is also given. In a follow-up reliability study in 1988, fairly satisfactory interpersonal reliability values of the Competence scale were found, while the values of the Style scale were lower. Cederblad, Hansson and Gustavsson emphasise the importance of training and co-training in order to reach higher accuracy of measurements (Hansson, 1989, Cederblad and Hansson, 1989).

CBCL (Child Behavioral Checklist)

In designing the Child Behavior Check List (CBCL), Achenbach used information from parents' descriptions of their child's symptoms and social competence.

The questionnaire consists of two parts; a competence scale and a problem scale. In this study only the results from the symptom-load reported by parents are given. The problem scale consists of 113 questions divided into eight sub-scales. After factor-analysis the sub-scales have been grouped into three meta-scales: Internalising, Externalising and one called Other problems.

Every question is answered by 0 = not true, 1 = true to some extent, 2 = true or most often true. A total sum of points, total amount of problems, is calculated by adding the number of ones and twos.

Studies of reliability are reported in the manual. Both interpersonal reliability and test - retest reliability have been regarded as high (r = .93 and above). In studies comparing CBCL with DSM-III diagnoses, concordance is noted for certain syndromes. The instrument has also been validated by comparing groups of children in child psychiatric treatment to children not receiving such treatment. The instrument was able to differentiate these two groups in different countries (Achenbach, 1991).

SCL -90

The Symptom Check List (SCL -90) was developed as an expanded version of the HSCL, from 58 to 90 items. The test is a questionnaire consisting of 90 statements describing problems and symptoms of different kinds. The person filling in the questionnaire determines to what extent he/she is troubled by these problems by choosing one alternative out of five. The nine symptom dimensions that the check-list is intended to measure are:

1. Somatization. 2. Obsessive-compulsive problems. 3. Social self-esteem. 4. Depression. 5. Anxiety. 6. Hostility. 7. Phobic Anxiety. 8. Paranoid Ideation. 9. Psychoticism.

Reliability studies were carried out with different measures regarding the first five scales: Coefficients alpha .87 - .84, test - retest .75 - .84. Interpersonal reliability .64 - .80. (Derogatis et al., 1973, Derogatis et al., 1974, Derogatis and Cleary, 1977). The conclusion nowadays is that the check-list measures a general factor concerning psychological pain and trouble (Cyr et al., 1985). The test has recently been standardised on a large Swedish population (Malling Andersen and Johansson, 1998).

SOC (Sense of Coherence)

Antonowsky developed the conception " sense of coherence", which he defined according to the following: A global attitude which expresses to what extent one has a penetrating and lasting, but dynamic, feeling of confidence concerning comprehensibility, manageability and meaningfulness.

Aaron Antonowsky developed a questionnaire (SOC) measuring these dimension. This study uses of a Swedish version of this instrument. The questionnaire consists of 29 questions. Every item is to be answered on a seven-point scale. Single items correlate satisfactorily with the total sum. High and satisfactory reliability data were found (Cronbach's alpha .77 - .95, test - retest .80 - .91) (Cederblad and Hansson, 1996). Non-clinical groups of adults seem in all cases to have a median value between 50 - 151. Factor analysis gives no clear factors according to the concepts Meaningfulness, Comprehensibility and Manageability. The conclusion drawn by the designers is that the factors should not be used separately. The form now seems to work very well from the age of thirteen upwards. The Swedish version of SOC has been validated against a number of other instruments. Results on the instrument co-varies in a meaningful way with different health variables, family function, temperament and optimism.

Statistical methods

The results of the respective tests before and six months after the commencement of treatment are presented. The statistical methods used are Paired and Unpaired T-test, One factor Anova, Two factor Anova, Orthogonal factor analysis (Statview manual, 1994).

Statistical and clinical significance: Summarised evaluation of treatment outcome.

How should one regard a statistical significance? What do a number of measured differences before and after treatment signify? Does the measure imply a clinical difference for the individual family? I shall complement the presentation of results with a number of measures of clinical significance.

We may ask what the presentation of statistical significances in group data are worth in the light of the individual family's and the individual family members' treatment fate. Maybe different families are responsible for the statistically significant results on the various instruments. Therefore, for the individual family, the effect would be very small as seen from the various ways of measuring treatment outcome. The answer to the question must therefore be sought with the help of the same family's treatment results on several of the different instruments measuring outcome. If these all confirm results in the same direction, one can begin to talk about treatment effects

I have chosen to use three instruments, each one of which measures the effect of family treatment in different ways: FARS (family function), SCL-90 (parents' symptom load) and CBCL (the identified problem child's symptom load as estimated by the parents). I have determined that an obvious

improvement according to each one of these instruments corresponds to one standard deviation in a normal material. For FARS, this corresponds to 11 points less (Cederblad and Höök, 1992), for SCL-90 16 points less (Malling Andersen and Johansson, 1998) for CBCL 14 points less (Botella et al., 1995). I have chosen to use the mothers' results, as their ratings are judged to be the most reliable and valid regarding the situation of the family and the various family members. The results for the mothers in all the families (86) included in the treatment evaluation have been classified regarding reported changes on the various instruments mentioned above. After this, I have determined that the families have reached a clinically significant change when the mothers' results have changed more that one standard deviation on at least two of the three instruments. I also look at how many of the mothers on the respective instruments FARS (family function), SCL-90 (parents' symptom load) and CBCL (the identified problem child's symptom load as rated by parents) have changed their rating of their family's function or their child's symptom-load from a clinical position to a position where non-clinical families are to be found. I have also compiled a small material from a two year follow-up which can also contribute to indicating whether or not the changes in the results before treatment in relation to six months after treatment are constant.

Results

The articles on which my dissertation is based as well as a couple of supplementary chapters, relate to different aspects of intensive family treatment. Together, they provide a comprehensive description of the treatment method. A general presentation of the total research results is given in the following order:

- A summary account of the results describing the treatment form.
- A summary account of the smaller study of the effect measurements used.
- The results of the main study regarding the effects of the treatment form. The results describing symptom variables and variables of family function are described separately.
- The account of the results is supplemented with an comparison of the respective units' results as well as measures regarding their clinical significance.
- The results of the IFTU group's measures are related to those of other comparable groups.
- A descriptive section presents information-seeking work for change.
- The treatment organisation's relation to effectiveness in the work for change is discussed.

Study group 1

Sundelin J. A Systems-Oriented Model for the Description of Intensive Family Therapy Units. Accepted Nordic Journal of Psychiatry, February 1998.

Sundelin J. A Systems-Oriented Model for the Description of Intensive Family Therapy Units, a pilot study. Accepted Nordic Journal of Psychiatry, February 1998.

The treatment form is presented and defined as one often employed in child and adolescent psychiatry. Treatment includes all or parts of families in a daytime or weekly program from Monday to Friday. Treatment consists of co-operation between families and a therapeutic team consisting of family therapists, milieu therapists and teachers in a co-ordinated program. This intensive treatment form lasts for three or four weeks and is focused on themes pre-agreed on by the family and the team. The intensive work is followed up by supportive and co-ordinating contacts.

The emergence of this treatment form in its clinical setting arose from the need for a more effective way of taking care of families and their children with complicated and numerous problems of a medical, psychological and social nature. Firstly, the results of out-patient treatment for socially underprivileged families with a complicated, problematic family situation were unsatisfactory. Secondly, traditional in-patient programs for children with severe problems were not compatible with the basic need of continual contact with their families and network.

Theoretical sources of inspiration are presented. These mainly come from the field of family therapy, here exemplified by the structural and systematic schools, but also from the field of care and nursing within the health services, group therapy and milieu therapy, as well as organisational psychology.

A model for describing the treatment form was developed based on traditional organisational psychology, research on institution-based treatment and treatment content. The model includes dimensions for treatment context,

commissions from families or referring institutions, the knowledge and other resources necessary for the success of such a treatment model and the criteria for goals and goal-attainment. The model also attempts to take into consideration the interaction between these dimensions.

The model (figure 2) is also intended to differentiate between well-functioning and less well-functioning treatment units.

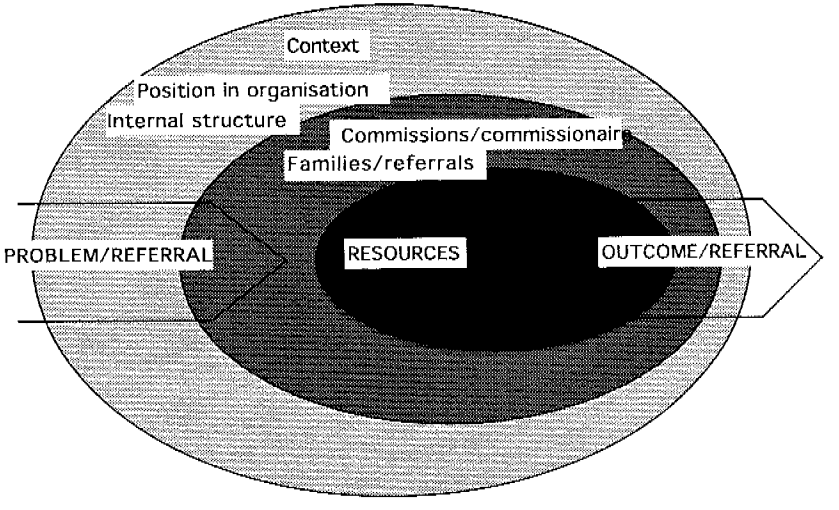

Figure 2: Graphic picture of the theoretical model presented for describing IFTUs

Starting from this model, instruments were developed to evaluate the units involved in the multicenter project.

The units describe themselves similarly in many respects regarding the treatment model. Some differences emerge regarding the units' description of their position in the organisation, commissions and paths of referral, treatment ideology and the allocated resources in terms of competence and number of staff etc. In summary, I find that the instruments developed with the support of the model are able to differentiate between the different units with respect to

their working profiles and that the results fall into three clusters. Two of the units report high job satisfaction and a clear-cut work process (higher degree of structure). One group of units has somewhat lower values for the variables structure and job satisfaction and one unit describes a profile characterised by a loose structure regarding work forms and poor job satisfaction (figure 3).

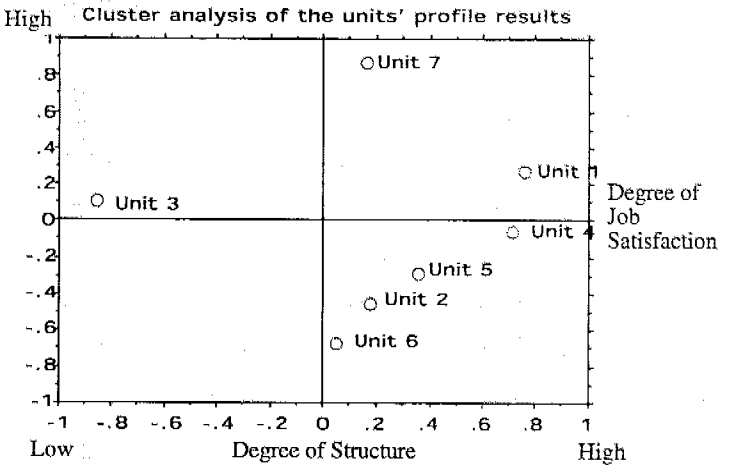

Figure 3: Cluster analysis for Style and Climate factors over units. The two cluster factors were named "Degree of Structure" and "Degree of Job Satisfaction".

Study group 2

The pilot studies

Sundelin J., Hansson K., Westlund M. Inpatient family therapy. Evaluation of the work at a treatment unit at the Clinic of Child and Adolescent Psychiatry in Falun 1986-1990. Translated for this volume from: Inpatient family therapy. Evaluation of a treatment unit's work at the Clinic of Child and Adolescent Psychiatry in Falun during the years 1986-1990. Fokus på familien, 4 1991; 221-231.

Psychiatry in Falun during the years 1986-1990. Fokus på familien, 4 1991; 221-231.

Hansson K, Davidsson-Gräns S,. Milling M., Johansson P., Silvenius U., Sundelin J., Westlund M. Inpatient family therapy. A multicenter study of families' and staffs' experience of family climate. Translated for this volume from: Nordisk Psykiatrisk Tidskrift, 1992; 336-343.

These two studies are to be regarded as pilot studies of the evaluation of intensive family therapy. Knowledge of and routines for clinical research were tested and developed. A description of the treatment form began to emerge. In the first of these two pilot studies the instrument "Family Climate" was used as the sole instrument to evaluate 40 families treated at one IFTU during a three-year period. The family members' evaluation of their family climate changed after the treatment period towards feelings of increased Closeness and decreased Distance and Chaos. A comparison of experienced family climate was made with the families who sought continued help after intensive family treatment and those who did not. Families who sought further help reported increased chaos after treatment.

The second article presents a multicenter pilot study of five different units for intensive family treatment. 59 families were treated and the treatment was evaluated only by the self-report questionnaire Family Climate during autumn 1989 - spring 1990. The results show that 50% of the families felt that their family climate had changed for the better during the treatment period. This must be seen as a good result, especially as this group of families had a heavy symptom load. Some differences between the units were noted regarding the length of the treatment effects after the conclusion of the intensive family treatment. This difference was interpreted in terms of the variation in treatment length. A somewhat longer treatment period stabilises the work of

change. Furthermore, the differences can be seen in the light of organisational stability and independence, just as competence and independence in the therapeutic role also enhances the durability of the treatment effects achieved.

The main study

Sundelin J., Hansson K. Intensive Family Therapy - a way to treat multiproblem families. A follow up study measuring individual psychopathology. Submitted, 1999.

Sundelin J., Hansson K. Intensive Family therapy - a way to change family function in multiproblem families. Accepted Journal of Family Therapy, 1999.

In this study of treatment effects, 109 families participated and 86 of these were followed up. Measurements of the families' experienced symptom load as well as self-ratings and observer ratings of functional level were carried out before and six months after the commencement of treatment. A large test battery was used. The results presented here concern the self-report questionnaire Child Behavioral Checklist (CBCL), Symptom Checklist (SCL-90), Sense of Coherence (SOC), Family Climate (FK) and Family Relation Scale(FARS) and video-taped observer ratings according to CRS-Turbo and the Beavers' Observational Scale.

Here follows a highly condensed presentation of the treatment results regarding statistical changes for the group of treated families.

Table 10: Parent-rated and self-rated change of symptom load pre-treatment and six months after start of treatment and "sense of coherence" for family members (paired t-test).

Scales	Mother	Father	Child (Identified patient)
CBCL Internalisation	-	-	***
CBCL Externalisation	-	-	***
CBCL Total	-	-	***
SCL-90 Total	***		*
SOC	***		-

* = p < .05
** = p < .01
*** = p < .001

Table 10 presents the results of CBCL only for the major syndromes internalisation, externalisation and for the total symptom load. The results on all three scales are unanimous. The group of identified problem children decrease their symptom load markedly between the two measuring occasions according to parental ratings (in most cases maternal ratings) on CBCL. We find no differences regarding either the age or gender of the child. As to the self-rated mental health of family members (SCL-90) we see that six months after treatment mothers experience their mental health as much improved. This applies also to the identified patients (IP<13 years) who completed the questionnaire. We also see the same tendency for fathers, even though the value does not reach statistical significance. On SOC, the change is very obvious for the group of mothers. The results for CBCL are clearly illustrated in figure 4.

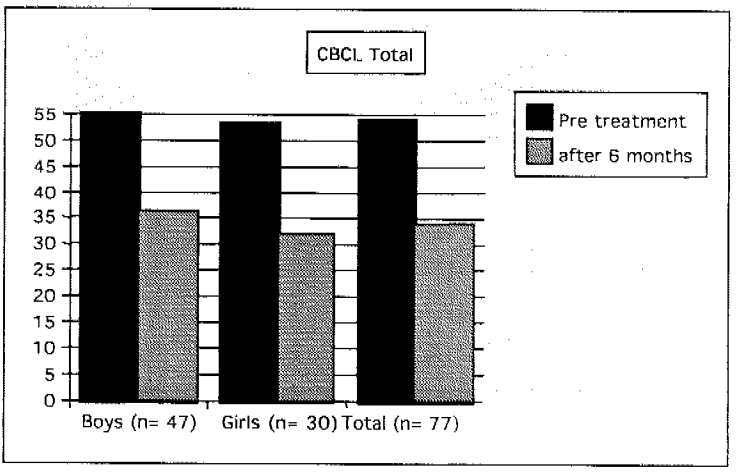

Figure 4: Parent-rated symptom-load for identified problem child pre-treatment and six months after start of treatment.

Table 11: Results from tests for statistical significance (paired t-test) pre-treatment and six months after start of treatment on two instruments for self-rating of family function by different family members and of observer ratings of family function according to two instruments .

Self-rating instruments:	Mothers	Fathers	Child (Identified patient)
Family Climate:			
Closeness	***		***
Distance	***	***	**
Chaos	***	***	**
FARS:			
Attribution	**		*
Interest	*		*
Isolation	***		*
Chaos	***	*	**
Enmeshment	***		***
Total	***	*	***

* = $p < .05$
** = $p < .01$
*** = $p < .001$

Concerning the measures of family climate and family function, we note that the values for the group of families in the study show statistically significant changes on the majority of variables between the pre-treatment measures and those done six months after the commencement of treatment (table 11). Concerning the groups of mothers, fathers and identified patients, table 11 illustrates a clear change in a positive direction regarding family climate for all groups from the start of treatment to six months after the commencement. Greater Closeness, less Distance and less Chaos are described. There is only one exception, and that is fathers' ratings of Closeness. Certainly, a greater degree of Closeness is experienced, but it does not reach statistical significance.

Regarding FARS, we see, in principle, the same tendencies as for family climate, namely, a clearly improved family function. Mothers and children consistently describe an improved situation on all the variables included in the questionnaire and, consequently, a higher total degree of family function. In the group of fathers we see the same tendency as for family climate, namely that they describe smaller changes although in the same positive direction. All changes are, however, expected and in a positive direction. Regarding the total value for the scale, the fathers also describe an improvement. The results of Family Climate and FARS are clearly illustrated in figures 5 and 6.

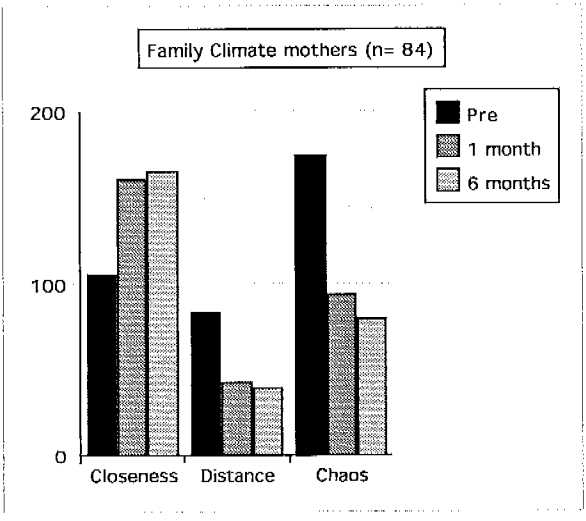

Figure 5. Self-rated family climate for mothers before treatment, after one month and at six months after start of treatment.

It is interesting to note that the changes mainly occur during the first month of intensive treatment period and then remain at almost the same level for the six months after the start of treatment.

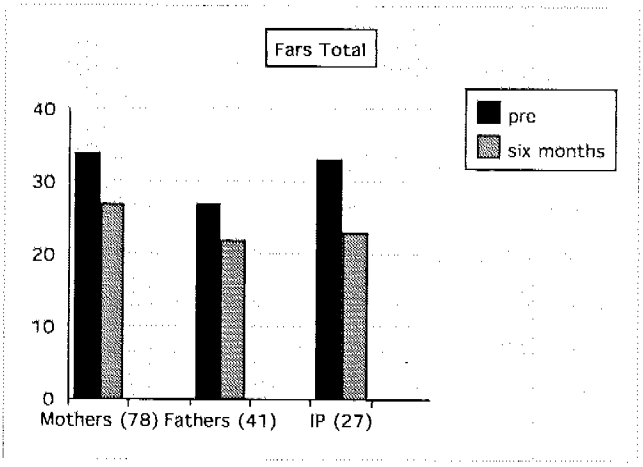

Figure 6. Differences noticed on FARS (total) between the measurement pre-treatment and six months after start of treatment for different family members.

In the previous tables we have accounted for self-rated family function. We also video-taped the families and let independent judges rate the families pre-treatment and six months after the commencement of treatment. The families were given different structured tasks to carry out, among others, a jigsaw puzzle and a problem to be discussed. The results from the CRS-Turbo and Beavers' rating scales show a clear change for the better in family function. The largest difference was found on the adaptability scale in CRS-Turbo. In the beginning families were mainly rated as chaotic whereas after 6 months family function was found to be almost normalised, i e even independent raters judged the family's function to be much improved in this respect. Regarding Cohesion, family function was rated as having changed from a disengaged position to a more balanced one, even though the change did not reach statistical significance. We find similar, though not significant, changes regarding Hierarchy. As the variables Adaptability and Cohesion are considered to have a so-called U-shaped distribution i e both high and low values are regarded as dysfunctional, we have constructed a divergent index showing that we have a significant change for the better as regards

Adaptability and Cohesion, i e the families are judged by independent raters to be less dysfunctional after six months. In principal, we find the same results regarding Beavers' rating scales. Families are judged as clearly more competent than before treatment, even though they do not reach a non-clinical score on this scale. Furthermore, we find that even here the families have become less chaotic. Thus, regarding family function we can establish a change in a positive direction in both self-ratings and observer ratings of family function. However, we must mention that only 42 families from some of the units were video-recorded and rated (unit 1: n=10, unit 5: n =8, unit 6: n=11, unit 7: n =13).

Table 12: Results from tests for statistical significance (paired t-test) pre-treatment and six months after start of treatment for observer ratings of family function according to two observer rating instruments.

CRS-Turbo:	
Adaptability	***
Cohesion	
Hierarchy	
Adaptability -M	***
Cohesion -M	**
Beavers' Observational System Scale:	
Family competence	**
Family style	*

* = $p < .05$
** = $p < .01$
*** = $p < .001$

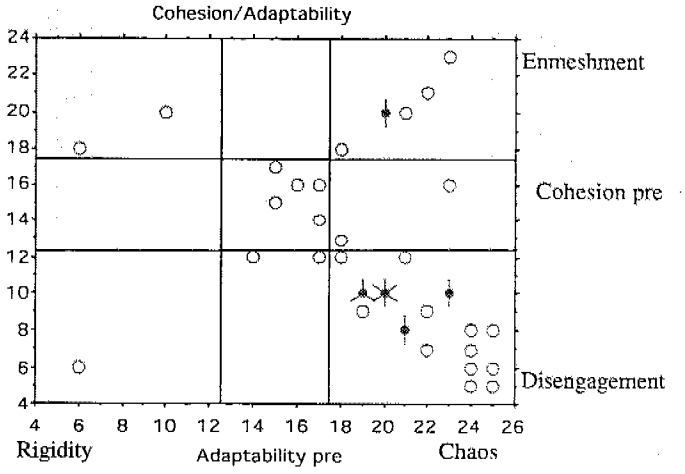

Figure 7: Scattergram for Cohesion/Adaptability (CRS-Turbo) for 42 families pre-treatment.

The majority of the IFTU families form a cluster high on the Adaptability scale and either low or high on the Cohesion scale. The results can be further illuminated by the lines which have been added to the figure to delineate an area M+ 1Sd for a Swedish control group consisting of non-clinical families (Thernlund, 1996).

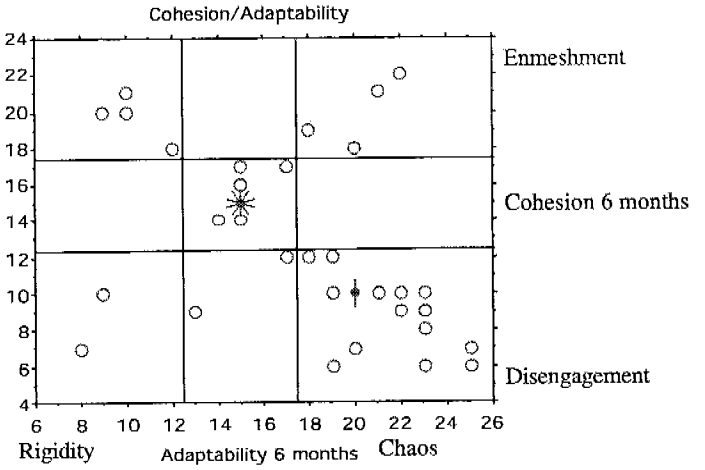

Figure 8: Scattergram for Cohesion/Adaptability (CRS-Turbo) for the same 42 families six months after start of treatment.

The family cluster is placed towards the center of the figure, i e the values for Cohesion and Adaptability tend to approach the values for a non-clinical group (Thernlund, 1996).

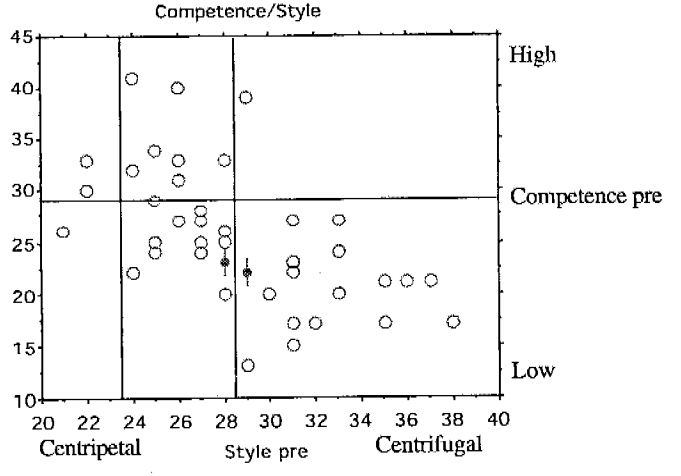

Figure 9: Scattergram for Competence/Style (Beavers' Observational System Scale) for 42 families pre-treatment.

As the majority of the families score low on the Competence scale, only one line marking M-1 Sd is added to the figure. For the Style scale, a field illustrating non-clinical families is added (Thernlund, 1996). The family cluster is positioned low on the Competence scale and high on the Style scale, i e the families are characterised as seriously disturbed centrifugal families (Cederblad and Hansson, 1989).

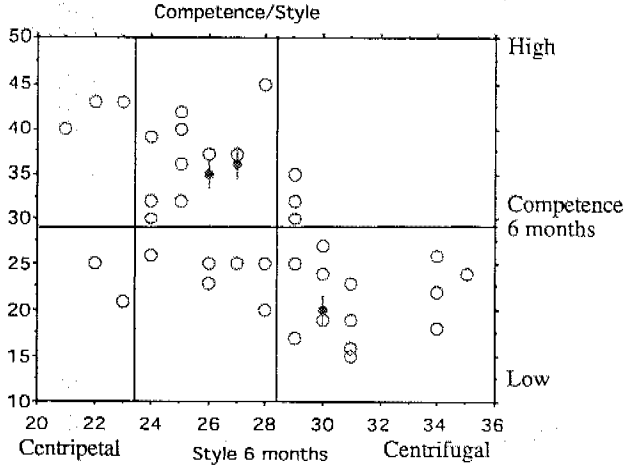

Figure 10: Scattergram for Competence/Style (Beavers' Observational System Scale) for the same 42 families six months after start of treatment.

In figures 9 and 10 a line is also added to the Competence scale indicating M-1 Sd. For the Style variable, a field is added(M+1 Sd) to show values for a non-clinical family (Thernlund, 1996). Compared to figure 9, we see how the family cluster in figure 10 has moved above the lower limit for the Competence scale. The pattern is almost the same for the Style variable, though positioned somewhat nearer the middle.

In order to check the precision of the observer ratings, it is necessary to look at inter-rater reliability. The reliability data for the pairs of independent raters are presented in table 13.

Table 13: The interrater reliability of five rating-pairs regarding family observations.

	Pair of raters				
Scale	1	2	3	4	5
Adaptability tot	.97	.96	.94	.86	.94
Cohesion tot	.90	.96	.83	.82	.90
Hierarchy tot	.93	.96	.83	.90	.90
Competence tot	.96	.89	.90	.91	.92
Competence glob.	97	.94	.88	.86	.93
Style tot	.81	.75	.79	.68	.77
Style global	.80	.97	.81	.77	.87

The interrater reliability of the different pairs of raters is very high. The Style scale has the lowest results which confirms earlier findings (Cederblad and Hansson, 1989). Even so, the values are on an acceptable level. (An account of reliability measurement according to Kappa was not considered to be necessary as the correlations were so high.)

An account of the different units' results on the various tests (multivariate analysis).

The following presents the results of each participating unit. In a multicenter study the degree of similarity or dissimilarity in the changes achieved by the different units are of interest. The units offer largely similar family treatment programs, but with different teams and in various parts of Sweden. The results are presented test by test. The internal drop-out for each unit and each test is presented, for example "1(n=6/10)". The statistical method used for this multivariate analysis is a two-factor repeated measures Anova.

CBCL

Table 14: Results CBCL Identified patients (boys) pre-treatment and six months after the start of treatment at different IFTUs (two-factor repeated measures Anova).

Unit	pre-treatment			six months after start of treatment		
	Intern. M (Sd)	Extern. M (Sd)	Tot. M (Sd)	Intern. M (Sd)	Extern. M (Sd)	Tot. M (Sd)
1 (n= 6/10)	14.5 (6.5)	33.0(13.7)	66.0(23.9)	9.7 (7.0)	20.5(13.9)	41.8(28.9)
2 (n=12/20)	9.1 (8.3)	19.5(16.1)	41.8(29.5)	6.2 (6.2)	13.1(10.7)	26.6(23.2)
5 (n= 4/7)	14.8 (7.8)	24.0 (7.5)	56.3(20.8)	12.2 (6.6)	14.3 (4.1)	39.3(11.6)
6 (n=15/18)	14.4 (8.6)	25.9 (8.7)	58.4(22.6)	11.1 (8.0)	16.8(11.0)	40.3(24.2)
7 (n=10/12)	19.4(10.9)	19.6 (9.1)	56.6(25.2)	9.5 (8.2)	13.9 (9.5)	34.8(20.9)

No significant differences are found between the units (n = 47, F-test 1.23 p = .31) but there is a significant difference between the two measurements (F-test 105.1 p = .0001). There is no co-variation between the variables place and time (F-test .92 p = .56) (two-factor repeated measures Anova).

Table 15: CBCL-results Identified patients (girls) before treatment and six months after the start of treatment at different IFTUs (two-factor repeated measures Anova).

Unit	pre treatment			six months after start of treatment		
	Intern. M (Sd)	Extern. M (Sd)	Tot. M (Sd)	Intern. M (Sd)	Extern. M (Sd)	Tot. M (Sd)
1 (n= 4/6)	9.8(10.1)	19.5(13.1)	41.8(31.5)	2.5 (3.1)	9.3 (5.9)	16.3(11.1)
2 (n= 8/12)	15.4(10.2)	18.5(10.0)	52.0(21.1)	9.8 (7.5)	11.4 (9.7)	29.3(18.1)
5 (n= 3/7)	21.3(17.2)	24.3(20.2)	61.0(49.2)	18.3 (9.3)	22.0(15.4)	48.7(29.4)
6 (n= 6/6)	21.2(11.2)	23.0 (8.7)	60.3(24.3)	10.2 (7.1)	16.8 (6.0)	35.3(13.6)
7 (n= 9/10)	11.6(10.9)	20.1(12.6)	50.3(31.4)	7.7 (8.6)	11.2(10.1)	35.3(24.3)

No significant differences are found between the units (n = 30, F-test .97 p = .44) but there is a significant difference between the two measurements (F-test 48.1 p = .0001). There is no co-variation between the variables place and time (F-test .41 p = .99) (two-factor repeated measures Anova).

SCL - 90

Table 16: Results SCL -90 comparison pre-treatment and six months after the start of treatment for mothers at the different IFTUs(two-factor repeated measures Anova).

Unit	pre-treatment		six months after start of treatment	
	M	(Sd)	M	(Sd)
1 (n = 8/11)	79.9	(45.3)	34.3	(27.0)
2 (n = 24/26)	69.2	(51.8)	32.7	(34.0)
5 (n = 11/11)	91.5	(58.8)	52.1	(33.2)
6 (n = 17/19)	67.1	(47.9)	46.5	(46.0)
7 (n = 18/19)	124.8	(67.8)	75.2	(51.1)

On two factor repeated measures Anova, statistically significant differences are found between the different IFTUs concerning location of the IFTU (F-test 3.8, p = .001) and between the two measurements (F-test 51.4, p = .0001). No interaction between location and time is found (F= .96, p= .44). It is principally the initial values that separate the units. Otherwise, they all follow the tendency for change seen in the group as a whole.

SOC

Table 17: Results SOC 94 mothers (two-factor repeated measures Anova) before and six months after the start of the treatment at the different IFTUs.

Unit	pre-treatment		six months after start of treatment	
	M	(Sd)	M	(Sd)
1 (n= 11/11)	129	(20.4)	142	(17.1)
2 (n= 24/26)	147	(24.4)	152	(22.0)
5 (n= 9/11)	129	(20.8)	134	(21.1)
6 (n= 18/19)	132	(32.6)	140	(27.0)
7 (n= 18/19)	119	(24.1)	129	(27.7)

Significant differences are seen with two-factor repeated measures Anova between the different IFTUs (F-test 3.42, p = .01) and between the two measurements (F-test 18.2, p = .0001). No interaction effect between the variables is found (F-test .43, p = .78).

Family Climate

The pattern of change regarding the mothers' experiences of family climate is mainly the same at the different units according to multivariate analysis (two-factor repeated measures Anova) for Closeness and Distance: Closeness: F-test concerning unit .80, p = .52, Distance: F-test 1.11, p = .36. The patterns for change concerning Chaos show a statistically significant difference between the units: Chaos: F-test 3.31 and p = .02. Incidence analysis shows that the pattern of change varies between the units so that the value for chaos rated by the mothers at unit number 1 is high after a month and then significantly drops at six months, while the values for chaos at the other units decrease steadily (unit number 6 and 7). Two units (number 2 and 5) report a pattern of substantial decrease of experienced chaos after a month and then a certain decline towards a higher degree of chaos six months after the start of the treatment.

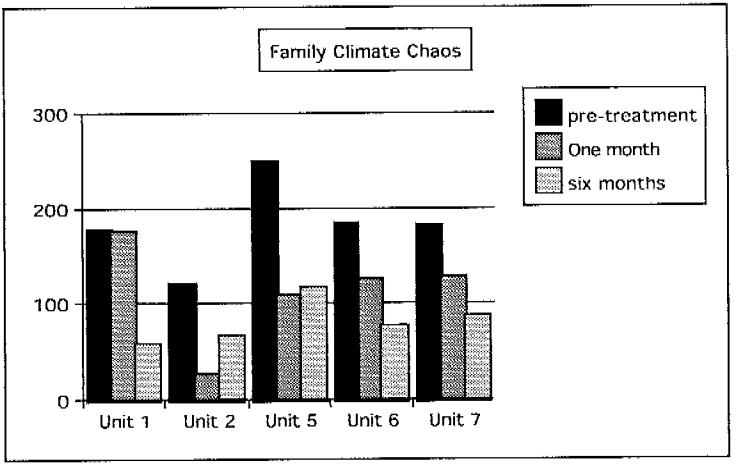

Figure 10: Results for the different units on Family Climate test: Chaos before treatment, one month after start and six months after start of treatment.

FARS

Table 18: FARS. Totally for mothers before treatment and six months after the start of the treatment from the different IFTUs (paired t-test).

Unit	pre		six months		t=	p=
	M	(Sd)	M	(Sd)		
1 (n = 8/10)	42.43	(17.63)	28.57	(9.69)	2.0	.09
2 (n =24/26)	30.38	(16.94)	25.54	(18.18)	0.36	.72
5 (n =11/11)	34.50	(10.44)	25.20	(13.38)	2.2	.06
6 (n =19/19)	33.05	(16.33)	27.45	(13.87)	2.6	.02
7 (n =19/19)	41.45	(20.23)	29.50	(17.72)	3.9	.001

The results change over time in the expected direction. A multivariate analysis showed no statistically significant differences between the units on the different scales or totally (two factor repeated measures Anova).

The units number 1 and 7 report both the highest initial values (the most dysfunctional) and the greatest nominal changes. Units 5 and 6 show moderate changes while unit 2 has low initial values that do not change over time.

In a univariate analysis concerning each of the units (paired t-test of the different scales before treatment - six months after the start of treatment) significant changes regarding unit 1 are seen in two scales: Attribution and Chaos. Units 2 and 5 show no statistically significant changes (total $p = .06$). Unit 6 reports statistically significant changes in the scales: Isolation, Enmeshment and totally. Unit 7 reports statistically significant changes in all the scales except Attribution.

To briefly summarise the comparison of the units' results concerning the pattern of change, we can establish that the tendency for change is more similar than dissimilar. There are signs of differences regarding symptom-load in the families at the different units and tendencies towards different patterns of change during treatment. I refer you further to the chapter analysing the interplay between organisation and change where the results for unit 3 can be found.

Comparison groups

The units' treatment results with different patient families and different therapeutic teams can be regarded as repeated measures of roughly the same working method and, in this sense, they constitute each other's controls. Matched or randomised groups are not used in this study. I have, however, compiled a table showing the various instruments used to measure the IFTU families and compared the values with those of other relevant groups of clinical and non-clinical families (tables 19 - 26).

Table 19: Childrens Behavioral Checklist (CBCL). Comparison between the values for boys from the IFTU families pre-treatment for the different scales with other relevant groups of boys (unpaired t-test).

	IFTU	Child Guidance	Non-clinical	IFTU v Child Guidance		IFTU v Non-clinical	
	pre-treatment M (Sd) n = 51	pre-treatment M (Sd) n = 99	M (Sd) n = 654	t=	p=	t=	p=
Withdrawn	4.6 (3.0)	3.3 (2.5)	1.2 (1.6)	2.65	.01	7.91	.001
Som. compl.	2.9 (2.8)	2.0 (2.5)	0.8 (1.4)	1.96	ns	9.25	.001
Anx./Depr.	9.0 (5.6)	6.5 (4.9)	2.0 (2.8)	5.43	.001	17.50	.001
Social probl.	5.2 (3.3)	3.7 (3.1)	0.8 (1.3)	2.68	.01	9.36	.001
Thought probl.	1.6 (2.1)	0.8 (1.2)	0.1 (0.6)	2.5	.02	5.00	.001
Att. Probl	8.4 (4.3)	6.2 (3.6)	1.9 (2.4)	3.14	.01	10.70	.001
Delinq. Probl.	5.3 (3.9)	3.6 (3.6)	1.2 (1.7)	2.57	.02	7.32	.001
Aggr. probl.	19.6 (9.9)	13.6 (8.0)	4.9 (4.9)	3.75	.001	10.50	.001
Intern.	14.2 (9.2)	11.4 (7.6)	3.9 (4.4)	1.77	ns	7.36	.001
Extern.	23.7 (12.0)	17.3 (10.5)	6.1 (6.1)	3.23	.01	8.51	.001
Total	54.6 (26.0)	44.2 (20.4)	14.9 (13.9)	2.49	.02	10.80	.001

We note higher values (higher symptom load) for the boys in IFTU families on nearly all the scales in relation to the group of out-patients in child psychiatry and in relation to the Swedish norm group at large (Botella et al., 1995)

Table 20: Childrens Behavioral Checklist (CBCL). Comparison between the values for girls from the IFTU families pre-treatment for the different scales with other relevant groups of girls (unpaired t-test).

	IFTU-families	Child Guidance families	Nonclinical families	IFTU v Child Guidance		IFTU v Non-clinical	
	pre-treatment M (Sd) n = 29	pre-treatment M (Sd) n = 78	M (Sd) n = 701	t=	p=	t=	p=
Withdrawn	3.3 (2.8)	3.3 (2.5)	1.3 (1.6)	0	ns	3.77	.001
Som. compl.	3.4 (3.7)	2.6 (2.6)	1.1 (1.7)	1.19	ns	3.71	.001
Anx./Depr.	8.9 (7.7)	7.6 (5.5)	2.1 (2.7)	0.83	ns	4.76	.001
Social probl.	3.6 (2.9)	2.7 (3.1)	0.7 (1.4)	1.40	ns	5.27	.001
Thought probl.	1.4 (1.4)	1.1 (1.9)	0.1 (0.6)	0.86	ns	7.88	.001
Att. Probl.	6.1 (4.1)	4.7 (4.1)	1.5 (2.0)	1.57	ns	5.97	.001
Delinq. Probl.	4.1 (3.3)	3.0 (3.0)	1.0 (1.5)	1.55	ns	5.00	.001
Aggr. probl.	15.4 (9.3)	10.7 (7.3)	4.5 (4.4)	2.46	.02	6.30	.001
Intern.	15.2 (11.6)	13.0 (8.4)	4.4 (4.6)	0.93	ns	5.00	.001
Extern.	20.6 (11.0)	13.5 (9.2)	5.5 (5.5)	3.10	.01	7.37	.001
Total	52.7 (27.0)	39.8 (23.3)	14.6 (13.0)	2.28	.05	7.56	.001

The girls in IFTU families have higher values (higher symptom load) regarding aggressive problems and on the externalisation scale in relation to the group of out-patients in child psychiatry and in relation to a Swedish norm group at large (Botella et al., 1995).

Table 21: Childrens Behavioral Checklist (CBCL). Comparison between the values six months after start of treatment for the boys from the IFTU families for the different scales with other relevant groups of boys (unpaired t-test).

	IFTU-families		Child Guidance families*		IFTU v Child Guidance		IFTU v Non-clinical	
	six months after start of treatment		eighteen months after start of treatment					
	M	(Sd)	M	(Sd)	t=	p=	t=	p=
	n = 51		n = 76					
Withdrawn	2.4	(2.2)	2.3	(2.1)	0.26	ns	3.82	.001
Som. compl.	1.6	(1.6)	1.3	(1.5)	1.07	ns	3.47	.001
Anx./Depr.	4.9	(4.2)	4.8	(4.7)	0.13	ns	4.85	.001
Social probl.	3.4	(3.4)	2.8	(2.5)	1.07	ns	5.43	.001
Thought probl..	0.7	(1.7)	0.8	(1.5)	-0.33	ns	2.51	.02
Att. Probl	5.1	(3.9)	4.9	(3.3)	0.30	ns	5.78	.001
Delinq. Probl.	3.4	(2.6)	2.7	(2.4)	1.52	ns	5.94	.001
Aggr. probl.	11.8	(8.3)	10.5	(7.3)	0.91	ns	5.86	.001
Intern.	8.6	(6.5)	8.1	(6.4)	1.17	ns	5.07	.001
Extern.	15.3	(10.4)	13.2	(9.0)	1.17	ns	6.23	.001
Total	34.2	(22.9)	33.2	(19.1)	0.26	ns	5.93	.001

No statistical differences are found between the two clinical groups (Botella et al., 1995)

Table 22: Childrens Behavioral Checklist (CBCL). Comparison between the values six months after start of treatment for the girls from the IFTU families for the different scales with other relevant groups of girls (unpaired t-test).

	IFTU-families		Child Guidance families*		IFTU v Child Guidance		IFTU v Non-clinical	
	six months after start of treatment M (Sd) n = 29		eighteen months after start of treatment M (Sd) n = 78		t=	p=	t=	p=
Withdrawn	2.0	(1.8)	2.3	(2.1)	-0.73	ns	1.69	ns
Som. compl.	1.9	(2.3)	1.3	(1.5)	1.30	ns	2.63	.01
Anx./Depr.	6.0	(5.9)	5.9	(4.7)	0.08	ns	4.96	.001
Social probl.	2.3	(2.3)	2.1	(2.5)	0.39	ns	2.53	.02
Thought probl.	0.3	(0.8)	0.9	(1.7)	-2.50	.02	0.63	ns
Att. Probl.	3.4	(3.4)	3.7	(3.7)	0.39	ns	2.61	.01
Delinq. Probl.	3.2	(2.4)	2.7	(2.4)	0.96	ns	4.53	.001
Aggr. probl.	10.3	(8.4)	8.8	(6.9)	0.86	ns	3.74	.001
Intern.	8.6	(8.1)	9.8	(7.0)	-0.71	ns	3.44	.001
Extern.	12.2	(10.3)	10.8	(8.6)	0.65	ns	3.45	.001
Total	30.9	(22.1)	30.5	(21.5)	0.08	ns	3.81	.001

The two clinical groups do not differ from each other (Botella et al., 1995)

Table 23: SCL-90. Comparison between the values for the mothers in the IFTU-Group initially with two other relevant groups (unpaired t-test).

IFTU-families		Families with an anorectic Ip		Swedish som. group		IFTU v Families with anorectic Ip		IFTU v Som. group	
Mothers (n=78)		Mothers (n=18)		Mothers (n=33)					
M	(Sd)	M	(Sd)	M	(Sd)	t=	p=	t=	p=
85.8	(59.8)	46.6	(22.5)	36.0	(17.3)	4.56	.001	6.72	.001

The group of IFTU mothers in this comparison have very high values on their ratings of their own mental health when compared with another Swedish clinical group (Wallin et al., 1996) and a Swedish normal material consisting of mothers seeking help at a health center for somatic reasons (Albertsson-Karlgren and Nettelbladt, 1995) (high values signify low estimated mental health). An extensive material to establish Swedish norms for SCL-90 has recently been presented as an examination paper at the Department of Applied Psychology, Lund University (Malling Andersen and Johansson, 1998). In this large material (n=546) women averaged a total of 55 points (Sd .46). In a comparative t-test on our group, we found a t-value of 4.37, $p = .001$.

Table 24: FARS. Mothers' in the IFTU-group initial values compared with other relevant groups: mothers to diabetic child at onset and a non-clinical group (unpaired t-test).

	IFTU-group (n=81)		Families with a diabetic child (n=38)		Non-clinical group (n=180)		IFTU v fam with a diabetic child t=	IFTU v fam with a diabetic child p=	IFTU v non-clinical t=	IFTU v non-clinical p=
Attribution	3.54	(1.88)	0.82	(1.27)	0.98	(1.52)	9.71	0.001	6.24	0.001
Interest	5.47	(3.16)	3.47	(3.06)	2.87	(2.71)	3.28	0.001	6.50	0.001
Isolation	4.26	(3.85)	1.66	(2.04)	1.17	(1.76)	4.64	0.001	6.87	0.001
Chaos	4.83	(3.46)	2.78	(2.30)	1.70	(2.16)	3.80	0.001	7.45	0.001
Enmeshment	5.65	(3.07)	3.38	(2.18)	1.83	(1.98)	4.54	0.001	10.32	0.001
Total	35.82	(17.89)	18.63	(13.05)	13.54	(11.20)	5.93	0.001	6.75	0.001

The group of IFTU mothers in this comparison have very high values on their ratings of dysfunctionality in their families.

Table 25: Family Climate. Initial values for mothers in treatment at an IFTU compared to a group of parents to diabetic children at onset and a group of parents to anorectics in treatment (unpaired t-test).

	IFTU-Group	Families with a diabetic child	families with an anorectic child	Non-clinical group			
	Mothers (n=84)	Mothers (n=38)	Mothers (n=20)	(n=378)	1 v 2	1 v 3	1 v 4
	M (Sd)	M (Sd)	M (Sd)	M (Sd)			
Closeness	1.06 (0.93)	3.22 (2.54)	1.92 (0.77)	2.00 (0.63)	t= -5.14 p= 0.001	t= -3.58 p= 0.001	t= -3.92 p= 0.001
Distance	0.84 (0.69)	0.75 (1.23)	0.29 (0.38)	0.30 (0.23)	t= 0.19 p= ns	t= 3.92 p= 0.001	t= 3.86 p= 0.001
Chaos	1.74 (1.33)	1.00 (1.33)	0.78 (1.63)	0.20 (0.21)	t= 5.29 p= 0.001	t= 2.46 p= 0.05	t= 9.06 p= 0.001

The group of IFTU mothers have lower values initially than the other groups on the Closeness scale. The values are about the same as a group of mothers to diabetic children at the onset crisis but higher than a group of mothers to anorectic children. On the Chaos scale the IFTU mothers rate significantly higher values than the other groups.

Table 26: Values initially for 44 families taking part in the independent observer ratings according to CRS-Turbo and Beavers rating scales compared with a Swedish norm group (Thernlund 1996) (unpaired t-test).

Scales	IFTU Group (n=44)		Norm Group (n=56)		t=	p=
CRS-Turbo	M	(Sd)	M	(Sd)		
Adaptability	19.1	(4.8)	14.6	(2.4)	5.70	.001
Cohesion	11.8	(5.0)	14.3	(2.7)	2.98	.01
Hierarchy	2.1	(1.2)	0.8	(1.1)	5.90	.001
Beavers' Observational System Scale						
Competence	25.1	(6.5)	36.3	(7.2)	8.00	.001
Style total	28.8	(4.1)	25.8	(2.6)	4.11	.001

Compared to a non-clinical group (Adaptability 15.0, Cohesion 15.0 and Hierarchy 0) the IFTU group initially shows that a lower degree of structure, lower degree of cohesion, a more indistinct hierarchical function, lower competence and a more centrifugal tendency than the comparison material.

With the help of the information in these eight tables, I conclude that the IFTU group is an extremely overburdened group of clients regarding both individual and family variables. The difference to the comparison groups is especially noticeable when it comes to the prevalence of what we can call behavior problems, aggressiveness and, in a family perspective, a chaotic family function.

Waiting-list group

The mothers in a group of families on the waiting-list for IFTU treatment were investigated with some of the instruments used in the study. They were measured twice with an interval of at least one month. The first measurement took place when treatment was planned and the other shortly before the commencement of treatment. This is an interesting group, as it is selected on the same premises as the group of families measured during the course of treatment. By following this group during the time on the waiting-list, we have a comparable group of families evaluated twice with an interval of one to three months without intervening IFTU treatment.

Table 27: Group of mothers in IFTU families (n=12) rated with some instruments twice before start of treatment (paired t-test).

	Point of measure 1		Point of measure 2			
	M	(Sd)	M	(Sd)	t	p
SCL-90	100	(52)	94	(54)	.79	.45
Family Climate						
Closeness	0.81	(0.71)	0.90	(0.75)	-.48	.64
Distance	0.97	(0.58)	1.16	(0.90)	-.98	.35
Chaos	2.03	(1.3)	1.99	(1.5)	.08	.93
FARS						
Attribution	3.8	(1.6)	4.4	(1.4)	-1.10	.29
Interest	5.5	(4.0)	5.2	(3.5)	.69	.50
Isolation	5.5	(3.8)	5.8	(4.1)	-.53	.61
Chaos	4.5	(3.3)	6.3	(3.4)	-1.92	.08
Enmeshment	7.3	(2.4)	7.7	(3.3)	-.41	.69
Total	41.3	(19.1)	43.3	(20.4)	-.40	.70
CBCL						
Intern.	16.7	(19.9)	19.7	(10.0)	-2.03	.07
Extern.	24.6	(10.2)	23.7	(11.1)	.63	.54
Total	54.4	(21.0)	55.8	(24.0)	-.59	.56

To sum up, I conclude that the values for families on the waiting-list are entirely comparable with the initial values for IFTU treated families (see above tables 19-26) During the waiting time, 1-3 months, the values are either stable or become somewhat worse. There are no significant differences between the two measuring occasions.

An overall consideration of the results on the different instruments

In order to measure the possible clinical significance of the treatment given, the treatment results for each individual family according to the various

instruments must be considered. I have chosen to do this in two ways. I have constructed the first measure of clinical significance by studying three different measures for one and the same family and registered the degree to which obvious changes can be seen on these measures. The other measure of clinical significance calculates how many families go from a clinical to a non-clinical position on the different instruments during the period of time for which they are followed in this study. The first measure of clinical significance was composed of the mothers' ratings of their family function (FARS), their self-ratings of their mental health (SCL-90) and their ratings of the problem child's symptom load (CBCL). I estimated that a reasonable improvement according to each of these instruments would be a change in the expected direction of one standard deviation in a normal material. For FARS this means an 11 point decrease (Cederblad and Höök, 1992, for SCL-90 a 16 point decrease (Malling Andersen and Johansson, 1998) and for CBCL a decrease of 14 points (Botella et al., 1995). I have chosen to use the mothers' results as their ratings were judged to be the most reliable and valid regarding both the family's and the individual family members' situation.

The results for the mothers in all families (86) included in the treatment evaluation were then classified regarding the changes reported on the above instruments. I decided that the families had reached a clinically significant change when the mothers' results changed more than one standard deviation on at least two of the three instruments.

Table 28: Number of families (and in percent) reaching different levels of improvement i.e. clinical significance (FARS, SCL-90, CBCL).

Number of instruments with improvement > 1 Sd	Number of families	%
= 0	18 families	21%
= 1	25 families	29%
0+1	43 families	50%
= 2	28 families	33%
= 3	15 families	17%
2+3	43 families	50%

To the left are the number of instruments where the results between measurements pre-treatment and six months after start of treatment differ more than one Sd.

With the help of these results, we see that exactly half the families included in this study have, through intensive treatment, achieved results which can clearly be said to indicate a change for the better. 80% account for at least some change. There is a certain difference between the units as units 5 and 7 have a rate of change higher than 50%, whereas the other units lie somewhat under 50%.

If only changes in rated family function are studied, the results are those presented in table 29.

Table 29: Percent of families changing > 1 Sd on Family Climate and FARS.

	Family Climate			FARS Total
> 1 Sd pre -six months	Closeness	Distance	Chaos	
% families changing	48%	57%	56%	45%
% families changing > 1 Sd on > one dimension on Family Climate		two 57%	three 29%	
% families changing on > one dimension on Family Climate and FARS total		28%		

An alternative way of weighing the results together is to analyse how family members rate themselves in relation to non-clinical groups before and six months after the commencement of treatment. I have therefore calculated how the mothers in the families have changed their positions on the instruments accounted for below. A critical point between a clinical and a non-clinical position was set at M + 1 Sd according to values for non-clinical groups. Thus, for SCL -90 M= 26, Sd .16 (Malling Andersen & Johansson 1998), for CBCL M= 15, Sd 14 (Botella et al., 1995), for FARS M= 13, Sd 11 (Cederblad & Höök, 1992) and for Family Climate: Closeness 2.0 - .63, Distance .30 + 23 and for Chaos .20 + .21 (Hansson, 1989). The number of mothers numerically and in % staying in a clinical position or non-clinical position or moving from a clinical position to a non-clinical position or vice versa from pre-treatment to six months after start of treatment are presented in table 30.

Table 30: From clinical to non-clinical positions on the tests, SCL-90 and CBCL, FARS and Family Climate during a period of six months from start of IFTU-treatment.

Test	from clinical to clinical position	from non-clinical to non-clinical position	from non-clinical to clinical position	from clinical to non-clinical position
SCL-90	n= 34, 44%	n= 18, 23%	n= 2, 2%	n= 24, 31%
CBCL	n= 38, 49%	n= 15, 19%	n= 0, 0%	n= 25, 32%
FARS	n= 38, 47%	n= 16, 20%	n= 5, 6%	n= 22, 27%
Family Climate				
Closeness	n= 23, 28%	n= 19, 23%	n= 6, 8%	n= 33, 41%
Distance	n= 12, 15%	n= 28, 35%	n= 4, 5%	n= 37, 45%
Chaos	n= 35, 43%	n= 11, 14%	n= 6, 8%	n= 29, 35%

The results indicate that most mothers position their families as clinical but with a normalised family climate, their own mental well-being as lower than normal and the identified patient's symptom-load as higher than normal even after treatment. 1/3 of the families reach a non-clinical position on each instrument (almost half the families on the Closeness and Distance scales in Family Climate). Very few of the families report deterioration in the family situation in connection with treatment.

Table 31: Results from 2 year follow-up from two (CBCL three) of the units (unit 1, unit 6 and unit 7) concerning mothers´rating on CBCL (rating the IP), FARS total and SCL-90 sum (unpaired t-test).

	pre	six months	two years	pre - six months		pre - 2 years		six months - two years	
	M (Sd)	M (Sd)	M (Sd)	t	p	t	p	t	p
CBCL (total) Unit 1 (n = 6) Unit 6 (n = 6) Unit 7 (n = 15)									
Total (n = 27)	58.2 (26.7)	38.8 (23.5)	36.3 (26.4)	3.64	.01	4.66	.001	.73	.47
FARS (total) Unit 6 (n = 12) Unit 7 (n = 10)									
Total (n = 22)	32.6 (18.8)	25.1 (12.9)	26.1 (19.3)	3.32	.004	3.12	.005	-.30	.77
SCL-90 (total) Unit 6 (n = 12) Unit 7 (n = 8)									
Total (n = 20)	79.2 (50.1)	49.4 (45.3)	52.7 (53.0)	3.79	.002	3.74	.01	-1.57	.13

This table shows that the results, at least as far as this small material goes, do not contradict the fact that the improvements noted at the six month follow-up are largely stable after two years.

From evaluation treatment/treatment evaluation to information-seeking work for change.

As previously explained (Sundelin, 1998 a, b) the tasks of an IFTU consist 80% of treatment commissions and 20% of what, in everyday language, are called investigative commissions. To do justice to the work of these units I must also make place for the part of their work which is commonly called family investigations. In this study I describe this work. The results, however will be presented in a separate article.

Because the word investigation does not do justice to the process we have in mind (Rimehaug and Helmersberg, 1995), we prefer to use the term information-seeking work for change. To exemplify, a referral from the social welfare authorities arrives at a child and youth psychiatric clinic seeking an expert opinion about a child who is at risk (usually during a §50 investigation at the department of social welfare in Sweden). The questions in the referral are of such a nature and gravity that carrying out the work on a out-patient basis is judged to be fraught with difficulties. The investigative commission is therefore referred to an IFTU. If the social authorities have their own IFTU the referral is most often sent there (Grandin et al., 1996).

The questions asked in connection with a §50 investigation in Sweden (SFS, 1980) are often: What are the necessary conditions for this particular child to develop optimally in its family and home environment? What is the nature of its relation to and contact with the parents? What resources do the adults possess regarding parenthood in general and this child in particular? How does the child relate to its siblings? Some form of answer is then forwarded from

the child psychiatric staff responsible for the investigation to the social welfare authorities.

Through co-operation between the family members and between the family and the professionals, new information emerges. This often raises questions as to which process one is involved and in what capacity. It is not always easy for the family members or the members in the professional team to keep these different roles and processes separate in their minds from the treatment work (Edwardsson et al., 1994, Rimehaug and Helmersberg, 1995).

Family-oriented, information-seeking work for change commences with a phase where conditions are clarified and the expectations of those involved are formulated. Often the family members concerned are invited to the unit. They are shown around the locality and the staff's different tasks and professional roles are explained. A process of mutual focusing on the task to be carried out is initiated, and the family members are invited to contribute with their reactions to and perspectives on the process and aims of the prospective work together. The context in which this is to be done is made as secure as possible, as it is important that the family and the team can relate to each other during the coming work process (Petitt and Olson, 1992). It is therefore essential that the different internal tasks of the investigative team are defined and separated from each other and that certain persons in the team have the task of mainly representing a generous approach and the creation of basic conditions for contact and trust in what is a difficult life-situation for the family. Trust, in its turn, creates the necessary conditions for the emergence of relevant information regarding the family's life and the time they spend together. Those who are then responsible for compiling and formulating answers can do so with as much detailed information as possible (Grandin et al., 1996).

Information-seeking work for change includes at least three clear components:

1. A component which describes a process with a number of given constants (questions, conditions and prerequisites).
2. An observing/describing and an explanatory/interpreting component.
3. An attentive/caring and co-operating component.

For a team working in this manner, it is necessary to assume a stereo-perspective on the clients, i e to see them both as objects in which to seek information and change and as participating subjects in a co-operative process focusing on this new information and its consequences.

The following points describe the work from an interactionistic or systemic perspective.

1. A commission for information-seeking work for change affecting the area of children and families must naturally be seen as a process. This means that talks and discussions between the referring institutions and those receiving the referral, about its formulation are a necessary introduction to a co-operative process. Do the interested parties understand each other? Is the commission formulated according to the current needs of the referring institution or does the language and form of the referral conceal a standard routine for contact between the institutions? Is a commission for information-seeking work for change communicated or is it in fact an ordinary treatment commission? What are the reasons that this type of work is of current interest? Has the referring institution alternative plans of action (Rimehaug and Helmersberg, 1995)?

2. Information-seeking work for change is organised as a process over a certain period of time. The various roles and tasks of the functionaries participating in the work are established. When a social welfare department

and an "institution of experts", whether it be a unit within child psychiatry or the social services are planning to co-operate, it is important to define and delegate the responsibility for information-gathering and the responsibility for the conclusions to be drawn on the basis of this information. This process includes individual information-seeking activities (e g of a child psychologist and/or milieu therapists and/or child neurologist) on the basis of specific questions in the referral, in order to illuminate the questions from as many angles as possible. It is also of central importance to organise forms for the exchange of information between the various professionals and the clients regarding the emerging mass of facts from different directions, in a context which provides processes, discussion and outlines for the continued investigation, consequences for those involved etc. What is described here is a process of information-seeking with a number of stations for self-correction which can direct the further course of the work by formulating the consequences of different alternative choices available to the participants at different points in the process. To give a drastic example, parents may choose to ignore the knowledge of a child's condition and the experiences gained in the work process or they may choose to terminate their participation in the process. A hopeful perspective can be created in the possibilities for constructive choices within the "system for the information-seeking work for change" (i e all those who in their various roles participate in this work process, including the clients). All participants accept responsibility in a mutually influencing process where those involved in information-seeking during the work process are subjected to a feed-back which affects the next step for each one of them (Edwardsson et al., 1994).

3. It is important to encourage information-seeking regarding resources and potential resources as well as deficits and potential deficient conditions in the situation triggering the present work.

4. Information-seeking work for change should be seen as a commission including the testing and implementation of the suggestions for new measures. Questions which must also be posed are whether the suggested perspectives obstruct constructive strategies or not. If a suggested measure really helps, what are the criteria for deciding whether it has been implemented, if it has had any effect and for how long it should continue etc.? Thus a system for evaluating the suggested and implemented strategies for change is built in, in order to decide together whether or not the suggested help really works and if not what changes need to be made.

5. Finally, information-seeking work for change should be seen as a process containing elements of self-reference, i e the system's working forms should contain possibilities for the participants to study and comment on the process up to the point when a plan of action is ready. In this context, independent consultants can play an important role for the investigating system by listening to how the system has experienced the mutual work process.

Now follows an outline of a conceptual framework for information-seeking work for change. It describes an action research process on two levels:

Level 1:
An important element in a successful process is that the person responsible for the task being carried out has made a decision as to which activities are to be initiated from the starting point of the questions posed, and firmly establish these in the information-seeking system. The person responsible must insist on a clearly formulated commission from the referring institution and, together with collaborators and those who are the object of the commission, decide what information is relevant to seek and how this is to be done. In a contextual/ interactionistic perspective, it can be especially important, besides discussing the various experts' answers to questions demanding their specific

professional competencies, to give priority to the mutual collecting of information regarding descriptions of the context (family and network) to which a child belongs. New shared pictures can help to create a better understanding of the effects of context and interaction on a child's problem. This is done in order to create a changed perspective as a basis for dissolving or ameliorating what seems an impassable or serious situation. Thus information-seeking work strives to create conditions where those involved in a new "change stimulating" experience of their problem can begin to hope that a positive development will emerge from a difficult and unacceptable situation and to work towards this. This is facilitated by working together to develop a new understanding of the situation and by developing new techniques which are felt to be usable in a constructive process of change.

Level 2:
Unless the entire process is to be regarded solely as a desk product and result in an unrealistic and consequently unuseable suggestion, the search for knowledge must be pursued in dialogue with those involved, with the aim of answering the question about what help is possible and "what help helps". From this point of view it is important that the process of gathering knowledge described here, should be judged as qualitatively good or bad depending on its constructive consequences.

Thus, the person in charge of the information-seeking work for change must organise the process together with those involved, not just so that the situation "under the magnifying-glass" is as completely and relevantly described as possible by all the professionals, but also so that those involved have a forum for a continual exchange of information and processing of the knowledge gained on every step of the way. This serves partly to give everyone the possibility to develop alternative ideas on the direction and focus for continued information-seeking and partly to bring those involved in the current process

up to date. Continuous feedback gives an opportunity for dialogue about "findings" and information about "contra-findings" which generates further talks and the mutual establishment of possible ways to continue the work. The relationship between the diagnostic language of the experts and the problem formulations of those involved in and concerned about these "diagnostic" findings is worked through and rendered comprehensible for all.

If the work is to be successful, functions as information-seekers and objects of the information search as well as functions which can perhaps be described as mediators and moderators are needed. Their contribution is that of containing, repeating and handling the current discussion within the framework of the information-seeking process.

Given this way of thinking, the role of the expert in the field is widened to include the roles of moderator, co-ordinator and process-maker. This extended role carries with it a responsibility for the overall production of information and expert knowledge concerning the care of those who are the object of the information-seeking or those who are affected by it.

The organisation and profiles of the different IFTUs and how this affects their results.

Summary

The contents of the following chapter aim at investigating whether the systemic description model presented in this dissertation and the results of the effect measurements, converge and, if so, in what way. That is to say, is it possible from this analysis to say how the IFTUs can best be organised in order to achieve the best results? The units are also categorised on the basis of the differences in their treatment profiles. Their treatment effectiveness is compared by a simple ranking system of the ratings of the mothers in respective unit (and the category of the units) on measurement 1 - measurement 2.

The results indicate that the best treatment results coincide with a clear group structure, a high therapeutic structure and a problem and behavior oriented focus in the treatment work. The work form of the group must have a clear process and the group climate must be warm. Resource rich units with a more independent treatment responsibility achieve better results than units with fewer resources. Good results seem to be negatively associated with a split and conflict-avoidant group. The consequences of future treatment programs for the group of IFTU families are outlined.

Theoretical model

The theoretical model which I put forward contains a number of areas describing hypothetically important factors for understanding how an IFTU functions (Sundelin 1998, a). The model uses a number of concepts which are defined according to the following:

Context

The concept of "context" contains an understanding of how the respective units are organised formally in a larger organisational structure (a clinic and a hospital etc.) and internally (leadership and responsibility) and in which degree the IFTU and the larger therapeutic context have reached a mutually confirmed understanding about therapeutic co-operation.

Commissions

How are routines for referrals, commissions, and co-operative methods and goals developed, agreed upon and executed?

Resources

By "Resources" I mean the number and categories of personnel in relation to expectations concerning commissions. I also mean the collective formal and informal knowledge, "the treatment culture" related to therapeutic tasks, experience and training at a unit as well as the group climate, well-being and desire for development in the staff group.

Effects

By treatment effects, I mean the effect criteria represented by the collective results of the different tests.

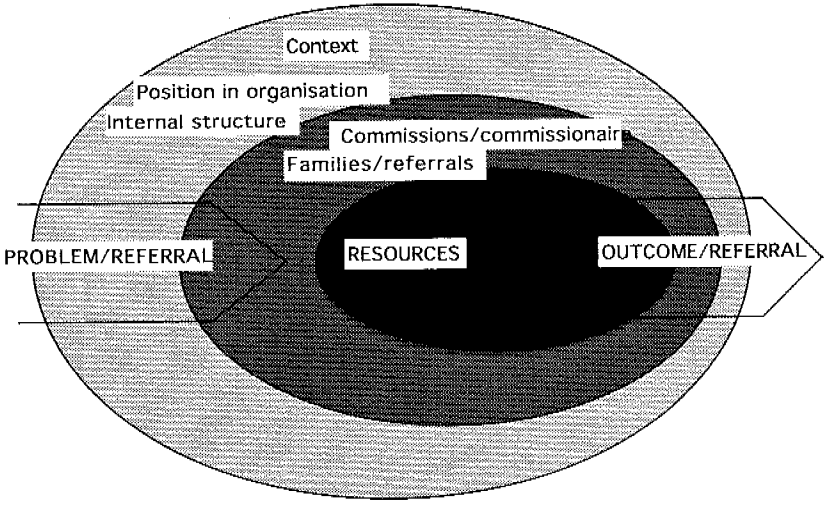

Figure 11. Graphic picture of the theoretical model presented for describing IFTUs.

Since this model was developed, Fridell (1996) has published a thorough overview of the organisation, ideology and results of different forms of institutional care, mainly focused on substance abuse.

Fridell describes outer and inner factors in the framework. In my model these are represented in the outer ring (context, position in organisation, internal structure). To the outer frame factors belong laws and regulations, consumers such as the County Health Services, attitudes of the general public and especially those of other institutions who frequently refer patients.

Among the inner factors, Fridell reckons various kinds of resources e g economic resources and those concerning staff competence, selection of

patients, goals and the way care is organised. These are held together and stabilised with the help of a treatment ideology or philosophy which creates a normative system for the work as a whole. The constellation of the staff group and, on the basis of the treatment ideology, the expressed criteria for competence become especially important factors within the inner framework.

Other factors are selection of the patient group and possibilities for co-operation between the unit and the referring institution about the set goals. Other inner factors are how the institution is organised regarding leadership function, how "credible" the interaction between the organisation and the treatment ideology is, different important ideological choices in the concrete treatment work, the job satisfaction and well-being of the staff. In my model, these factors are grouped under the concept commission/commissioners, families/referrals and resources.

Fridell summarises that the effect, in practice, on the patient is a question of the system's collective possibilities for influence. This is a main argument in his conceptual structure and would also appear to be extremely relevant in our context. The contextual model developed in this dissertation also stresses that the interaction between content and organisation, thought and action, ambitions and practical reality etc. must harmonise. It is the total effect of what the treatment system can achieve together with client families that counts. In this respect, organisational factors such as co-operation, leadership, teamwork, decision-making processes, participation, co-operation etc., are extremely important when it comes to practically channelling therapeutic competence.

Fridell takes up two important and critical aspects of leadership in a publically administrated treatment institution, namely the problem of parallel decision-making hierarchies and the question of the leader's degree of legitimisation. It is not unusual that staff in the nursing and caring professions have difficulty in

seeing clearly the boundaries of their superior's authority. Who, decides what, where and how? The doctor, the unit supervisor or the administrator? Legitimisation concerns the group's acceptance of its supervisor as a leader.

When Fridell reviews existing research in the areas of social-psychological environment and organisational conditions, he discusses three critical factors, namely leadership, job satisfaction/well-being and climate/culture. He considers leadership to be of prime importance.

Leadership

Fridell accounts for an interesting model for functional leadership constructed by Hersey Blanchards, which, on the basis of systemic theory, describes good leadership as an adaptation to and function of the interaction between the leader and the group, the nature of the task and the maturity/competence of the group. The leader can then develop his leadership from the position of "telling" via "selling" to "participating" and finally "delegating". Fridell emphasises the importance of a good leader who is present in person or a leader on an intermediate level within every organisation. Besides such leadership qualities as the ability to structure and reflect and to be able to adapt leadership style according to the model described above, a leader on an intermediate level must also win the respect of the group regarding legitimacy and be able to create a space for the group upwards in the organisation. He/she must also be able to limit his/her work downwards in order to create a space for co-workers.

Well-being

Factors of well-being have been extensively studied, according to Fridell. There is a large degree of concordance in this area. He describes a modern

model, constructed by Einar Thorsrud, illustrating the most important factors for well-being. Contact and affiliation with others, a work content which makes the most of each person's resources, meaningful and complete tasks and the possibility to see the meaning of these for other people, reactions on the outcome of the work done, being able to learn in the course of work and being able to see opportunities for personal development are all essential factors.

Climate/culture

Fridell also takes up questions of climate and culture. He discusses the in-depth differences between the two concepts, where "culture" stands for basic assumptions and values and is more difficult to capture. He compares the concept of culture with that of ideology which is the holding framework, for better or for worse, as it creates stability, but also provides a basis for myth formation and common projections which obstruct development and change. Research on work climate is more empirical and easily captured. He names as indicators of bad climate short-term absenteeism, a high rate of staff change, arriving late at work and accounts for empirical relations between a good climate, decentralisation, size of the organisation and leadership style.

A relatively newly published investigation regarding leadership, organisation and job satisfaction within home nursing is relevant in this connection. The authors find that formalised decision-making paths which are well known to those concerned, such as regular meetings where the members of the group participate in decision-making, increases the efficiency of the work group whereas few, irregular meetings and lack of clarity with parallel hierarchies etc., renders the work of the group more difficult (Olsson et al., 1995).

Contrary to Fridell, who takes the organisation as a starting point when describing the complicated interplay leading to effective care, Olsson (1998)

approaches the subject from the point of view of the group. In his book he dwells on "searching for the soul of the group" and touches on the important aspects of the life of a group in general and the working group in particular. He mentions the importance of leadership for group climate. He points to the ability of a democratic leader to organise the work of the group by means of a clear work process leading to a decision which concerns every one and creates a "we" feeling not unlike that which Ekvall (1988) describes as the humanocratic organisation. Olsson takes up the difficult concept of "cohesion" and its role as an identity marker for the group or its "immune defence". With this he has arrived at the difficult balancing act which every group recognises, balancing processes which demarcate the group, isolate it and give it identity and strength and keeping the group open for conflict resolution both within the group and in relation to the outside world. The soul of the group, the subtle strength that is difficult to create and easy to demolish, emanates from the individual's identification with the group. But, in this connection, he also refers to the concept of "groupthink" which is a sign of an isolated group with negative processes of narcissistic culture and unconscious mutual projections onto the outside world. Thus, he develops ideas as to the importance of the form of the organisation for group climate which were originally reported in the above mentioned study (Olsson et al., 1995) by stating that: "We found a clear association between group climate and organisation form. The cohesive groups had a delineated task, a clear group affiliation, possibilities of daily contact with the work supervisor and above all regular meetings where the group could make decisions regarding their work situation. The split groups had little control over their work tasks, an unclear group task with indistinct boundaries towards other groups, irregular meetings or meetings that only served to give information from above and downwards" (Olsson 1998, p 107-108).

Profile measures

The instruments developed to measure unit profiles in accordance with my model are described in detail elsewhere (Sundelin 1998,b). The results of the units on these measures resulted in a cluster analysis which differentiated the units on two factors, "Structure" and "job-satisfaction". Both of these are named "profile measures".

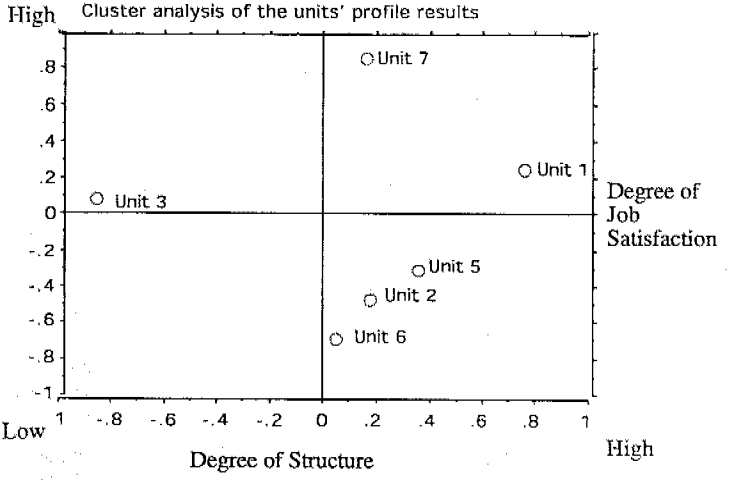

Figure 12. Cluster analysis for Style- and Climate factors over units. The two cluster factors were named "Structure" and "Degree of Job satisfaction".

Two of the units report a high degree of job satisfaction at their place of work and high degree of structure (a clear-cut work process) (Units 1 and 7). A group of units report somewhat lower values on the two variables structure (clarity/distinctness) and job satisfaction (Units 2, 6 and 5) while one unit describes a working profile characterised by loosely structured forms of work (unit 3).

Method: Profile measures - Effect measures.

The results from the description of similarities and dissimilarities regarding organisation, context and work tasks, ideology and resources at the different IFTUs are now related to the results of the measurements carried out on families who underwent treatment at these units.

This is done by :

1a. Comparing the results of each unit regarding effect before treatment and six months after the start of treatment (mothers' m 1 - m 2).

1b. Besides a comparison between units, the units are grouped according to the differences in their treatment profiles. These categories are constructed on the basis of hypotheses generated by the descriptive model and literature references.

2. The units and categories of units are compared regarding the measures (mothers' m 1 - m 2) on each effect scale used in the study and then ranked.

3. The total results of the category/effect comparison are ranked once more. Finally the results are related to the descriptive model and a discussion follows as to whether the model is a valid instrument for describing this treatment form and its development.

Unit 3 was excluded from the effect measurement study because of too large a drop-out. However, the results are included when the work form and organisation are weighed against the results. Unit 4 was excluded entirely from this comparative study because their work with families is carried out in a

different context (social services) and is often in the nature of information-seeking work for change.

Results

When the units' descriptions of themselves on the group climate test are ranked from the starting-point of a profile characterising a well-functioning group (Hansson and Olsson, 1991) i e a group with a high degree of solidarity, low split, low conflict avoidance, high structure and low negativism, the following ranking is found: (Negativism is not included as the units do not differ on this scale).

Table 32: Ranking among units on Group Climate test according to an instrumental and goal oriented group.

	Solidarity	Split	Confl. Av	Structure	Total	Total rank
Unit 1	1	1	1	2	5	**1**
Unit 2	2	2	6	5	15	**4**
Unit 3	4	6	4	6	20	**6**
Unit 5	3	4	5	3	15	**4**
Unit 6	3	5	2	4	14	**4**
Unit 7	4	2	3	1	10	**2**

This ranking is based on statistically determined differences (factorial anova), which means that some units have the same rank. It can be established that units 1 and 7 describe their group climate as that of a well-functioning work group according to the theory behind the group climate test (Hansson and Olsson, 1991). Unit 3, at this point in time, describes the most negative group climate.

Calculations of the differences between measurement 1 (pre-treatment) and measurement 2 (six months after the start of treatment) have been made on each scale for the group of mothers at each unit and are presented in the following table. The values represent the average for the group of mothers at each IFTU. The results are then ranked on the basis of differences in the size of the degree of change.

Besides comparing the values of change for each unit, the units have been grouped in categories according to differences in profile and work method which hypothetically affects the effectiveness of an IFTU. The tables are to be regarded as a variation on the same information and not as new information. The ranking on each of the subscales is only given in table 33.

Table 33: Ranking of mothers m 1-m 2 at respective units.

Unit	1	2	3	5	6	7
Family Climate						
Closeness	1	4	5	2	3	6
Distance	5	3	4	1	2	6
Chaos	1	5	6	1	3	4
FARS						
Attribution	1	6	4	3	5	2
Interest	3	6	4	1	5	2
Isolation	1	5	6	3	4	2
Chaos	1	4	4	4	3	2
Enmeshment	1	6	6	3	4	2
Fars Total	1	6	5	3	4	2
Rank. points	15	45	44	21	33	28
Ranking fam	1	5	5	2	4	3
SCL-90	1	4	6	5	3	2
SOC	1	4	6	5	3	2
CBCL						
Boys Intern.	1	4	6	2	3	4
Boys Extern.	1	5	6	4	3	2
Girls Intern.	2	3	4	6	1	4
GirlsExtern.	1	3	5	6	4	2
Boys Total	2	3	4	6	1	4
Girls Total	1	2	5	6	3	4
Rank. points	10	28	42	40	21	24
Rank. ind.	1	4	6	5	2	3
Ranking points	25	73	86	61	54	52
Total ranking	**1**	**5**	**6**	**4**	**3**	**2**

These results clearly indicate that the units achieve varying degrees of effectiveness according to the measures. This is reflected in the averages of the mothers' self-ratings on the different scales for the different units. The tendency between units is mainly the same in the family measures as well as individual measures.

Context/Commission

Information regarding the units' organisational structure, formal context and allocated resources in the form of jobs, competence etc. and their relation to their commissioners are found in the questionnaire Referral Attitude (RA) and Form Background (FB) (Sundelin, 1998 b).

Differences in independent status are noted regarding treatment responsibility. There are also differences in the inner organisation of the various units. The units were grouped into three categories according to their total position on 1. Intensity of care (day treatment/ 24 hour treatment), 2. Number of staff, 3. Staff's level of training. The units were also categorised on a intensity dimension into: high intensity, moderate intensity and low intensity, according to the number of staff into: large group, medium-sized group and small group. Regarding the staff's level of further training the units were categorised into: High level of further training, moderate level of further training and low level of further training. The rank position of each unit on these three dimensions was summed up to a meta-rank on a meta-dimension which I have called organisational resources. Three categories of units are clustered high: unit 1 and unit 7, intermediate: unit 5 and unit 6, low organisational resources: unit 2 and unit 3).These categories are then compared in a simple ranking regarding the effect measures. The results are presented in table 34.

Table 34: "Organisational resources" versus m 1 -m 2 for each category of units. Three categories composed of total rank of 1. Intensity of care (day-treatment/ 24 hour treatment), 2. Number of staff, 3. Staffs level of training.

Unit	1,7	5,6	2,3
Category	high	inter-mediate	low
Family Climate **FARS** **SCL-90** **SOC** **CBCL**	ranking according to scales table 31.		
Sum Ranking points	22	30	49
Tot. ranking	**1**	**2**	**3**

The IFTUs' resources concerning treatment intensity, size and number of staff and the staff's level of training covaries with the size of the changes in the families as reported by the mothers.

Table 35: The units divided into three categories concerning "degree of independence" 1.Degree of organisational independence, 2. Length of average treatment-period, 3. Clearness in structure for commission/n versus m 1 - m 2 for each category of units.

Unit	1, 7	5, 6	2, 3
Category	high degree of independence	inter-mediate	low
Sum Ranking points	22	30	49
Tot. ranking	**1**	**2**	**3**

A categorisation of the units according to their independence, operationalised by a meta-ranking regarding 1. Degree of organisational independence, 2. Length of average treatment period, 3. Clearness in structure of commission yields the same grouping of units in all three categories. There are clear indications that independence and control of treatment planning covary with better treatment results as measured in this study.

Commissions

The units mainly receive commissions from out-patient clinics belonging to the same organisation, but some of the units also receive direct referrals from social services, paediatric clinics etc. The referring institutions mostly show great respect for the work carried out at IFTUs. Criticism can briefly be said to be concentrated on inflexibility in the treatment structure and difficulty with continuity in treatment planning after discharge from an IFTU.

Different attitudes from the referring parties are found concerning the way the local IFTU meets their expectations. Units 2 and 3 seem to meet the referring parties better than units 1,5, 6 and 7 (according to the results from Referral Attitude Scale, RA).

Table 36: Degree of referee's acceptance of the respective category versus m 1-m 2 for each category of units.

Unit	2, 3	1, 5, 6, 7
Category	high	low
Sum Ranking points	33	18
Tot. ranking	**2**	**1**

A better relation to the referring institutions does not appear to covary with good results for change.

Resources (Treatment Ideology)

Regarding treatment ideology, differences between the units can be seen in a cluster analysis (Figure 12). If we place these results side by side with those in table 33, we see a clear correspondence between the units' rankings m 1-m 2 and on the structure and job-satisfaction scales.

Resources (Group Climate)

Differences were found regarding group climate in the different teams. Three categories were created on the basis of the index value for the scales Solidarity and Structure in the Group Climate test (Index Solidarity/Structure = Total of M for Solidarity + Total of M for Structure/n) Table 37. Similarly, three categories were created for the index Splitting/Conflict Avoidance.(Index Split/Conflict Avoidance = Total of M Split + Total of M Conflict Avoidance) Table 38.

Table 37: The units divided into three categories ranking sum factor-index for Solidarity/Structure (Group climate) and ranked according to m 1 -m 2 for each category of units.

Unit	1	2, 5, 6, 7	3
Category	high	inter-mediate	low
S Ranking points	18	33	49
Tot. ranking	**1**	**2**	**3**

Table 38: The units divided into three categories ranking sum factor-index for Splitting/Conflict avoidance (Group climate) and ranked according to m 1 -m 2 for each category of units.

Unit	1, 7	2, 5, 6	3
Category	low	inter-mediate	high
S Ranking points	21	32	49
Tot. ranking	**1**	**2**	**3**

The results in tables 37 and 38 indicate that the categories including units with a high degree of structure and solidarity and a low degree of split and conflict avoidance, achieve a greater degree of change in the families, according to mothers' ratings m1 - m2 for each category of units.

Discussion

The results presented in this chapter must be regarded as rough outlines and tendencies. No consideration has been taken to initial differences or to the units' context specific aims and target groups. The effect differences are solely based on averages without regard for the within group variation regarding change. Differences are measured by a simple ranking procedure based on significant differences between these categories. The measure m 1 - m 2 on all scales is used without consideration to the dependency between the subscales and the total on a test. However, taking these weaknesses into account, the outcome may be tentatively discussed.

On many of the measurements regarding job satisfaction and ideology, there were similarities between the units in the way they rated their places of work. The level of knowledge and specialisation within the area of family therapy is,

relatively speaking, high at all units. Therefore, all units can be considered as having good basic competence in family therapeutically oriented broad spectrum work such as previously described. However, this knowledge must be put into practice and it is here that Fridell's (1996, p 60) description of effectiveness as the "collective effect of content and organisation" again becomes an important starting point. This central line of thought will therefore form the basis for a continued analysis of similarities and dissimilarities between the units.

Interaction between the referring institutions and units for intensive family treatment has often been described in conflict-ridden terms. This fact is also confirmed by our results. The situation can be described as an "encounter between treatment traditions". An IFTU is incorporated in a caring context and, apart from direct commissions from the families themselves, almost always has to relate to other care-giving institutions in co-ordinated therapeutic efforts. How does a unit with special knowledge about what is needed in a treatment program for the group of families treated at an IFTU meet the referring out-patient clinic's legitimate demands for close co-operation and at the same fulfil the special care needs of this group of clients? In our study, we can see a clear tendency that units with the clearest structure and decision-making process and a more problem and behavior oriented treatment perspective have the best results with the client families, but the worst relations to the out-patient clinics. The criticism directed at these IFTUs often concerns views on the treatment form as being altogether too rigid or inflexible, that there are difficulties with continuity of treatment and difficulties in helping to refer families back to the out-patient clinic after they have been at an IFTU. This situation is definitely a challenge without a simple solution as out-patient clinics' need of flexible specialist resources are quite legitimate. At the present time we can wonder whether the usual child psychiatric out-patient care has the necessary respect for the alternative

competence which every IFTU has developed regarding the treatment of the majority of the families who come to them, i e families mainly with severe acting-out problems together with underorganisation in the family and social problems. One may also wonder if the form for post-IFTU care and treatment at an out-patient clinic should be formed more in accordance with IFTU treatment methods than with standard child psychiatric out-patient methods. Clinical experience at IFTUs, which is in line with treatment research in the area regarding the client group's treatment needs, contains a number of critical factors such as concentration on creating trust (Colapinto, 1995), care and attachment (Sundelin 1998 a), clear, concrete agreements (Petitt and Olsson, 1992) practical work with opportunities for training in different ways and on different levels (psychological, social and socio-economic)(Alexander and Pugh, 1996, Alexander et al., 1996, Forgatch and Patterson, 1997, Goldstein, 1987, Kazdin, 1996, Pinsof, 1995, Pinsof and Wynne, 1995) in combination with intensive talks over a not too short a period of time followed by a longer follow-up period in which the therapeutic work is consolidated in a more extensive form (Henggeler et al., 1995).

There is, in all probability, a limit for how small an IFTU can be. A larger unit is more stable over time and is able to attract and keep higher competence than a smaller unit. Regarding processes of co-operation within each unit and between the unit and the surrounding organisational structure, they must be clearly and firmly established among all involved parties. This study lends support to previously mentioned research-based opinions on this point (Olsson et al., 1995). The unit must in all probability be large enough to differentiate itself from the environment and to found its own "culture" or "ideology". However, contact with the environment must be maintained in order to allow an inflow of cultural and ideological impulses to such a degree that development is stimulated. In all probability, work groups in the process of their lives go through phases when they need to retire and consolidate

themselves as well as phases when they need to be open for impulses from without. It is always important to avoid the extremes of rigid self-satisfaction and lack of identity.

The work group's climate of high solidarity, clear structure and good cohesion (like good parents) covaries with a good result. This climate is, above all, created with the help of a good leader and a clear structure/ process for well-established decisions in the group. These decisions support a functional structure of delegation to the members of the team which stimulates the development of competence and increases trust between co-workers with different roles in an IFTU. The leader and the group experience mutual legitimacy (Fridell, 1996, Olsson, 1998). It is interesting that an ideological striving towards a clear structure, as measured in this study, seems to be present in the more effective units. This has nothing to do with strict authoritarian discipline but rather with a deepened democratic decision-making process which is made clear and distinct through functional leadership (Olsson, 1998). Roles and responsibility are firmly anchored with those involved in an accepted clear and distinct work process. To maintain this structure and stability requires a stable and well-adjusted leadership with competence to steer from a clear and well-defined position. The leader's ability to create a working-day where more things are possible than impossible is extremely important.

This requires strength to "protect the group" upwards in the organisation. At the same time, the leader must see to it that team members feel that they are participating in and can personally identify with the unit's collective tasks, which gives them a feeling of involvement and job satisfaction. Different competencies for therapeutic sessions, milieu therapeutic work and networking must be available at the units. The task of the work leader is to fulfill this function as it is important that the staff and professional resources in the local

teams co-ordinate their efforts in a well-oiled integrated form. This is probably facilitated by a common organisational affiliation for those working together at such a unit and argues against co-opted co-workers (as consults or psychotherapists) who are only loosely affiliated to the unit in their expert capacity.

The group climate in the team is obviously of the greatest importance for translating the unit's resources into effective treatment. The Group Climate test's theoretical basis for well-functioning relations in a work group is valid even in this respect. The group climate must be characterised by a clear structure interacting with high solidarity and the courage to contain differences. The individual team member's feelings of satisfaction with his/her work also covary with a structure and leadership which contributes to creating a credible treatment ideology. The ideology must be credible in relation to the resources placed at the disposal of those carrying out the work. It must also be useful as a "practical theory" and a creative instrument so that the team together with the family members can create a comprehensible therapeutic context for change.

The development of the treatment form must be carried out with the knowledge of the families' care needs. There must be an essential, stabilising care-giving and caring structure, even when the treatment is partly given on an out-patient basis. The force-field in family-oriented work for change should not be underestimated. The covariation which takes place in relation to a treatment group makes the process even more powerful. The IFTU formula is largely a clinical consequence of this knowledge. If the concept "different efforts in simultaneous co-operation" is to work, it requires an "organisational costume" which comes up to scratch. If this stabilising factor functions, the sum of the measures will be more powerful than each one on its own. What the team can achieve as a group can never be achieved by the individual members

on their own. This argument can be compared with team games and team spirit in the world of sport. A team playing with a team spirit and adjusted technique can often play "better than it can". If the individual members of an IFTU were to be placed two by two in an out-patient clinic the "turbo-effect" would in all probability vanish. The "organisational costume" provided by the unit must be replaced by independent professional competence of another nature if an outer structure is to be replaced by an permanent inner one. All this leaves no garantees that the team's collective "soft therapeutic warmth" in the form needed by IFTU families will ever be able to be retained in an out-patient setting. Increased basic competence probably creates a possibility to provide IFTU methods in an out-patient context when the team around a family can be kept together as before working in the home and local environment and with a clinic as a base. However, co-workers in out-patient clinics also need further training in team leadership and a good measure of enthusiasm for working with these families according to this team-based method. In all probability many of the IFTU families treatment needs could be met in a more relevant manner than today if the IFTU method was more frequently used as a working method in out-patient clinics. However, this would entail a review of how resources are used and dispersed and even require a discussion of what competencies should be available in child psychiatric out-patient clinics, which client groups are to be given priority and which treatment method should be given priority when working with these clients. This is an entirely new discussion!

Discussion

It is now time for a final discussion to summarise the experiences of what are, to my knowledge, the largest family therapy oriented studies hitherto published in Scandinavia. This project has been going on since 1986. There is therefore reason to reflect over this work from many angles and I shall do under a number of headings.

Criteria for therapeutic change

The question of how family therapy research should be pursued has been much discussed in the course of this project. On the one hand, family therapy is about a very special human encounter which becomes meaningful and enriching through personal presence, intuition and compassion etc. On the other hand, like Armelius (1985), I want to apply a scientific perspective to this field of knowledge. With this perspective, a number of questions arise: How does one find a balance between essentialness and precision? How does one define an important therapeutic change? Should it be defined by the person who has undergone treatment or be controlled by an outsider? Should criteria for change be open or should the standards and criteria for change among which the client can choose be specified. Should there be several criteria for change and if so how should they be weighted? In our project, we have chosen to use criteria for change in the form of different instruments in order to fulfil the requirements for scientific precision and, at the same time, create the possibility for several aspects of change to appear (Lambert and Hill, 1996). However, I am aware that there are several criteria for change which have not been captured by this study. I also understand that the family members have had goals with the treatment that the plan of the study has not given them the

opportunity to report to what degree these aims have been achieved. I have, however, chosen to use group data in order to work with a generalised measure of the effectiveness of the treatment method, aware of the relativity of the significance in the measurements. In the future, a test battery could be supplemented by criteria for treatment success in line with those described by Sells, Smith and Sprenkle (1995), Lambert and Hill (1996) and Alexander et al. (1996), namely to measure the outcome even in relation to the therapeutic goal formulated together by the client and the therapist.

On a number of pages in this dissertation lists of questions are found centering on research in this area. Because of the present state of clinical treatment research, it is imperative that these questions are clearly formulated and discussed. It will be obvious to whoever reads this book that it is one matter to formulate desirable research criteria in theory and quite another matter to arrange and implement the required conditions in practice. The Latin saying "per aspera ad astra" (aim at the stars in order to reach the treetops) seems to be in place here. The following review of various therapeutic schools and their views on treatment, especially of acting-out problems, and the presentation of an integrated treatment perspective will also be an important basis for continued discussions on matters concerning the choice of relevant process quality variables and relevant criteria for measuring the effects and results of family therapy oriented treatment.

The tasks of an IFTU consist to 80% of treatment commissions and 20% of what are commonly termed investigative commissions. The latter are process-oriented efforts to explore and develop alternative ways of functioning for and with a family, often in co-operation with social authorities. To do IFTUs and their work justice, a description of tasks usually called family investigations must also be included. This work, with its different basic premises, is called information-seeking work for change. The evaluation and development of this

type of work presents further challenges in the future (Edwardsson et al., 1994, Starrin and Svensson, 1994, Sells, Smith, Sprenkle,1995)

Therapeutic processes and therapeutic goals

How should the link between the therapeutic process and outcome measures be formulated? At the present stage in our study, the link is made by comparing the organisational and content differences which have been found in the group of IFTU units and the units' results regarding treatment effects. This is a rough measure, but it can, with all certainty, be refined by means of a closer link between the therapeutic process in a family and the family's result regarding treatment outcome. An interesting future project would be to develop more precise methods to measure the link between the interactive processes which serve to mark family therapy, the path leading up to the therapeutic contract or therapeutic theme, the carrying out of this work as it is reflected in interactive processes in the therapeutic system and the outcome of treatment measured by different criteria. An interesting continuation would then be to develop a frame program for treatment planning directed at different problem areas on the basis of this research-based developmental work (Kazdin, 1996, Alexander et al., 1996).

Statistical and clinical significance and the collective judgement of treatment effects

In summary, I can establish that the results clearly show that the family members (above all according to the mothers' ratings) have changed in the expected direction during the period from the first pre-treatment measurement and the measurement six months after the start of treatment. What is the value of such a statistical significance? What do a number of measured differences

before and after treatment signify for a group of families? Is this measure a difference which implies a clinical difference for the individual family? I have tried to supplement the presentation of results with a measure of clinical significance, namely a difference which is truly a difference for the individual family (tables 28-30). With the help of these results, I can establish that about half of the families included in this study can be said, through intensive family treatment, to have achieved a result clearly signifying a change for the better. Two thirds of the families report at least some change for the better. A third of the families report a change from a clinical position to a position comparable with the results of non-clinical families on each test. Tables 28-30 also give me grounds for stating that the families who often reported clear improvements during the treatment period are the group of IFTU families with a heavy problem load. A certain internal drop-out has, in all certainty, decreased the results which still obviously agree with the previously presented conclusions regarding the treatment effects of intensive family work in the multicenter pilot study (Hansson et al., 1992). I have chosen to emphasise the mothers' ratings because their participation in the investigation is the most stable and probably yields the most reliable results. However, it must naturally be pointed out that theirs is only one voice in the family and that the mothers' statements are thus a party statement.

In all these results must be regarded as promising as these families, often called multiproblem families, with a large burden of problems often have a long history of failed treatment at other care institutions when they come to an IFTU.

Changes achieved at the six-month follow-up remain in the small material which has hitherto been gathered from the two-year follow-up (table 31). This group reports data from three of the units. Naturally, after two years, the drop-out is even larger. It may also be assumed that there is a bias towards

families that function better after two years. However, the results in this group before treatment, after six months and after two years, signal that they do not deviate noticeably from the main group. I therefore maintain that the results indicate that the change achieved after six months seems to remain after two years.

Control group

Finding a control group with which to compare the results of an investigation is no easy task in the clinical world. Discussions are needed on how to ethically defend a randomised study with a treated and non-treated group as far as this particular group of clients are concerned. All these families have a long and often unsuccessful treatment experience behind them and there is also often a time factor that demands a quick solution so that the social services do not have to take protective measures for the children in these families by separating them from their parents.

The possibility of using a waiting-list group consisting of the same families who eventually entered treatment was one alternative, but was hindered by the fact the length of time on the waiting-list would be difficult to predict because the clinical assessment that the family naturally should be offered intensive help as soon as possible must take precedence over the design of the research project. A further possibility was debated and then abandoned. This was to choose families judged by out-patient clinics to be suitable for IFTU treatment, but who refused for one reason or another. Motivational factors, among other things, would have made comparisons of treatment results difficult to interpret. We therefore chose to construct a waiting-list group of other families waiting for treatment at an IFTU and to compare other groups of clinical and non-clinical families, clearly aware of the weaknesses in this arrangement.

The results presented leave unanswered questions as to the active agents behind the change or as to what change could have been achieved by standard treatment. In this study, I have chosen to argue that the different IFTU's act as each other's controls, as largely the same method has been used by different staff groups together with different families in different parts of the country. I have supplemented this with a small comparison group from the waiting-lists of three of the IFTUs included in the study. This enables us to compare the treated families with similar families waiting for treatment. The comparison group is measured on two occasions with a one month interval, with some of the instruments used in the investigated group. This is a relevant comparison group without being a control group in the strict sense of the word. I have also compared the results of our families with other non-clinical and clinical groups of families. This was done to form a reference for our families with a heavy symptom-load and the changes they underwent during the treatment period.

Representativity

The representativity regarding units and families can naturally be questioned. Neither of these is a random choice. The units are mainly from southern Sweden. Still, I assume that they are largely representative of the IFTU model practised in Sweden. All families coming to the units were invited to participate in the study. It can therefore be said to have reached a very large proportion of the families who have undergone IFTU treatment in Sweden during this period of time. Referring to " tested experience", I mention my extensive experience as a teacher and supervisor within the field of family therapy in general and intensive family therapy in particular. With this experience as a background, I can also safely say that the families who have recieved treatment during this period are representative according to my clinical judgement.

Drop-out

The study is forced to account for a large drop-out and thus confirms one of Kazdin's discussions on the dilemma of clinical research (1994). It is interesting to note that this is not a drop-out from treatment, but a drop-out from participating in the measuring procedures. Clinical research in general and especially research with complicated family situations is not always easy to align with scientific precision. However, I have been able to show that the families who decided not to participate in the continued measuring procedures do not differ to any great extent regarding initial values from those who fulfilled their participation (table 9). Chance has, in all probability, played a part in the drop-out, even if this explanation is not very satisfactory. Evaluation routines ought to be a much more natural and integrated part of family therapy work in the future.

Measuring procedures

How can the measuring procedures have influenced the results? The establishment of the project at the various IFTUs differed somewhat. At one unit the drop-out was so large (unit 3) that the unit's results had to be excluded from the total effect study. The other places of work developed a way of presenting the project as an integrated part of treatment. This implies that they found meaningful ways to co-operate in the evaluation project and that the completion of all the questionnaires was taken as a matter of course.
In all probability the attitudes towards the research project at the different units covaried with how each unit related to its own variant of intensive family therapy.

Can completing the same questionnaire on several different occasions explain change? One might suspect this. However the results of the waiting-list group indicate that this was not so. Ideally, measuring changes in a family should entail listening to the voices of all family members. In this study it is above all the parents, especially the mothers voices, that have been heard. This must be seen as a flaw in the study. The instrument intended to give the children a chance to express themselves did not capture any changes. A closely related question is whether the filling in of the questionnaires suited mothers, fathers and children equally well. One may wonder how gender-based attitudes to one's own life situation and to completing questionnaires also influences the way in which mothers and fathers respectively describe themselves in these questionnaires. We do not know to what degree mothers and fathers really relate to different family problems and to the help offered to the family at an IFTU (Sigafoos et al., 1985). As to measuring how the children's situation changed during the treatment period, the study would have benefited by using methods where the children could express themselves through play, painting and drawing and by using individual behavior observations.

Regarding the observer ratings made in the study, we used standardised instruments and co-trained raters and are therefore relatively secure with the ratings, even though the basis for rating varied somewhat from unit to unit. However, interrater reliability was good.

There is also reason to briefly present how the integrity of the treatment process and the research process was handled. The work at the various units has mainly been regarded as a stimulating developmental project. Those responsible for treatment have also been largely responsible for carrying out the project. The flow of information between both the fields has varied somewhat at the different places of work, but been consciously encouraged in the action research oriented developmental work. The main reason was to

establish an evaluative perspective as a natural aspect of therapeutic work. It was important to ensure that the research project was not considered as separate from the everyday life of the unit and an extra burden for the majority of the staff, not to speak of an overwhelming burden for a few select team members. Carrying out a research project with this inner perspective has, of course, obvious methodological shortcomings. However, a lot spoke in favor of this way of doing things if the project was to be carried out at this point in time.

Regression effects

A comment must be made on the statistical regression effects in the measurements (Armelius, 1985). "Ceiling effects" have in all probability been present in the pre-treatment measurements in relation to the measurements six months after the start of treatment as the units, according to the results on some of the instruments, seem to have treated families with a problem-load of differing severity (an example of this is the results of unit 2 on FARS). At units where the families initially showed levels approaching those of the non-clinical family, the IFTU families did not have the same space for changing for the better.

The IFTU family

It has been important to establish which families come to IFTUs for treatment, not least in light of the heated debate between representatives for the units and those of the referring institutions. The criticism has often been that IFTUs treat the "wrong" families in the sense that, different reasons, they do not admit those who are most in need of this special treatment form.

I state the following:

- The IFTU family has a heavy symptom and problem-load both in comparison to non-clinical groups of families and other clinical groups of families, mainly those seeking help at a child psychiatric clinic.
- The IFTU family is often a one-parent family.
- The IFTU family have often contacts with other social institutions.
- The IFTU family often seeks help for externalised problems.
- The IFTU family sees treatment through once it is commenced.

No association was found between the characteristics of an IFTU family and treatment success. The varying degrees of success can probably be explained by varying degrees of motivation for treatment, the nature of family dynamics and the possibilities for the IFTU team to meet the family on a level where there were possibilities of working together.

The systemic model for description

The systemic description model seems to have captured critical characteristics regarding the effectiveness of the treatment. The scales developed have succeeded in tapping important differences. The model in the concrete illustration emphasises Fridell's (1996) statement that a treatment institution's effectiveness is best measured by a collective evaluation of its organisational form and practical applications. One important aspect of a successful care program is its inner and outer organisation, its structure and leadership processes and its decision-making functions. The other aspect, which must be anchored in a "credible form" to its outer framework, is a well thought-out, shared treatment ideology and a feeling of participation and meaningfulness in the team. A picture emerges of a cohesive, integrated framework for the

treatment program which, without being threatened in its identity, can meet different people in different functional ways in a treatment program with a "backbone". The model also makes it possible for the individual units to interact with their partners without either shutting themselves inside their own world or appearing contourless and abandoned when it is necessary to stress the unit's need to function optimally from the starting point of the treatment needs of client families. At the beginning of its existence the model was open and tentative. I suggested that the different units' different characteristics probably were adjusted to their context and function (Sundelin, 1998 a). Today, I give my standpoint a clearer profile. The model must more clearly stress the total importance for a functioning family therapeutic treatment unit of the following:

- Knowledge in the field of family treatment, the development of a treatment culture.
- Mutual legitimisation between the leader and the team members.
- Clear routines for the decision-making process at the unit.
- Consideration both from within the team and from co-operating partners regarding the need of the work group for both privacy and communication with co-operating partners.
- An ideology which is steered by the feedback of results (problem/solution-based).

The IFTU treatment form

In this study, the emergence and current status of the treatment form has been described. The treatment form has been defined. This in itself has, hopefully, more clearly than before, put it on the treatment map as a good alternative in appropriate cases. The integrated treatment program of psychotherapy, milieu

therapy and networking offered by an IFTU is not only supported by the treatment results but also by comparison with successful international projects for treatment of the same or similar problems. The challenges posed when working with this type of problem seem to have led to unanimously similar experiences as to the necessary conditions for successful treatment. Above all, the need for integrated treatment efforts by a co-ordinated team and co-operation with representatives for the local network in the form of meetings held in the places where the problem is experienced (see Functional Family Therapy, Oregon Social Learning Center OSLC., Multisystemic Therapy, Multidimensional Family Therapy).

There are however challenges to be faced. Intensive family therapy is an extremely expensive form of treatment. The costs must be motivated. It is therefore important to develop ways of measuring cost-benefit effects (Alexander et al., 1996, Kazdin, 1996). These should include measurements of how the family manages in its social context after treatment: sick leave, work, contact with social authorities etc. Increased effectivity in different ways is necessary. What we can learn from the international programs is, among other things, to retain the intensity through the integrated team-based treatment plans and, at the same time, gradually transfer further work to an out-patient basis. In order to achieve these goals simultaneously, there must be an increase of competence in the teams in the form of further training in independent therapeutic work. It is important that the "turbo" of the integrated powerful IFTU program is not diluted to become standard out-patient treatment in connection with financial cutbacks in care programs. Another way to stabilise the activities is, as in international programs, to develop clearer frames and procedures for the manualisation of treatment work. The stabilising routines of institutions could thus be replaced by stabilising out-patient routines and thus provide a quality guarantee for each individual treatment irrespective of variations in the staff combination of the treatment team. This of course

requires flexibility and sensitivity for the individual situation's unique conditions within the framework for quality guarantee. Program development is also emphasised as a way of achieving greater possibilities of being aware of what one is doing, for feedback and evaluation and consistent development. Finally it must be stressed that an organisationally well-functioning IFTU achieves better treatment results than an organisationally poorly functioning IFTU.

A further future challenge is to discuss more clearly which families are to be the prime target group for IFTUs. According to the principle Aptitude by Treatment Interaction (Sundelin, 1998 a) one can maintain that different families' needs for help must be met by different treatment measures. We know that traditional child psychiatry is struggling unsuccessfully to find functioning treatment forms for the group of families and their children who come to IFTUs. Sometimes things have gone so far that one tries to define and exclude the families who constitute the majority of the IFTU target group from the child psychiatric field of responsibility, perhaps mainly for the very reason that a functioning treatment method has not been found. These families seem to a large extent to have found the treatment which has suited them at an IFTU. A reasonable conclusion of this study is that this group of families with their heavy psychological/psychiatric and social problem load even in the future should be given priority at child and adolescent psychiatric clinics and also that the preferred method should be based on IFTU methods: a functioning Scandinavian variant of an internationally based treatment concept built on a broad spectrum perspective.

The path of referral to an IFTU is in itself a great challenge. The IFTU families need for a "house of helpers" with everything this implies of attachment, security-creating periods of preparatory contacts, trust-creating measures etc. requires the accessibility of an IFTU. Referral paths where

expert after expert guides these families forward towards an IFTU treatment can easily fail as the families are usually ambivalent to offers of treatment and sensitive to breaks in personal contact with helpers and the therapeutic alliances. This is a dilemma for the future which may possibly find an organisational solution by revising the organisational affiliation of IFTUs as a bridge between the social authorities and child psychiatry and giving the target group direct access to the treatment when necessary.

Child and adolescent psychiatry in Sweden has been the subject of a recent government proposition (SOU, 1998.31). It was established that child and adolescent psychiatry should concentrate on the most needy, i e those who run an early risk of developing mental disturbances. According to the proposition, there are strong reasons for developing specialised teams for treating this group. Those working within child psychiatry have a need for further training in the areas of parent-training and short-term psychotherapy with children, adolescents and their families. The aims are to care for, treat, habilitate and rehabilitate. The proposition states statistics on the prevalence of different psychiatric syndromes in childhood and adolescence. The real need for social support of those with psychiatric problems/disturbances in early years is suggested to lie in the region of 10-30%. Not unexpectedly, the syndrome MBD/DAMP and behavior disturbances together have an undisputed lead, constituting 6-12% of the 10-30% (> 40%). Further, the proposition describes this group requiring the most in-patient care days. Children and adolescents with acting-out behavior and emotional disturbances have twice as many care days (>30% of the total number of in-patient care days) as anorectic patients who are in second place.

The proposition strongly questions the present capability of the collective competence and methods of child and adolescent psychiatry to meet these needs. The importance of giving priority to the group of acting-out children is stressed and, at the same time, the importance of developing co-operative and

integrative treatment models between health authorities and social authorities in order to do this. A conclusion of the present study is that the IFTU model's methods could be an important starting-point for this developmental work.

My contribution to the debate: child and adolescent psychiatry and the future

This study is a contribution to the debate on society's care for children, adolescents and their families in general and as to which criteria should form the basis for the development of care and treatment forms. The main line of thought in this dissertation is clear: Family therapy should be developed through systematic scientific feedback (Liddle, 1991) and not through charisma, faith and tradition. Clinical research projects like this one are very difficult to carry out with perfect scientific precision but necessary for the process of development. Tested experience ought to be given a wider possibility to draw systematised conclusions through the development of stricter scientific methods for the development of clinical quality and for research.

I maintain that the IFTU family is part of the target group given priority in the child and adolescent psychiatry proposition (SOU 1998:31). In order to live up to this we must develop our competence within child and adolescent psychiatry regarding treatment methods which are well adapted to the needs of this group. The quality of the treatment for this target group are illustrated by the concepts continuity, co-ordination, integration, multi-systemic perspective and problem-solving perspective in the concrete problem situation. This treatment method, from the starting-point of a research-based development of IFTU methods, stresses a multi-systemic treatment program where difficult and multi-faceted problems are met with simultaneous, goal-directed efforts on

different levels (individual, family and network levels) The total treatment package should consist of integrated components of a therapeutic and pedagogical nature and be co-ordinated both among themselves and in conjunction with other efforts to help the families.

The individual work should be carried out by a treatment team in organised, co-ordinated and supervised co-operation which erases the boundaries between school, social services and child psychiatry. Continual organisation and planning, i e co-operation and context-marking before and during treatment should be given priority as a goal in itself for those participating in the treatment work. Competence and skill in the art of co-operation must be given its own priority through training and practical experience. The treatment measures for the individual family must be sustained and, when required, based on continual contact with the institution where intensive periods of treatment are interwoven with sparser periods of therapeutic contact. The treatment program should be continually evaluated and corrected. Thus, I argue that the IFTU model can achieve praiseworthy treatment results with the heavily loaded problem group above described as an IFTU family, both regarding effect on family function and the individual family member's symptom-load.

Populärvetenskaplig sammanfattning på svenska (Summary in Swedish)

Denna avhandling handlar om intensiv familjeterapi. Presentationen av arbetet är upplagt på så sätt att jag börjar med en genomgång av forskningsläget för familjeterapeutiskt arbete. Jag presenterar därefter olika familjeterapeutiska skolors bidrag till tankestoffet inom intensiv familjeterapi. Inom denna del finns också presentationer av behandlingsprogram med bredspektrumperspektiv från den internationella scenen. Ett tämligen stort avsnitt beskriver intensiv familjeterapi genom ett antal kliniska vinjetter.

Själva studien är en multicenterstudie som består av fyra delar. Den första delen beskriver intensiv familjeterapi som en form för familjebehandling med bredspektrumperspektiv där familjesamtal och träningsprogram i konflikt- och problemlösning varvas till en integrerad helhet. Det teambaserade arbetssättet beskrivs. Undersökningsgrupp i denna del är sju svenska enheter för intensiv familjebehandling. Jag utvecklar en teoretisk beskrivningsmodell för dessa enheter som jag utgår ifrån när jag utvecklar mätinstrument och mäter dessa enheters likheter och olikheter vad gäller organisation, resurser och utgångspunkter i sina sätt att arbeta. Jag finner att enheterna har många likheter men skiljer sig åt vad gäller grad av tydlig struktur och klarhet avseende organisation och arbetsform, funktion och mål och avseende personalgruppens upplevelse av mening och trivsel med sina arbetsuppgifter. Jag ställer frågan huruvida de funna skillnaderna mellan enheterna kan öka förståelsen för varför de olika enheterna når olika resultat i sina behandlingsarbeten.

I den andra delen i studien mäter jag 109 familjer som genomgår intensiv familjebehandling vid dessa olika enheter (86 av dem följs upp). Dessa familjer beskrivs och jämförs med andra grupper av familjer. Familjerna mäts före behandling och sex månader efter behandlingsstart med ett antal olika mätinstrument. Sättet att mäta är att familjemedlemmarna får fylla i ett antal standardiserade enkäter som mäter symptombelastning och familjefunktion. Familjerna mäts också vad gäller familjefunktion genom att de videofilmas i intervjusituationer. Dessa intervjuer skattas av oberoende bedömare enligt standardiserade förfaranden. Resultat från denna del presenteras både för samtliga enheter tillsammans och för enheterna var för sig. De sammanlagda resultaten visar tydligt att de 86 familjer som genomgår mätningen före och sex månader efter behandlingsstart drar stor nytta av behandlingen både avseende symptombelastning och familjefunktion. Tittar man på hur varje enskild familj beskriver sin situation före behandling och sex månader efter behandlingens start, ser vi att ungefär hälften av familjerna rapporterar avsevärda förbättringar. Detta menar vi är ett gott resultat med tanke på den tunga problembelastning som dessa familjer vanligtvis har och hur tidigare misslyckade behandlingsförsök brutit ner deras tilltro till att kunna få hjälp.

Den tredje delen och den som knyter samman och ger mening åt de två första delarna försöker väga ihop fynden från hur de olika enheterna är uppbyggda och fungerar och vilka behandlingsresultat de familjer fått genom den behandling de genomgått på de olika enheterna. Jag finner att de enheter som är mest framgångsrika är större, mer välorganiserade och har en samlad kompetens. Dessa enheter har också fokus på välformulerade hanterbara terapeutiska mål och arbetar uthålligt och med kontinuitet efter en metodik som innehåller integrerade moment med både terapeutiska och pedagogiska inslag.

Dessa resultat bildar sedan i första hand ett underlag för en diskussion om fortsatt utveckling av intensiv familjebehandling. Jag diskuterar också förutsättningar för bra behandlingsprogram för denna målgrupp i allmänhet med utgångspunkt från intensiv familjebehandlings principer. En fjärde del tar i ett beskrivande kapitel kortfattat upp en annan aspekt av dessa enheters arbetsuppgifter nämligen det som i vardagligt tal benämns familjeutredningar. Detta arbete utgör upp mot 20% av arbetet vid dessa enheter och beskrivs som en "informationssökande förändringsprocess" i en teoretisk framställning.

Så här vill jag sammanfatta mina resultat:

- IFTU-familjen är tungt problem- och symptombelastad både i jämförelse med icke kliniska grupper av familjer och i jämförelse med andra kliniska grupper av familjer, företrädesvis familjer som sökt hjälp inom Barn- och Ungdomspsykiatrin.
- IFTU-familjen är företrädesvis en enförälderfamilj.
- IFTU-familjen har ofta kontakt med övriga hjälpinstanser i samhället.
- IFTU-familjen söker företrädesvis för externaliserade problem.
- IFTU-familjen genomför påbörjad behandling.

En välfungerande Enhet för Intensiv Familjebehandling utmärks av:

- Kunskap på området familjebehandling.
- Utvecklad behandlingskultur.
- Ömsesidig legitimitet mellan ledaren och arbetsgruppens medlemmar.
- En klar tågordning för beslutsprocessen vid arbetsenheten.
- Stort hänsynstagande både inifrån arbetsgruppen och från samarbetspartners avseende arbetsgruppens behov av avskildhet och kommunikation med samarbetspartners.
- En ideologi som styrs av resultat-feedback.

I en slutlig diskussion och argumentering med utgångspunkt från studien hävdar jag följande:

IFTU-modellen bör utgöra utgångspunkten för det allmänna utvecklingsarbetet i samhället av behandlingsprogram för denna prioriterade målgrupp därför att en bra vårdinsats för denna målgrupp bör samordna olika typer av psykologiska och sociala, terapeutiska och pedagogiska insatser. Insatsen måste vara uthållig i alliansbyggande och förtroendebyggande och vara uthållig. Metodiken bör vara konkret orienterad mot problem som klienterna beskriver. Denna arbetsmetodiken kan därför med fördel ha sin utgångspunkt i en forskningbaserad utvecklande IFTU-metodik. Det enskilda arbetet skall genomföras av ett behandlingsteam i ett organiserat, koordinerat och väglett samarbete som spränger gränser mellan skola, socialvård och BUP. Ett bra samarbete kräver att såväl planerande, organiserande som genomförande av den sammanlagda behandlingsinsatsen lyfts fram till ett speciellt ansvar för en speciell befattningshavare (koordinator). Kompetensutveckling i samarbetets och samordnandets skicklighet skall prioriteras genom utbildning som ett mål i sig. Behandlingsinsatsen skall vara uthållig samt under regelbunden utvärdering och korrigering med utgångspunkt från denna.

Epilog

När avhandlingsarbetet i stort var avslutat julen 1998, åkte jag tillsammans med Majt, Jerker, Anna-Maria och Jon till sydligare breddgrader för att fira en annorlunda jul. Där på stranden till den paradisiska ön såg jag varje dag samma lilla bruna pudel oupphörligen jaga fram och tillbaka längs vattenbrynet i den bländvita sanden - inte efter fjärilar utan efter deras skugga!

Epilogue

When the main work with this dissertation was completed in December 1998, I travelled to more southern latitudes with my wife Majt and our children Jerker, Anna-Maria and Jon to celebrate a different sort of Christmas. Every day, on the beach of our paradisical island, I saw the same small brown poodle run back and forth in the dazzling white sand along the water's edge - not chasing butterflies but their shadows.

Appendix

Items in profile forms

Referral attitude, (RA)

Administered to team leaders at the referring outpatient clinics.

Part 1 descriptive: RA: Questionnaire to team leader or corresponding at clinics referring families for investigation or treatment to the unit for intensive family therapy in question. Please complete the questionnaire with the last six months in mind.

1. Describe briefly the type of case at your clinic which makes you consider the family unit as an treatment alternative.

2. In general, how would you rate the climate of co-operation between your clinic and the family unit regarding sensitivity for what you and the family need help with, the contact between you while the family is at the unit, at the termination of treatment at the unit and in the cases where families are referred back to you at the clinic.

3. What, according to you, are the strengths and weaknesses of the family treatment unit.

4. How do you rate the collected competence of the family treatment unit qualitatively and quantitatively?

5. Where do you consider that the family unit's potential for developing co-operation with you lies?

6. How would you describe similarities and differences between your clinic and the family treatment unit regarding ideology for describing and understanding families with problems and for carrying out treatment and investigations?

7. Describe:

a) The place of the family treatment unit in the organisation-
b) The aims that have been formulated by the organisation regarding the tasks of the family treatment unit.
c) The responsibilities of the treatment unit's leader upwards in the organisation
d) How internal questions of responsibility are regulated in the treatment team

The families come to our family treatment unit by

Self referral
Referral from own out-patient clinic
Direct referral from other institutions
Other ways
(give proportion in %)

Work tasks (in %) are

Investigations regarding child/family at the request of other institutions
(c g social authorities, courts)

Part of own clinic's investigations at the request of other institutions

Treatment investigations for own clinic
(e g how could work with this family be organised?)

Intensive family treatment

Other tasks

Comments

Our unit's total contacts with the families usually run over a period of (state number of months)

12 ten-scale questions:

Our IFTU's functions and work tasks are
completely different from my ideas on what they should be — wholly in accordance with my ideas

1 2 3 4 5 6 7 8 9 10

The treatment periods of "our IFTU" are
to long to short — exactly the right length

1 2 3 4 5 6 7 8 9 10

My opinion of the family unit's structure regarding the work routines is that
they do not agree at all with my own opinion — they agree completely with my own opinion

1 2 3 4 5 6 7 8 9 10

"Our" IFTU's time perspective of treatment time agrees with my expectations on it's tasks and function
not at all — yes, completely

1 2 3 4 5 6 7 8 9 10

"Our" IFTU's way of working is in accordance with my opinion concerning it's function
not at all — yes, completely

1 2 3 4 5 6 7 8 9 10

An IFTU may be described as either working from a therapeutic position closer to a pedagogical, informative position or closer to a reflecting, mirroring therapeutic position.
"Our" IFTU works in accordance with my opinion

not at all yes, completely

1 2 3 4 5 6 7 8 9 10

An IFTU may be described as either working aiming at solving a formulated problem or aiming at a better understanding by developing the formulation of the family problem. "Our" IFTU works in accordance with my opinion.

not at all yes, completely

1 2 3 4 5 6 7 8 9 10

An IFTU may be described as either working with a defined problem towards a goal or more process- and growth oriented.
"Our" IFTU works in accordance with the main opinion at our clinic

not at all yes, completely

1 2 3 4 5 6 7 8 9 10

An IFTU may be described as either working for support in an ongoing family crisis or for inducting the family into a family crisis.
"Our" IFTU works in accordance with my opinion

not at all yes, completely

1 2 3 4 5 6 7 8 9 10

An IFTU may be described as either taking on the responsibility for change in a family or making very clear the family members own responsibility for therapeutic change.
"Our" IFTU works in accordance with my opinion

not at all yes, completely

1 2 3 4 5 6 7 8 9 10

According to my opinion, "Our" IFTU works with the right families

not at all yes, completely

1 2 3 4 5 6 7 8 9 10

In my opinion "Our" IFTU works with families in the right way

not at all yes, completely

1 2 3 4 5 6 7 8 9 10

Background data (FB)

(to be completed by the IFTU's team leader)

Personnel Basic training Further training

Other affiliated resource persons:

Describe:
The place of the unit in the organisation
The aims that have been formulated by the organisation regarding the tasks of the treatment unit.
The responsibilities of the treatment unit's leader upwards in the organisation.
How questions of internal responsibility are regulated in the treatment team.

Our family unit has been in existence since _____

Families come to us by
- Self referral
- Referral from own out-patient clinic
- Direct referral from other institutions
- Other ways
- (give proportion in %)

Work tasks (in %) are

Investigations regarding child/family at the request of other institutions
(e g social authorities, courts)

Part of own clinic's investigations at the request of other institutions

Treatment investigations for own clinic
(e g how could work with this family be organised?)

Intensive family treatment

Other tasks
Comments

Our unit's total contact with families usually runs over a period of (state number of months)

Our yearly budget is approximately

Working Profile, (WP)

Administered to the members in the different IFTU-teams.

Factor 1 "Profile concerning Structure, Directiveness and Responsibility".

"Our" IFTU's family therapy sessions are often commissioned by
the person responsible for the referral — the family members

1 2 3 4 5 6 7 8 9 10

"Our" IFTU's therapeutic family work in milieu are often commissioned by
the person responsible for the referral — the family members

1 2 3 4 5 6 7 8 9 10

"Our" IFTU's milieu work is often in accordance with
the milieu therapists deem best — commissioned by the family

1 2 3 4 5 6 7 8 9 10

"Our" IFTU's therapeutic talks with the families usually assume
a directive, "prescribing" position — a suggesting "giving ideas" position

1 2 3 4 5 6 7 8 9 10

"Our" IFTU's family sessions usually assume
a pedagogical, informative therapeutic position — a reflecting mirroring therapeutic position

1 2 3 4 5 6 7 8 9 10

"Our" IFTU's milieu work usually assumes
a directive, "prescribing" position — suggesting "giving ideas" position

1 2 3 4 5 6 7 8 9 10

"Our" IFTU's milieu work usually assumes
a pedagogical, informative therapeutic position. — reflecting, mirroring therapeutic position

1 2 3 4 5 6 7 8 9 10

Factor 2: "Profile concerning Length of Time for Treatment Process, Locus of Change, Degree of Problem/Solution Focus".

Our unit's commissions mean that our work is carried out in
a short time perspective — a long time perspective

1 2 3 4 5 6 7 8 9 10

Our unit's way of working primarily concentrates on
superficial, observable behaviors and symptoms — experiences and meanings of what is happening

1 2 3 4 5 6 7 8 9 10

Our unit's way of working can best be described as
therapy sessions supporting milieu work — milieu work supporting therapy sessions

1 2 3 4 5 6 7 8 9 10

In therapeutic sessions with families, our unit aims at

solving a formulated problem — developing the formulation of the problem

1 2 3 4 5 6 7 8 9 10

In milieu work, our unit aims at

solving a formulated problem — developing the formulation of the problem

1 2 3 4 5 6 7 8 9 10

In therapeutic sessions, our unit concentrates on

The problem, the aim the solution — the process, growth

1 2 3 4 5 6 7 8 9 10

Attitude to one's own working profile 10 items (AWP)

Administered to the members of the different IFTU-teams.

An IFTU's family therapy sessions may assume a directive, "prescribing" position or a suggesting "giving ideas" position. My unit's way of working

is not at all in accordance with my opinion — is in full accordance with my opinion

1 2 3 4 5 6 7 8 9 10

An IFTU's family work in milieu may assume a directive, "prescribing" position or a suggesting, " giving ideas" position. My unit's way of working

is not at all in accordance with my opinion — is in complete accordance with my opinion

1 2 3 4 5 6 7 8 9 10

An IFTU's family therapy sessions usually assumes a pedagogical, informative therapeutic position or a reflecting, mirroring therapeutic position. My unit's way of working

is not at all in accordance with my opinion — is in complete accordance with my opinion

1 2 3 4 5 6 7 8 9 10

An IFTU's milieu work usually assumes a pedagogical, informative therapeutic position or a reflecting and mirroring therapeutic position. My unit's way of working

is not at all in accordance with my opinion — is in complete accordance with my opinion

1 2 3 4 5 6 7 8 9 10

An IFTU's family therapy sessions may aim at solving a formulated problem or at developing the formulation of the problem. My unit's way of working

is not at all in accordance with my opinion — is in complete accordance with my opinion

1 2 3 4 5 6 7 8 9 10

An IFTU's milieu work may aim at solving a formulated problem or at developing the formulation of the problem. My unit's way of working

is not at all in accordance with my opinion — is in complete accordance with my opinion

1 2 3 4 5 6 7 8 9 10

An IFTU's family therapy sessions may concentrate on the problem, the aim and the solution or on the process, the way and growth. My unit's way of working

is not at all in accordance with my opinion — is in complete accordance with my opinion

1 2 3 4 5 6 7 8 9 10

An IFTU's milieu work may concentrate on the problem, the aim and the solution or on the process, the way and growth. My unit's way of working

is not at all in accordance with my opinion — is in complete accordance with my opinion

1 2 3 4 5 6 7 8 9 10

An IFTU's total work can be said to be characterised by crisis intervention (support in crisis) or crisis induction (creating crisis). "Our" IFTU works in accordance with my opinion

not at all — yes, completely

1 2 3 4 5 6 7 8 9 10

An IFTU can usually be characterised by temporarily taking over responsibility from the family or clarifying the family member's own responsibility for therapeutic change. "Our" IFTU works in accordance with my opinion

not at all yes, completely

1 2 3 4 5 6 7 8 9 10

Salutogenic group, (SG)

Administered to the members of the IFTU-teams.

Factor 1, "Job Satisfaction - me and my job"

During the last six months my workload has been

very unsatisfactory very satisfactory

1 2 3 4 5 6 7 8 9 10

During the last six months conflicts and differences of opinion in the team have usually been solved

very unsatisfactory very satisfactory

1 2 3 4 5 6 7 8 9 10

Sometimes people I trust at work disappoints me

very often very seldom

1 2 3 4 5 6 7 8 9 10

My daily duties at work are a source of pleasure and satisfaction

almost never almost always

1 2 3 4 5 6 7 8 9 10

I feel I am unjustly treated by my colleagues

very often almost never

1 2 3 4 5 6 7 8 9 10

During the last six months I have been happy at work

not at all completely

1 2 3 4 5 6 7 8 9 10

My work is varied and meaningful to me

do not agree at all agree completely

1 2 3 4 5 6 7 8 9 10

I have lost faith in our way of working

completely not at all

1 2 3 4 5 6 7 8 9 10

My work enriches my life

do not agree at all agree completely

1 2 3 4 5 6 7 8 9 10

Factor 2: "Comprehensibility, Meaningfulness, Manageability"

During the last six months it is my opinion that my therapeutic work with families at the unit has been meaningful

not at all completely

1 2 3 4 5 6 7 8 9 10

I often feel that I am in an strange situation and do not know what to do

very often very seldom

1 2 3 4 5 6 7 8 9 10

During the last six months I have usually been clear over my part in the team's therapeutic work

not at all completely

1 2 3 4 5 6 7 8 9 10

During the last six months it is my opinion that our therapeutic team together with the families has generally found constructive methods to tackle the problems formulated

very poorly very well

1 2 3 4 5 6 7 8 9 10

I usually understand the aim of the therapist's talks with family members

very poorly very well

1 2 3 4 5 6 7 8 9 10

I often feel I have no control over my work situation

agree completely do not agree at all

1 2 3 4 5 6 7 8 9 10

I often doubt the meaningfulness of my work

agree completely do not agree at all

1 2 3 4 5 6 7 8 9 10

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Article 1 - 6

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Article 5:
Sundelin J., Hansson K. Intensive Family Therapy – a way to treat multiproblem families. A follow up study measuring individual psychopathology. Submitted, 1999.

Article 6:
Sundelin J., Hansson K. Intensive Family Therapy
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I

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.

Johan Sundelin
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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.

Comparison between measurements	Distance Index 0	>0	X^2-value p-value	Comparison between measurements	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 Observ. time	1987 more than 34 months	1989 23-15 months	1990 10-5 months	Total
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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II

INPATIENT FAMILY THERAPY

a multicenter study of families' and staff's experience of family climate.

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Abstract

Within child and youth psychiatry family therapy has been a common treatment method. Even inpatient treatment has used this by bringing the whole family into the ward. This study presents the results from a multicenter study of impatient family therapy. The study has followed five family units (Lund, Växjö, Uddevalla, Falun and Umeå) during 1 year. The results show that immediately after the treatment half of the families report more positive family climate than at the beginning of the treatment. A follow-up study shows some difference between the units, but the results are still positive, especially considering the heavy problems in the families. We can also see that there is considerable correspondence between families' and staff's ratings of the 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 behaviour 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?

Method

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, Växsjö, 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. Collection of the material distributed on place, number of evaluations and evaluation perspectives

	Lund	Falun	Växjö	Uddevalla	Umeå
Observation time (weeks)	35-19	36-22	40-31	41-26	48-15
Inpatient time (weeks)	4 (2-6)	4	2 (1.2)	3	4
(Total) number of measurements	4	6	5	5	3
before admittance	0	1	1	1	0
at the clinic	4	4	3	3	2
out-patient follow-up after 3 months	0	1	1	1	1 (6-7 months)
The families evaluate family climate	yes	yes	yes	yes	yes
The staff evaluate family climate	yes	yes	yes	yes	yes
The staff evaluate group climate	yes	yes	yes	yes	yes
The families evaluate group climate	yes	no	no	no	no

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. Internalised 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 behaviour, problems concerning visitation rights, evaluations of various kinds etc.

The research instrument

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).

Table 2. Description of families divided on place with regards to dropouts, children, adults, age, type of family, social group and "type of problem".

	Place					Total
	Lund	Falun	Växjö	Uddevalla	Umeå	
Number of families:	15	11	11	15	7	59
Dropouts	2	0	0	2	1	5
Number of people:	44	44	46	56	25	215
Adults	23	20	18	26	11	98
Children	21	24	28	30	14	117
Ages:						
0-6	7	7	13	10	4	41
7-15	14	7	10	19	9	59
16-20	0	10	5	1	1	17
21-35	14	8	7	12	6	47
36-50	8	11	9	12	3	43
51-	1	1	2	2	2	8
Family type:						
Nuclear family	8	4	4	7	3	26
Step family	2	3	3	3	2	13
Single parent family	3	4	1	3	1	12
Divorced family	0	0	3	0	0	3
Social group:						
1	2	1	0	1	0	4
2	1	1	3	3	2	10
3-4	10	9	8	9	4	40
Problem/diagnosis:						
Extrovert	5	2	4	8	5	24
Introvert	5	6	4	4	1	20
Other	3	3	3	1	0	10

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.

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 in 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 children's 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 actives during the day. The unit staff is complemented by a psychiatrist, psychologist and psychiatric social worker and there is also a pre-school, 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 focused 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 schoolfobia 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 3 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.

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 tables 4 and 5). The results in all cases where the families report positive changes in regard to **closeness**, **distance** and **chaos**, are statistically significant ($p < .001$).

Table 3. Family climate (average values) according to families divided between number of evaluations and place.

Place	Closeness	Distance	Spontaneity	Chaos
Ratings	m	m	m	m
Lund (n=13)				
2	1,56	,50	,83	1,33
2	1,72	,35	,55	,90
4	1,82	,28	,55	,28
5	1,99	,46	,51	,61
Växjö (n=11)				
2	1,22	,72	1,71	1,38
3	1,33	,81	1,30	1,06
4	1,54	,47	1,27	,79
6	1,14	,83	1,18	1,22
Falun (n=11)				
1	,79	,74	1,60	1,42
2	1,28	,61	,76	1,16
3	1,42	,43	1,12	,89
4	1,25	,70	1,18	,24
5	1,40	,46	,62	,85
6	1,42	,45	1,30	,39
Uddevalla (n=15)				
1	1,12	,81	,84	1,40
2	1,52	,44	,51	1,02
3	1,28	,51	,55	1,14
4	1,15	,59	,62	,85
6	1,85	,31	,57	1,41
Umeå (n = 6)				
2	1,22	,40	1,82	1,14
5	1,15	,40	1,04	,86
6	,96	,24	2,66	1,27

Table 4. Experience and evaluation of family climate according to the families, comparison between the first and the last rating during the time of treatment at the clinic.

	Closeness		Distance		Chaos		Closeness + Chaos Positive change	
	+	-/0	+	-/0	+	-/0		
Place								
Lund	7	6	5	8	9	4	4/13	13%
Växjö	6	4	7	3	8	2	6/10	60%
Falun	11	0	9	3	7	5	7/11	64%
Uddevalla	10	5	7	8	9	6	8/15	53%
Umeå	4	2	3	3	3	3	3/6	50%
Total	38	17	31	24	36	19	28/55	51%

+ = positive change (higher Closeness, less Distance, less Chaos)
-/0 = negative or no change (less Closeness, higher Distance, higher Chaos)

Table 5. Experience and evaluation of family climate according to families, comparisons between the first evaluation at the clinic and at the follow-up after approximately 3 months.

	Closeness		Distance		Chaos		Closeness + Chaos Positive change	
	+	-/0	+	-/0	+	-/0		
Place								
Växjö	5	5	3	7	6	4	4/10	40%
Falun	7	0	7	0	6	1	6/7	86%
Uddevalla	3	4	6	1	4	3	3/7	43%
Umeå	3	3	3	3	2	4	2/6	33%
Total	18	12	19	11	18	12	15/30	50%

+ = positive change (higher Closeness, less Distance, less Chaos)
-/0 = negative or no change (less Closeness, higher Distance, higher Chaos)

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 (table 6).

Table 6. Comparison between the families´ and the staffs´ evaluation of the family climate within the families (on the first and last rating at the clinic).

		Closeness		Distance		Chaos		%
		Therapists		Therapists		Therapists		agreement
		+	-/0	+	-/0	+	-/0	
Place								
Lund								
Families	+	6	1	3	2	9	0	
	-/0	1	5	3	5	2	2	77%
phi			.69		.22		.64	
Växjö								
Families	+	5	0	5	1	5	2	
	-/0	2	2	1	2	1	1	74%
phi			.64		.50		.19	
Falun								
Families	+	9	2	5	3	6	1	
	-/0	0	0	1	2	2	2	73%
phi			-		.26		.39	
Uddevalla								
Families	+	8	1	3	2	7	1	
	-/0	1	2	3	4	1	3	75%
phi			.56		.17		.62	
Umeå								
Families	+	2	2	3	0	1	2	
	-/0	2	0	1	2	1	2	56%
phi			-.50		.71		0	
Total								
Families	+	30	6	19	8	28	6	
	-/0	6	9	9	15	7	10	73%
phi			.43		.33		.42	
%								
Accordance			76%		67%		75%	

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.

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 4) 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 5), 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 would most likely yield some interesting information.

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 decrease in individual symptomatology. As none of the studies referred to have been focused 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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III

A SYSTEMS ORIENTED MODEL FOR DESCRIPTION OF INTENSIVE FAMILY THERAPY UNITS.

Johan Sundelin

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 IFTUs 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.

IFTUs 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 IFTUs

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 IFTUs 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 IFTUs. 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 if 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 IFTUs 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 IFTUs 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 IFTUs 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 IFTUs, 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 IFTUs 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. Commissional 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 rescources 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 IFTUs 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.

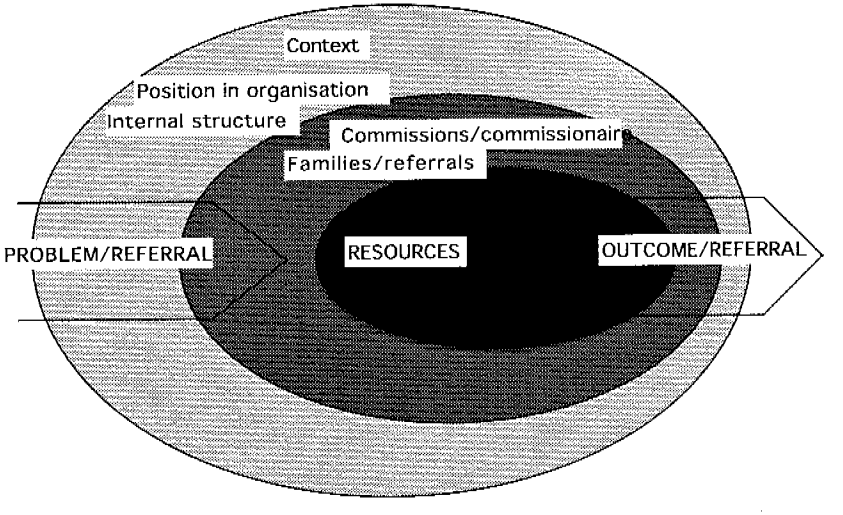

Figure 1: Graphic picture of the theoretical model presented for describing IFTU:s.

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 IFTUs 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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IV

A SYSTEMS ORIENTED MODEL FOR DESCRIPTION AND ANALYSIS OF INTENSIVE FAMILJ THERAPY UNITS.

A Pilot Study.

Johan Sundelin

Running head: Intensive family therapy

Abstract

This is the second of two articles concerning the development of a systems-oriented model for description of Intensive Family Therapy. This article concerns the introduction of the units for Intensive Family Therapy participating in the study and a presentation of similarities and differences among them. Some preliminary instruments according to the model for a systems-oriented description of Intensive Family Therapy are introduced to the reader. These instruments are preliminary efforts to operationalize in order to make possible un empirical validation of the model.

These questionnaires and scales are administered to the intensive family therapy units in the study and the results are evaluated to some extent in respect to reliability and validity of the scales and in respect to similarities and differences between the units.

Although the different units give answers mainly in similar fashion, some differences concerning context, commissions, treatment ideology and resources are found between the different intensive family therapy units (IFTU:s). Differences are noticed concerning responsibilities, mandate and organisational arrangements as well as in resources, ideological issues and group climate in staff groups for different IFTU:s.

Differences found will be further evaluated in later articles to see if they provide significant criteria for explaining differences between the IFTU's "therapeutic effectiveness".

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

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As part of an ongoing multi-center study of intensive family therapy in Sweden, a description of the units providing this form of therapy is indicated. Within the multi- center study, 109 families are investigated with an extensive test-battery on different occasions over a period of two years following the start of treatment at intensive family therapy units (IFTUs). These units offer a full day multi-impact treatment program for families during an intensive period of approximately one month which is preceded by a period of planning and preparation and followed up for a period varying between 1 - 6 months at different IFTUs.

A theoretical model for describing this kind of family therapy has been developed (1). The purpose for developing the model is to describe certain significant dimensions along which different units may be placed. In order to do this we operationalize these dimensions through measures under development. The different units are then compared along these measures. The different IFTU's positions in these dimensions will later be used in a comparison with different outcome measures of different kinds for intensive family therapy done at these units. The different units' outcome results will then be discussed in relation to the different units' profiles. These results will hopefully be informative and add to the discussion concerning further development of Intensive Family Therapy.

The model describes important dimensions chosen from research on organisations and treatment institutions, clinical experience and clinical theories: Context (micro and macro organisation, mutuality concerning treatment ideology), commissions towards families and referrals, team resources of different kinds and different perspectives on outcome/effects.

The theoretical model stems from many years experience of this model for Intensive Family Therapy. Theoretically, we refer to different sources such as

organisational psychology when looking for answers concerning what every effective organisation needs to possess: goal orientation, sensitivity for feedback, flexibility and shared values (2, 3). Furthermore we refer to research concerning different premises for institution-based treatment programs summarised in the terms "outer and inner factors" and good pre-requisites through adequate and recognized leadership, a trustworthy structure for descisionmaking processes and interrelatedness and a good staff policy (4, 5). In addition, we refer to different family therapeutic theories concerning the connection between and the joining of client family and institution and the interplay between reflection on family dynamics and social training in the therapeutic process (6, 7, 8). "Family reality" and "The Language of Change" are central concepts coming from systemic, post-systemic, narrative and solution-focused tradition (9, 10, 11, 12, 13). For a contextualized perspective of the space within which the therapeutic impact takes place, we draw on the Model for Contextualization for inspiration (14). Knowledge from multi-systemic treatment models give us tools to produce intense, contemporaneous achievements, all together sufficient to create change (15, 16, 17).

The aim of this paper is:

1. To develop tentative scales according to the model of description previously presented (1) which measure critical dimensions in the treatment model of intensive family therapy and

2. To see if the units differ along these dimensions in a meaningful way.The model for description of IFTU:s already was introduced in detail (1) is built on the following concepts: context, commission/referral, resources, effects.

Method

The study group

The study group consists of seven intensive family therapy units at the child and youth psychiatric clinics in Falun, Växjö, Uddevalla, Karlshamn, Helsingborg, Lund and "Skutan" Social Welfare Göteborg. These units accepted an invitation from the Department of child and youth psychiatry at the University of Lund to participate in the study. They are representative for the treatment model in Sweden although they only constitute about 1/4 of the total number of this type of unit within child and youth psychiatry and social welfare in Sweden.

The study group is presented according to significant dimensions concerning their respective context, commissions and resources in table 1. The columns to the left in table 1 need some explanation in order for the reader to grasp the information in the table more fully.

Table 1: Some significant characteristics for the IFTUs involved in the study.

	Karlshamn	Lund	Helsingborg	Skutan	Uddevalla	Växjö	Falun[1]
Day care (x) 24 hours care (xx)	x	xx	x	xx	xx	xx	xx
Referrals from	Own outpatient	Own outpatient region	Own outpatient	Soc welfare bureaus	Own outpatient	Own outpatient	Own outpatie 35% region, other sources 65%
Intensive fam. ther.tasks in %	65%	87%	90%	50%	100%	85%	55%
Other tasks	35%	23%	10%	50%		15%	45%
Estimated duration of tot contact with fam intens+extens.	1 month	3 months	2 months	2 months	5 months	6 months	8 months
Number of staff with dipl. in psychotherapy	0	0	1	7	0	3	4
Number of staff	10 + 6 aff. ther.	12 + 6 aff. ther.	6 + 0 aff. ther.	10 + 0	10 + 2 aff. ther.	7 + 0	15 + 0
Further training Milieu and Family therapy	internal	internal high	internal	internal external high	internal	internal external high	internal external high
Unit starting year	1981	1985	1982	1981	1990	1983	1981
Employed staff N working years at unit (1995)	8.5	9	9	10	5	7	11
N Intens Family cases per year	30	40	17	17	27	12	25

Day-care (x) 24 hour care (xx) differentiate the units as to whether they meet their families under treatment during daytime or if the families stay in the institution Monday through Friday. Referrals from describes whether the units get their referrals only from outpatient units in the same organisation or if referrals come from different sources. Different solutions indicate different therapeutic tasks, different degrees of autonomy and considered competence. Intensive family Therapy tasks in % other tasks indicates to what degree the different units focus on intensive family therapy in comparison with other forms for therapeutic and investigation work. Estimated duration of total contact with the families indicates the time for therapeutic responsibility put more or less solely on the unit. Number of staff with diploma in psychotherapy gives information concerning formal level of competence in the staff group. Number of staff describes the size of the unit. The "+" means number of affiliated therapists with a looser connection to the teamwork done at the unit. Further training milieu and family therapy means my classification of reported accomplished further educational programs at the units. Starting year and employed staff N working years at the unit (1995) give an idea of the

[1] The order of presentation is different from the numerical order in which the units are presented elsewhere in this article

unit's collected experience as an intensive family therapy unit and an idea of the stability of the staff group. N intensive family therapy cases per year indicate how many families go through an intensive program per year.

All units within child- and youth psychiatry except Falun, have a child psychiatrist in charge of the treatment. Falun has a social worker as responsible as has Skutan which is organised within social welfare.

All units are family-oriented and have obvious similarities which can be defined within this treatment model. All of them work with families in a daily intensive program over a period of time. The work is carried out by a team of milieu therapists and family therapists working together. There are some differences in the capacity to provide night accommodation for families. The duration of the therapeutic work with families differs considerably. The units differ in size and resources available as well as flexibility in the unit's program. Differences are also noticed concerning organisational affiliation, tasks and commissions. The basic training profile among staff is very similar consisting of nurses, psychiatric nurses, children's nurses, pedagogues of different kinds, pre-school teachers etc. Formal further training of staff groups differs quite a bit. The units are of different ages but none of them is quite new. A noticeable characteristic is the stability of the staff groups.

The data collection procedure

Questionnaires and scales were constructed from the model presented above. They were constructed by the author of this article after seminars with local staff groups and tested for comprehensibility on a staff group not included in the study. The construction was built on face-validity catching different facets of the concepts through a number of questions or scales (18).

The questionnaires and the original scales were distributed and collected during September 1995. The answers on the different scales were factor-analysed. Criteria for an item to be included in a factor were determined (> .50, < .25 in another factor). The factor-analysed scales constituted the basis for the different units' results.

Statistical Methods

In the process of homogenisation of scales, factor analysis with orthogonal transformation solution - varimax rotation has been used. When comparing analyses between the IFTU:s, one factor Anova has been used (Statview II). In the concluding cluster analysis, factor analysis as above was used. Numeric results of the factor analyses as well as the newly constructed scales may be obtained from the author.

Results

Development of questionnaires and scales

Before we introduce the different operationalised measures, an overview of the different questionnaires and scales are presented in connection to the model and it's theoretical references in table 2.

Table 2: An overview of the connections between the model of description and the different questionaires and scales.

Questionnaires and scales	Location in model	Theoretical reference
Referral Attitude (RA)	Context/Commissions	Contextualisation (Petitt, Olson 1992)
Form Background (FB)	Context/structure	Organisation/Leadership (Fridell 1996)
Working Profile (WP)	Resources	Ideology Fridell 1996, Ekvall 1988)
Salutogenic Group (SG)	Resources	Sense of coherence/ Antonowsky (1991)
Group Climate (GC)	Resources	Group Climate (Hansson, Olsson 1991)
Attitude Working profile (AWP)	Resources	Sense of sharing (Ekvall 1988)
Attitude new Knowledge (ANK)	Resources	Ideology, Flexibility (Schein 1965, Fridell 1996)
Different measures of outcome	Outcome	Effect (Lambert & Hill 1996)

Context

RA (Referral Attitude)

The questionnaire RA is administered to the directors of the referring units and belongs to the "context" dimension in the model of description. The questionnaire refers to the theoretical model of the importance of a clear and mutually accepted relation between the commissioner and the performer (14). The answers to RA provide information about the "working alliance" and " experienced mutually" in the relation between referrals and the IFTU from the referral perspective. The questionnaire consists of two sections: The descriptive section consists of 10 open questions concerning the local IFTU from the perspective of the referring units as, for instance experienced climate of co-operation. The other section consists of twelve 10-point attitude items. This scale is supposed to catch a general measure of knowledge of and confidence in the local IFTU on the part of the directors of referring units by asking them to judge the degree of agreement from their point of view, on the local IFTU's treatment ideology.

The second part of RA, the attitude form, is homogeneous. Every single item correlates highly with the total score (M .69 range .52-.86). Internal consistency (Cronbach's Alpha) is .84. (19)

FB (Form Background)

The questionnaire FB is administered to the IFTU´s leader. It consists of four broad category questions concerning inner and outer organisation such as structure of leadership, number of staff, organisational relations for the IFTU, tasks in %, etc. (1, 3, 17).

Resources

WP (Working Profile)

Referring to sources pointing to the importance of a shared treatment ideology (3, 4) and to some important polarisations within family therapy theories (6, 9, 11, 12, 13) we developed the form Working Profile (WP). It was filled in by every member of the respective staff, including resource personnel and addressed 5 hypothetical aspects:

1. Team style 2. Time 3. Structure 4. Style 5. Focus.

1. Organisational level: *Team style.* I.e. if family therapy sessions and milieu therapy activities functioned in close collaboration or if they were separate from each other.

2. Commissional level: *Time.* Is the unit working on short or long-term commissions?

3. Ideological level: *Structure.* Is the unit operating in a generalised and predictable structure with a program-directed treatment process or is the treatment process individualised, need-directed?

4. Treatment level: *Style.* Supportive style or challenging style?

5. Treatment level: *Focus.* Problem/solution and behaviour oriented or process/growth and meaning focused?

Factor analysis yielded a two-factor solution. Factor 1 included 7 items and was named "Profile concerning Structure, Directiveness and Responsibility".

Lower values on these scales mirror a tendency towards a high and predictable Structure in the unit, a directive therapeutic style and assuming responsibility for change, while higher values mirror a differentiated structure, a non-directive reflective therapeutic style and shared responsibility with the family. Internal Consistency (Cronbach's Alpha) was .73.

Six items make up factor 2 named "Profile concerning Length of Time for Treatment Process, Locus of Change, Degree of Problem/Solution Focus". Lower values on these scales mirror a tendency towards short time focus, focus on external behavioural change and a problem/solution oriented style while higher values mirror a tendency towards the perspective of a longer therapeutic process, focus on experience rather than behavioural change and on growth rather than on problem/solution one. Internal consistency (Cronbach's Alpha) was .74.

SG (Salutogenic Group)

The significant importance of staff groups' comfort and well-being for successful therapeutic programs has been stressed by several researchers (4, 20, 21).

Well-being at work and Sense of Coherence were measured by a form named SG. The form was tested for homogeneity and a two-factor solution was chosen on 16 of these items. Factor 1 was named "Job Satisfaction - me and my job" (9 items). Internal Consistency (Cronbach's Alpha) was .87. One example of the type of item in this factor is "During the last six months, questions of conflicts and different opinions have been solved very unsatisfactorily/very satisfactorily". Factor 2 was named Comprehensibility, Meaningfulness and Manageability (7 items). Internal Consistency (Cronbach's Alpha) was .90. One example of the type of item in this factor is " During the last six months,

it is my opinion that my chores and tasks together with the families I worked with, have been of importance to them".

GC (Group Climate)

GC (22) was filled in by the staff at the IFTU:s including resource personnel. GC consists of a list of 85 words from which one has to choose at least 15 words describing characteristics of a group's climate. Five factors are described: Solidarity, Split, Conflict Avoidance, Structure/Control, Negativism. This test was chosen because it is an established instrument for measuring group climate constructed from the perspective of experienced group processes whereas SG is constructed more from existential hypotheses.

AWP (Attitude Working Profile)

The importance of a clear and trustworthy ideological frame together with an experience from every staff member of being part of and sharing this ideology are considered very important for good outcomes in therapeutic programs (3, 4).

AWP is concerned with staff attitude to its own working profile and is filled in by the staff at the IFTU's including resource personnel. It was constructed by first asking the staff to estimate the usual profile (WP) at their work and afterwards asking for their personal opinion, item by item, about that profile. This attitude was measured by an attitude schedule consisting of ten 10-point rating scales. Each item correlates with total score M .80 range .87 - .71. Internal Consistency (Cronbach's Alpha) .93.

ANK (Attitude to New Knowledge)

The importance of openness to feedback and a flexibility towards change and development in accordance with a constant flow of new challenges from theoretical as well as from empirical perspectives, are considered very important for a staff group (2, 4). This scale was constructed on this issue. However it did not work at this stage and is therefore excluded from further presentation.

Results from internal correlation concerning Group Climate in our study group show agreement with the manual for the Group Climate test (22). Table 3 and table 4 show correlations between Group Climate scales and the other scales and correlations between the new scales. These results are further discussed under "Discussion Instruments".

Table 3: Correlations between the different scales in Group Climate and the other tests (n=69).

G C	WP 1	WP 2	WPA	SG 1	SG 2
Solidarity	-.02	.12	.21	.18	-.15
Split	-.07	-.36**	-.01	-.29*	-.02
Confl av	.08	-.04	-.12	-.18	-.03
Structure	.01	.20	-.10	.15	-.09
Negativity	-.07	-.16	-.13	-.21	-.19

G C= Group Climate, WP= Working profile, WPA= Attitude to working Profile, SG= Salutogenic group. Critical value (n=69) is .23 at 0.5 level of significance and .30 at 0.1 level of significance.

Table 4: Correlations between Working profile-factors (WP), Salutogenic group-factors (SG) and (n 69 out of n 78).

	WP 1	WP 2	WPA	SG 1	SG 2
WP 1		.26*	-.03	-.01	.09
WP 2			-.05	.18	.02
WPA				-.13	-.13
SG 1					.43**
SG 2					

Results

Comparison of units

A comparison of the units will now be made according to the systems-oriented model presented earlier.

Commission

Short resume of referral units' attitudes towards respective IFTU´s (summarised conclusions made by author from answers to 10 open questions RA).:

Unit 1: "The milieu therapeutic setting is an excellent complement to other forms for investigation and therapy." Difficulties are reported concerning continuity in the therapy process when a family has been in the ward for a period and is referred back to the out-patient unit. Unit 1 is also criticised for a non-flexible form for structuring the intensive period.
Unit 2: "One strength is the possibility to join families for a therapeutic process otherwise out of reach for out-patient family guidance." Some difficulties were reported concerning continuity in the therapy process when families were followed up as out-patients.

Unit 3: "The climate of co-operation between referral unit and the IFTU is good. A tendency of diverging interests among personnel at the intensive unit has been noticed recently." This discussion mainly concerns the role of the intensive family therapist and the level and length of responsibility that is placed on the intensive unit.

Unit 4: Representatives from the referring units report a very good climate of co-operation around family investigations. The group at the unit is very competent and people are impressed by the group's ability to formulate the commission in a constructive dialogue.

Unit 5: The family intensive unit offers the possibility for intensive family work in a milieu therapeutic setting. More flexible forms for intensive work are desired as well as a discussion concerning the problem of reconnecting to local resources and continuity in the therapy process.

Unit 6: The treatment structure is important for many families. The competence is high but, of course, limited. Some problems are reported concerning continuity and an inflexible treatment structure.

Unit 7: Special difficulties are reported concerning dialogue and contact. Ideological differences between the outpatient unit's more traditional child guidance perspective and the family therapy unit's family perspective are reported. More flexible forms for using the competence at the unit are asked for in order to increase the climate of co-operation.

Results from the referral attitude form is presented in table 5. We started from a total median value of the attitude to the IFTU of all participating referring units. Each referring unit was then positioned in regard to "their" IFTU as above median (means generally positive to their IFTU) or below median (means generally negative to their IFTU).

Table 5: Results from the Referral attitude form (RA) filled in by the directors of referring outpatient teams. A comparison between units.

Unit	1	2	3	4	5	6	7
Positive attitude	0	2	2	4	1	1	1
Negative attitude	3	1	0	0	3	2	3
(No answer	2	0	0	6	0	0	1)
Total	5	3	2	10	4	3	5

Different attitudes from referrals can be noticed concerning the way the local IFTU meets the expectations from the referring units. Units 2, 3, and 4 seem to meet the referring units better than units 1, 5, 6 and 7. For unit 4 only 40% of referring units answered the questionnaire.

Resources (Treatment Ideology)

Questionnaire Working Profile (WP)

WP was based on hypothetical dimensions according to aspects of the units´ "therapeutic cultures" or "treatment ideology". Results are presented in a two factor solution: Factor 1 "Profile Concerning Structure, Directiveness and Responsibility and factor 2 "Profile Concerning Time, Locus of Change and Problem/Solution Focus".

Table 6: Working profile factor 1 "Profile concerning structure, directiveness and responsibility". Results from different units. Lower values mirror a tendency towards a high and predictable structure in the unit, a directive therapeutic style and taking on a responsibility for change. (N= number of filled in forms/total number of staff.)

Units	N	M	Sd	1	2	3	4	5	6
1	16/18	45.7	(6.7)						
2	5/6	61.4	(6.3)	**					
3	10/10	56.9	(6.7)	**					
4	10/10	40.8	(7.0)			**			
5	07/10	49.8	(7.6)			**	*		*
6	7/7	51.6	(5.8)			*	*	**	
7	14/15	61.8	(5.3)	**			**	**	**
Total	69/76								

1-factor Anova: F = 13.5, P = .0001, * - 0.05. ** - 0.01.

Differences between units were tested. Results of a comparison on factor 1 "Profile concerning Structure, Directiveness and Responsibility" show apparent differences between the units. Units 1, 4, 5 and 6 show lower values and units 2, 3 and 7 higher values. Lower values mirror a tendency towards a high and predictable structure in the unit, a directive therapeutic style and

taking on a responsibility for change. Higher values mirror a differentiated structure, a non-directive reflecting therapeutic style and a shared responsibility with the family.

Differences between units were also tested on factor 2. On this factor, lower values mirror a tendency towards short-time focus, focus on external behavioural change and a problem/solution oriented style while higher values mirror a tendency towards a longer therapeutic process, focus on experience rather than behavioural change and a growth perspective rather than a problem/solution one. Results on factor 2 point out unit 7 as different from the other units with a working profile towards a more non-directive reflecting therapeutic style (1-factor Anova: F= 4.94, P=.0003.)

Resources (other staff-related factors)

Attitude to one's own Working Profile (AWP)

The AWP was measured by a rating scale of ten 10 point scales. The different units' results were compared.

A high rate of satisfaction was registered. Differences between the units were tested. No total differences were seen (1-factor Anova: F-test = 1.95, P= .86.)

In a comparison between pairs, significant differences were found between unit 1 and unit 7(**) and between unit 6 and unit 7(*) * - 0.05, ** - 0.01.

Salutogenic Group (SG)

Factor 1: "Job Satisfaction - me and my job". Factor 2: "Comprehensibility, Meaningfulness, Manageability". Higher scores correspond to higher satisfaction.

Job Satisfaction has been judged as high on all units except unit 3 (One-factor Anova: Factor 1: F-test 2.36, P= .04.). On this factor, a total difference was seen. Unit 3 differed from other units with a lower score (unit 1(*), unit 4 (*), unit 5 (*), unit 7 (**). On factor 2, no total difference was observed (Factor 2: F-test 1.26, P=.29). In a comparison between pairs, a difference was found between unit 6 and unit 7 (*).

Group Climate (GC)

The different units were compared with the test Group Climate. The form was completed by each member of the staff.

Table 7: Group Climate. Comparison of units over the five factors. (N= number of filled in forms/total number of staff.)

		Solidarity	Split	Conflict Av	Structure	Negativism
Unit	N	M (Sd)	M (Sd)	M (Sd)	M (Sd)	M (Sd)
1	16/18	1.7 (0.6)	0.1 (0.3)	0.3 (0.4)	2.0 (1.5)	0.7 (1.1)
2	6/6	1.6 (1.1)	0.3 (0.4)	1.9 (2.1)	1.5 (1.4)	0.9 (1.5)
3	09/10	1.2 (0.6)	1.2 (1.0)	0.8 (1.2)	0.5 (1.0)	0.9 (1.3)
4	10/10	1.2 (0.3)	0.7 (1.0)	1.2 (0.7)	1.5 (2.0)	0.3 (0.8)
5	07/10	1.2 (0.7)	0.8 (0.7)	1.3 (1.7)	1.7 (1.6)	0.7 (1.2)
6	7/7	1.3 (0.5)	0.9 (0.6)	0.6 (1.3)	1.6 (1.5)	0.6 (1.7)
7	14/15	1.2 (0.6)	0.3 (0.5)	0.7 (0.9)	2.2 (1.5)	0.7 (0.2)
Total	69/76					

Solidarity: F = 1.5, P = .18.*Split:* F = 4.0, P = .02.*Conflict Avoidance:* F = 2.23, P = .05.*Structure:* F = 1.33, P = .26.*Negativism:* F = .62, P = .71.

Solidarity: A comparison between pairs shows a significant difference (*) between unit 1 and unit 7.

Split: A total difference was found. A comparison between pairs shows significant differences between unit 1 and 3 (**), 1 and 4 (*), 1 and 5 (*), 1 and 6 (**), 2 and 3 (**) and 3 and 7 (**).

Conflict Avoidance: A total difference was found. A comparison between pairs shows significant differences between unit 1 and 2 (**), 1 and 4 (*), 1 and 5 (*), 2 and 4 (*) and 2 and 7 (*).
Structure: No total difference was found. A comparison between pairs shows significant differences between unit 3 and 1 (*) and 3 and 7 (*).

Negativism: No significant differences were found

Most notable are the differences found between units for factors Split (unit 1 especially low, unit 3 especially high), Conflict Avoidance (unit 2 especially high) and Structure (units 1 and 7 especially high).

Cluster analysis was made on Style- and Climate factors over units (RA, GC factors, WP factors, AWP, SG factors, figure 2). For each factor a 1 or 0 value was scored for respective unit due to an original score above or below the total median value for all units. The two cluster factors were named "Structure" and "Degree of Comfort".

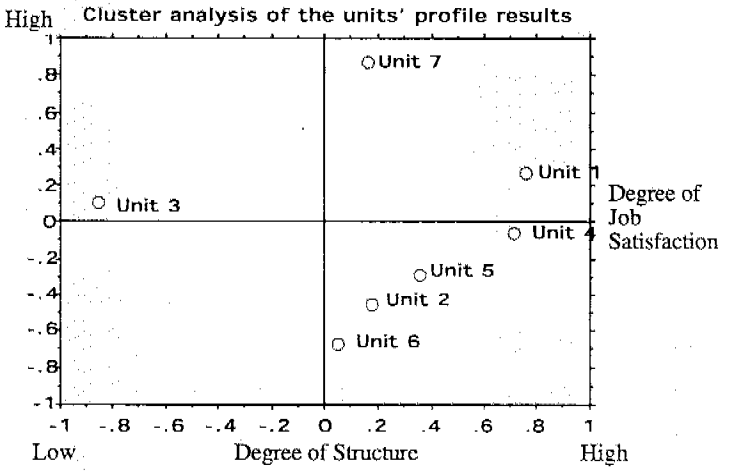

Figure 1. Cluster analysis for Style- and Climate factors over units. The two cluster factors were named "Structure" and "Degree of Comfort".

Three clusters of units may be distinguished, namely, cluster 1: units 1 and 4 , cluster 2: units 2, 5 units 6. Units 3 and 7 differentiate in unique ways.

Discussion

Instruments

Most of the scales developed in order to describe and measure the different IFTU's staff groups' resources and styles, give hope for the future, as they differentiate the units in different ways. However, at this stage they have to be considered and judged as very provisional paths towards a better understanding of potentially important therapeutic factors within Intensive Family Therapy. The validation of the scales is at this point insufficient. The scales are constructed from hypothetical dimensions experienced in a clinical context although there is support from different fields of psychological theory. The proof for generalizability and stability of the scales is of course not at all sufficient at this point and the results must be replicated in order to draw more than tentative conclusions.

However, some comments can be made concerning the results so far.

The significant correlation between WP2 and Split is expected from the fact that a more time-limited and temporary perspective probably puts more pressure on a staff group than a more total therapeutic process with the unit in charge over a longer period of time. If this difference is important for outcome in a shorter or a longer perspective, it will be very interesting, indeed. The significant correlation between SG1 and Split is also expected as "comfortable with my job" reasonably should correlate with an experience of cohesion in the staff group. WP1 is not at all correlated to group climate in line with the central ideas in the systems-oriented model introduced in a previous article (1) where it is stated that comfort among staff and group

climate probably is more related to organisation and structure of the unit. This is also true for WP factors and AWP which do not correlate.

WP1 and WP2 correlate, as they probably reflect a conjoint therapeutic strategy in line with a structural family therapeutic style. As expected SG1 and SG2 correlate to a great extent.

Differences between the IFTUs

The theoretical model described in the previous article (1) seems to be relevant in the sense that it creates guidelines for construction of scales that would seem to capture different styles and profiles at the IFTU's.The differences between the seven units may be summarised as follows: Concerning attitude from referring partners one notices that unit 3 and unit 4 are described in more positive terms than the other units concerning contact and flexibility. The treatment model is often respected, but considered rigid and too highly structured as far as the other units are concerned. It seems as if a balance between accommodation to expectations from outpatient perspectives of how to do therapy and how to find the most constructive ways to get help from a unit for special care, collides with unique experiences within these units about what is needed in treatment programs to this target group of families concerning bonding, intensive caring, structure and endurance. Concerning organisation, three patterns can be noticed. Unit 3 is very closely related to the out-patient clinic with all psychotherapists as affiliated co-workers, while the other units are more independently related to the organisation. To a certain degree this is so for unit 1 and 4. Unit 7 has a very independent position. The described difference is also valid for internal structure and leadership with unit 3 as loosely structured and the other units with varying degrees of a more highly structured way of operating. The time during which responsibility is solely put on the IFTU unit differs. The more independent and resourceful units assume

responsibility for the families for a longer period of time. The comfort, experiences of shared values among staff is also slightly different. Unit 3 describes itself as a group with split and relational difficulties. The other units describe themselves having moderate comfort and units 1 and 7 describe themselves as having a high degree of comfort and a good group climate. It seems also that some of the units count themselves as working according to a structural tradition (unit 1, 4, 5 and 6) while other units see themselves as adhering more to a systemic tradition (unit 2, 3 and 7). Except for unit 3 this difference does not seem to covary with the idea of a fairly highly structured organisation within the unit and between the unit and the partners. The important relationship pointed out in our previously mentioned references concerning a fairly high degree of structure, clear and recognized leadership, clear commissions etc. to comfort issues for the staff, seems to be supported by our study. Another question of special interest, is if it is more informative to look for differences along organisational and structural criterias in understanding effectiveness concerning the IFTU model instead of experienced content differences. The question is whether an available structure containing more general principles for good caring and space for questioning, training and reflecting related to the special needs associated with the selected group of clients referred to these units, is more important than a described specific treatment content related to a specific family therapeutic school?

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V

INTENSIVE FAMILY THERAPY – A WAY TO TREAT MULTIPROBLEM FAMILIES.

A follow up study measuring individual psychopathology.

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Intensive Family Therapy – a way to treat multiproblem families.

A follow up study measuring individual psychopathology.

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

	pre treatment M (Sd)	six months after treatment M (Sd)	t-value	p-value
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

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 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.)

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

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

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 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)	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).

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

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

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

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 selfrated 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.

Clinical significance

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 times	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 %

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 symtom 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 noteably. 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 childrens' 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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INTENSIVE FAMILY THERAPY

- a way to change family functioning in multiproblem families.

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Abstract

Intensive Family Therapy

- a way to change family functioning in multiproblem families.

A single group treatment outcome study of Intensive Family Therapy (IFT) is presented. 109 families from 5 Swedish units participated and results on family measures for 86 of these families are reported. This multi-center study is the largest study so far of this treatment model. The units offered a full day multi-impact treatment program for families during an intensive period of approximately one month preceded by a period of extensive planning. Measures used were the self-rating "Family Climate" and Family Relation Scale and observer rated CRS-Turbo and the Beavers Scales. Significant changes in the direction towards a better family climate and a higher family functioning occurred. Given the very difficult circumstances of these multiproblem families the results are considered promising.

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

Running headline: Intensive Family Therapy

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Introduction

Intensive family therapy is defined in this project as a method to treat the whole family in an full-day treatment setting during a period of 3-4 weeks. Our way of working was inspired by writings on the effectiveness of a multi-systemic perspective (Henggeler et al., 1995, MacGregor, 1962, Hallström, 1991, 1992). For the milieu work we used techniques from earlier reports on therapeutic communities (Kennedy et al., 1987, Gillis et al., 1989, Jones, 1970, Feldman, 1970) and the "Flying teams in Norway" (Haugsgjerd, 1974). The therapy methods used have been based on structural, strategic and systemic family therapy and milieu therapy (Minuchin 1974, Minuchin and Fishman, 1981, Haley, 1980, Boscolo et al., 1987). A treatment team trained in family therapy and consisting of psychologists, psychiatrists, social workers, pre-school teachers, school teachers etc. works together with the family and referring institution in a co-ordinated multi-impact approach. The intensive, multi-impact approach could be said to be the trademark of the treatment model. Milieu therapy and the family therapy are seen as complementing each other. Themes discussed in the sessions are worked through in practical exercises and daily activities in different environments. For example if a single mother has lost control and authority as a parent in a chaotic family system this can be focused on in a family therapy session. The mother can then practice being in control, supported by the therapists, by visiting a supermarket together with her children and negotiating what to buy and not to buy. The feelings and thoughts evoked in each family member by the new parental role performance are then discussed in a family therapy session. The mother is encouraged to practice her new hierarchical position in various daily situations, until it has stabilised. The same theme may later be discussed between mother and the therapeutic team together with the local network consisting of pre-school teachers and other supportive resources. Although

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

The aim of this study is to present the evaluation of intensive family therapy using multiple methods to assess changes in the family system in a large multi-location project.

Method

Participating families

A total of 109 families from 5 treatment units participated in this study and went through an intensive treatment program. Participation in the study was voluntary. All families attending the units during 1993 - 1994 were invited to participate in the study. The criteria of exclusion were difficulties with the Swedish language to such an extent that it was not considered meaningful for the families to fill in the questionnaires (n= 8) and families who felt extremely insecure or threatened by participating in the study (n= 5). A few families were excluded as they broke up in the course of the study. In some cases the family or family members moved from the district or other changes occurred making further contact with the project impossible (n = 4) . 86 (79%) of these families were followed up.

The included treatment units were not randomly chosen but consisted of established Intensive Family Therapy Units (IFTUs) in Sweden. The five units participating in the study were all organised in a similar fashion. The families under treatment were referred from outpatient-units, where they most often have received family-oriented therapy on an outpatient-basis without satisfactory results.

The IFT included a period for planning and preparation; an intensive period with daily treatment contact for about one month and a follow-up period with extensive contact between the family and the unit during 2 - 6 months. Participating units employed between 7-15 and treated between 12 - 40 families per year (Sundelin , 1998,b).

The single parent family was the most common at all the units (53%), nuclear families 31% and step families 16%. In general, the families were sociocconomically underprivileged with a high degree of unemployment and dependency on social welfare and a low educational level. The average of the families in our study (3.3 members) corresponds to what is common in Sweden, but must be understood in the light of the relatively high number of single parent families in our sample. The average age of the mothers was 37 years (Sd 7.3). Boys were identified as IPs more commonly than girls (n=boys 70, n=girls 39). The average age for the children was 10.8 years (Sd 3.8). In 60 % of the cases conduct problems were the presenting complaint. The remaining 40 % were distributed equally among internalised problems and other problems such as attention problems and social problems, which are not easily categorised as either acting-out or internalisation.

Instruments

Family climate. The Family Climate Test consists of 85 adjectives describing the family's current emotional climate (Hansson 1989). Factor analysis reveals four factors: Closeness, Distance, Expressiveness and Chaos. The test - retest reliability is satisfactory (three weeks r = .95, 5 months r = .89) and Cronbachs alpha was for Closeness .98, Distance .91, Expressiveness .71 and Chaos .92 (Non-clinical group, n=123) (Hansson, 1989). On Closeness a high value indicates a nonclinical position, on Distance and Chaos a low value indicates a nonclinical position. The Expressiveness factor is not reported in this study as it did not function satisfactorily either here or in earlier studies (Sundelin et al.,1991).

Family Relations Scale. (FARS) (Cederblad and Höök, 1992) also measures family functioning. The rating scale consists of 46 statements about "my family" that the person filling out the test has to take into consideration as to

whether the statements fit or not. Factor analysis gave five factors: Attribution, Interest, Isolation, Chaos and Enmeshment. Alpha-coefficients and stability over time have shown that FARS has a high reliability (Cronbachs alfa .90 for mothers and .89 for fathers). Covariance between this measurement of family functioning and other family measurements and also the differences between the clinical and non-clinical samples on this measure demonstrate that the validity is satisfactory (Cederblad and Höök, 1992). A low value indicates a nonclinical position.

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

Beavers' Observational System Scales. The scales emanate from Beavers - Timberlawn family model (Cederblad and Hansson, 1989). The two scales are Family Competence and Family style. The higher the value on the Competence scale the higher the family's competence and level of functioning. The Family Style scale relates to the family's way of interaction. The scale goes from a centripetal tendency (satisfaction is sought within the family, high values) to a centrifugal tendency (satisfaction is sought in the world outside the family, low values). A global rating measurement for each scale is also established. In

earlier studies, inter-rater reliability of the scale Competence was r=.94 and for Style r=.79 (Hansson, 1989, Cederblad and Hansson, 1989).

Procedure

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

Results

The selfrating instruments Family Climate and FARS were scored by research assistents at the local IFTU and later coded according to the manuals. Observer ratings of family function were checked initially for inter-rater reliability. Ratings were made by two raters for each of forty-two families. Correlations of ratings for all the dimensions of the CRS-Turbo and Beavers' Observational System Scales ranged from .80 - .97 indicating good inter-rater reliability. Dependant t-tests were used to assess the significance of clinical changes from pre-treatment assessment to the assessment occurring six month after the beginning of treatment

Family Climate

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

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

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

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

Statistically significant changes in the expected direction occurred on all scales except on fathers closeness. The change is most profound on the mothers' ratings. The total results from this scale give strong support for the effectiveness of treatment.

FARS

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

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

FARS	pre treatment		after 6 months		t-value	p-value
	M	(Sd)	M	(Sd)		
Attribution						
Mothers (81/86)	3.54	(1.88)	2.77	(1.97)	3.08	.003**
Fathers (41/63)	2.81	(1.91)	2.30	(1.99)	1.57	.12
IP > 11 years (29/60)	2.68	(1.89)	1.80	(1.59)	2.42	.02*
Interest						
Mothers (81/86)	5.47	(3.16)	4.52	(3.00)	2.27	.012
Fathers (41/63)	4.69	(3.30)	4.40	(3.25)	.80	.42
IP > 11 years (29/60)	5.41	(3.29)	4.00	(3.27)	2.27	.03*
Isolation						
Mothers (81/86)	4.26	(3.85)	3.07	(3.24)	3.81	.001**
Fathers (41/63)	2.64	(2.53)	2.52	(3.26)	. 61	.54
IP > 11 years (29/60)	4.32	(4.01)	2.97	(3.52)	2.48	.02*
Chaos						
Mothers (81/86)	4.83	(3.46)	3.53	(2.92)	4.08	.0001***
Fathers (41/63)	4.07	(3.32)	3.38	(3.48)	2.10	.04*
IP > 11 years (29/60)	5.00	(2.95)	3.66	(2.70)	2.75	.01**
Enmeshment						
Mothers (81/86)	5.65	(3.07)	4.17	(2.75	4.23	.0001***
Fathers (41/63)	4.75	(3.19)	4.40	(3.50)	.48	.63
IP > 11 years (29/60)	5.15	(3.05)	3.28	(2.25)	3.66	.001***
Total						
Mothers (81/86)	35.82	(17.89)	27.21	(16.94)	5.47	.0001***
Fathers (41/63)	29.55	(16.64)	25.03	(19.22)	2.26	.03*
IP > 11 years (29/60)	34.53	(18.69)	23.62	(16.18)	2.97	.001***

Self-rated improvement of family functioning according to scores on the FARS occurred. This is most obvious for the mothers but also for the identified patients and, to a somewhat lesser extent, fathers. Table 2 shows strong support for the hypothesis that family members can benefit from the treatment as family functioning develops in a more positive direction.

CRS-Turbo and Beavers' Observational System Scales

Ratings of 42 families' patterns of functioning according to CRS-Turbo and Beavers' scales are presented. Of a potential number of 73 families treated at four of the five units, 66 families agreed to participate. Later, 42 of these families were followed up. As the scales Adaptability, Cohesion and Family Style are supposed to be non-linear we have constructed a "deviance index" i.e. each rating's deviance from a predefined normal value (Adaptability and Cohesion M= 15 and for Style M= 26) (Thernlund, 1996). This means that the lower value the more close it is to a non-clinical value. These results are presented in table 3.

TABLE 3 *Results from the CRS-Turbo and the Beavers' Observational System Scales. before treatment and six months post treatment.*

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

Note: n= 42 in all analysis.

The results from the CRS-Turbo and the Beavers scales show statistically significant changes from a dysfunctional position to a more functional one on all subscales except the CRS-Turbo hierarchy scale and the Beavers global style scale.

Clinical significance

As far as clinical significance over the treatment period is concerned, we looked for large changes in the families in the expected direction in Family Climate and FARS. Cases were classified as improved if their scores changed by one standard deviation in the expected direction over the course of treatment (Family Climate: Closeness Sd= .63, Distance .23 and Chaos .21

Hansson, 1989) and FARS Sd 11 (Cederblad and Höök, 1992). We found that the mothers rated family function after six months as being much better than at the start of treatment. On Closeness 48%, Distance 57% and on Chaos 56% of the mothers rated family function as changed to the better. On FARS 45% of the mothers rated a positive change. 29% of mothers rated a positive change on three out of four of the variables in Family Climate and on FARS total.

We were also interested to see if self rated-family functioning changed from a clinical to a non-clinical position over the course of treatment. Critical values for clinical and non-clinical positions were chosen as M + - 1 Sd according to values for non-clinical groups (FARS M= 13, Sd + - 11 (Cederblad and Höök, 1992);

Family Climate: Closeness M=2.0, Sd + - .63, Distance M=.30, Sd + -23, Chaos M= .20, Sd +- .21. (Hansson, 1989); Adaptability M= 15.0 +- 2.5, Cohesion M= 15.0 +- 2.5, Hierarchy M= 1 +- 1, Competence M= 36 +- 7.0, Style M= 26 +- 2.5 (Thernlund, 1996).

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

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

Note: FARS and Family Climate Scales are based on mothers report only.

From tables 4 it can be seen that on the Family Climate, the FARS, the CRS-Turbo and the Beavers Scales a number of the mothers rated their family functioning as clinical on both occasions (15-47 %). We also found, however, that several of the mothers rated a change (35-45%) to a non-clinical family functioning on Family Climate. On the two observer rating instruments we noted that between 29 - 40% of the families were rated as moving from a clinical to a non-clinical position on the different scales. About 50% of the families were rated as clinical on both occasions.

Discussion

In terms of family functioning as measured by Family Climate and the FARS, it is evident that there are improvements for a number of the families during the treatment period. These changes are most obvious from the mothers' perspective, but are also reported for the fathers and the children who filled in the questionnaires. From the results from CRS-Turbo and Beavers' scales, we also found a shift among the participating families towards values indicating normalisation. In this case it was usually a shift from Disengagement and Chaos towards a higher Structure, Cohesion and Competence. It could be argued that such extreme values shown by these families can only change in one direction, to a more positive one (regression to the mean). However the positive results from the treatment program were also verified by the clinical significance of results.

Clinical research on IFT or similar treatment models has so far been very rare, especially with an international perspective. Reports of pre-post-treatment designs are even more rare. To our knowledge, this is the first study including standardised measures of family functioning, both self-rating and observer-ratings, before and after treatment in the study of intensive multi-impact therapy. To be able to report any constructive changes at all in this group of multi problem and treatment resistant families is in itself very positive.

The drop-out in this study is high (21%) but compared to similar studies it is not that remarkable (Borduin et al., 1995). In many studies of multiproblem families there is a drop-out rate between 25 and 50 % reported. However, the drop-out only concerns participation in the study as very few families broke off their engagement in the actual therapy. This fact itself describes a

problematic reality that the clinical researcher is challenged with when collecting information and supervising the research process at the units. The pre-treatment data on the group that was not followed up, did diverge from those of the group that participated during the whole period. This means of arguing for representativity despite a high drop-out rate has also been used elsewhere (Borduin et al., 1995) and points out that the drop out group does not systematically differ from the outcome group. Drop-out can be understood not as the most difficult families leaving the study but on the basis of several factors, such as, insufficient routine among the staff concerning the collection of information, resistance to participating in the project by some of the staff, more time pressure and stress during certain periods.

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

In this study we report on family functioning as it is experienced by family members and by independent observers. Difficulties with self-report methods are obvious and it has occurred to us that fathers and mothers have very different experiences of the family. This may be a gender specific finding as in this study the fathers' views of the family are closer to non-clinical families. In

that respect they have no reason to change! Maybe the fathers wanted to protect the family by reporting a non-clinical picture or it may be that the fathers knowledge of the family is limited to the unproblematic part of the families' life. These are matters that can only be adressed by further study.

In conclusion the Intensive Family Therapy Treatment which was assessed in this study has been demonstrated to lead to improvement in half of the families. The results from the two perspectives harmonise and fortify each other. The families have gained considerably in functionality according to our measures. When offered to families difficult to treat in less intensive settings it may be a valuable model. However, since half of the families were still considerably dysfunctional at the follow-up, they would benefit from continued support in a long term treatment programme including "booster doses".

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