Family Ward: A New Therapeutic Approach
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Abstract. This article describes a new integrated child psychiatric family ward treatment model at the Tampere University Hospital. Theoretically, the treatment is based on an integration of systems and psychoanalytical theories as well as behavioral approach. A centerpiece of the model is a 3-week treatment period for the whole family at the family day ward. The work of the multidisciplinary team on the ward focuses on family relationships, on representational level, and on the interactional behavior of the family. Interaction and relationships are also used as tools, including a reflective working model and sharing concrete interaction with the family. So far, the family ward has offered 165 family treatment periods for 113 different families. Altogether in 63% of the total treatment periods one or both parents have had mental illness and in 15% of the total treatment periods there have been serious custody disputes with accusations of sexual abuse of the child. Helping these multi-problem families is a special challenge for our treatment model and at the moment we are developing new methods for assessment and support of parenthood. (Keio J Med 48 (3): 132–139, September 1999)

Key words: Psychiatric family treatment, multi-problem families, deficient parenting

Introduction

In Finland child psychiatry has an exceptionally long and remarkable history; the first child psychiatric department in Europe was opened in Tampere area as early as 1927. Today, Finland has 15.1 child psychiatrists per 100,000 under twenty year old inhabitants which is the second highest figure in Europe. These facts reflect both the value and status that children have been given in our society and the increasing concern over mental health problems in children and during childhood.

However, even in Finland the need for child psychiatric services has been clearly greater than available resources. In this situation the fairly long treatment periods both in outpatient clinics and especially in hospital wards and long queuing times common in child psychiatric field have been criticized. Also, the fact that the time from the first signs of a child's mental distress or disorder to the point when she or he is really given professionally help and care could take years, is unethical and inefficient. There has been, and still is, a clear need for new treatment models especially for early interventions.

In the Child Psychiatric Department at the Tampere University Hospital, which provides services for a total population of 440,900 inhabitants, we opened a new child psychiatric family ward five years ago in December 1993. The reasons for developing an integrated family treatment model came from several sources. First, the new and rapidly growing research evidence really stresses the importance of early family interventions especially during infancy and toddlerhood when interaction and relationships between a child and her or his caregivers are developing. Attachment research has indicated that the quality of the attachment relationship shapes and organizes the child's behaviour both in her or his early years, and later in life. Second, there are preliminary results indicating that early, relatively short interventions might prevent later psychopathology in children by changing undesirable family relationship patterns. Published case studies on treatments with focuses on the child-caregiver relationship have been encouraging. Finally, Finnish child psychiatry is heavily family orientated and family therapy is the most widely practiced and high quality therapy method in our country. Also, family interventions tend to be shorter than other treatment models.
The fact that Finnish families consider the role of the whole family essential to the well-being of the children made it possible to plan new resources for family intervention.

Our family ward is a day ward with capacity for two families at a time. The staff consists of a child psychiatrist and a head nurse, who have joint responsibility for the ward; a junior child psychiatrist who is undergoing specialist training, a psychologist and a social worker, who are highly qualified family therapists, and five nurses with child psychiatric and adult psychiatric expertise. The ward has nicely decorated homelike premises with a living room, a kitchen, two family rooms, family and interactional therapy room with a one-way mirror and video equipment, a water playroom for young children, a multipurpose room for different kinds of activities, and some office facilities.

In Finland the costs of children's hospital treatments for the family are quite low. So, the three weeks' family ward treatment costs for the family about FIM 430 (US$80). The overall costs of this treatment are about FIM 73,500 (US$13,675) which is paid by community's tax money. Most of the parents apply during the treatment period for three weeks' unpaid leave from their work and the National Insurance Institute recompenses them for the loss of earnings. Some parents use their vacation, some parents are unemployed.

Theoretical background

The theoretical background for our integrated treatment model in the family ward is, first, based on systems theory and on its family therapeutic modifications. The other cornerstone for the treatment model is, of course, psychoanalytical theory. Psychoanalytical thinking offers possibilities to understand human beings as individuals and systems theory helps to understand the relationship context in which interventions are carried out. Also cognitive learning theories and their behavioural modifications are included in our integrated treatment model to make practical working in the ward possible.

Our bridge between different theories, especially between systems and psychoanalytical theories is in the first place based on interaction and relationships. We have found therapeutically useful integration between Wynne's9,10 views on relational systems and Emde's11,12 ideas on the parent-child relationship. In our treatment model, we make considerable use of interaction and relationships as tools to understand and intervene in interaction and relationships. In our family ward the staff works in pairs at all levels: a pair of primary nurses, a pair of family therapists, and a pair of persons in charge interact with the family and with each other at all time. We also use trios and bigger teams to make a more complex interaction and relationship context possible, but working pairs (like couples) is the basis.

To make this integration concrete and therapeutic, we have found Tomm's13 views on reflective working most useful. The pair of primary nurses and the family in the ward work together through a circular reflective process using two-way "feedback" discussions. The family therapists also use a reflective working model during their sessions, and in case conferences the whole staff uses reflective double teams.14

The second mode of integration in our treatment model is based on the developmental viewpoint.15 The developmental phase of a family and developmental stage of a child are combined and parallely proceeding processes, which continuously have impact and reflections on each other. Parenthood is also seen as a growth process in adults influenced by a child's psychobiological maturing. The parent-child relationship is a developmentally changing relationship and this special in-built reality offers a family natural possibilities for changes.

The third mode of integration deals with combining theoretical thinking and practical working. It is not just using a theory and its therapeutic techniques in therapy sessions. This integration means more profoundly and concretely combining shared live interaction between the family and staff members and using theoretical thinking to achieve joint understanding. In this integration openness is essential, actually, we think that openness is a key element in our treatment approach.

The Family Ward Treatment Model

This model consists of four separate phases. First, the preadmission phase; second, the family inpatient period; following that the information transfer meetings; and finally, the follow-up phase (Fig. 1).

Preadmission phase

The referral starts the preadmission phase, during which the family is seen four times. The first family visit to the ward is an interview, in which the referring team members also participate. In the interview led by the senior child psychiatrist and the head nurse, the family and the referring team openly discuss the problems they are concerned about and that have given rise to the referral. All participants together assess the problems and evaluate the suitability and effectiveness of this treatment approach. The aims and objectives for the treatment are jointly defined by the family and the professionals and the decision about coming to the ward is made.

The other family meetings during the preadmission
phase focus on detailed planning of the treatment, for example, choosing one to three main problems that the family wants to work on. All participants involved discuss what kinds of changes the family wants to make, how to see if a change takes place, and how to measure and assess these changes. During the preadmission phase, the family therapeutic process starts with the first family therapy session. The last of the preadmission meetings is a home visit made by the pair of primary nurses. At the home visit, the living conditions, lifestyle, and social network of the family are observed and discussed.

The overall aim of the preadmission phase is to promote the family’s motivation and commitment to the changes they themselves want. It is important that the change is worked out in such detail that the family will get a positive experience of change in their daily life. Getting acquainted and “joining in” is another important task of this phase. In-depth discussion and definition of the aims and the focus of the treatment with the family and the referring team is important to achieve the openness necessary for this treatment model and for the short intensive treatment period to be successful.

Family inpatient period

The main tasks of the family inpatient period are the diagnostic assessment of the referred child, the evaluation and diagnosis of the family relationship patterns, strengths and problems, assessment of parenthood and, further, based on all this, designing and carrying out the family interventions to improve family functioning. The first challenge for the team, however, is to form a good working alliance and stable holding environment with the family.

The pair of primary nurses and the junior child psychiatrist constantly work closely with the family and form a subteam, whose thoughts, feelings, and experiences regarding the family are reflected by the other team members. In this way the rest of the team is involved in the treatment indirectly by participating in the therapeutic reflective team process. The child psychiatrists make the individual child psychiatric evaluations and the pair of family therapists evaluate the family in their sessions.

The family inpatient treatment is a 3-week period, during which the family stays at the ward every weekday from about 9.30 a.m. until 2 p.m. The daily program is planned by the family and the subteam. The days are structured around jointly agreed focused issues: therapeutic discussions, different kinds of shared activities, shared meals and coffee, and some free playtime for the children and parents.

The quality of the relationship on the representative level, the quality of the observed interaction and relationship patterns, and the past relationship history of the child and the family are studied carefully. The assessment of the family interactions and the interventions for improving the family functioning are carried out in basically two ways. One way to address the family relationships is the so-called functional sessions, which is a new method and possible only in the family ward context. At the 90-min functional session, the family members and the pair of primary nurses participate together in a formerly agreed activity, which is usually a typical family activity during their leisure time. The most used activities are games, music, sports, handicrafts, or baking and cooking in the kitchen. During the intimate interaction of these shared activities, the primary nurses observe, assess, and concurrently
carry out interventions focused on the strengths and problems of interactional behaviour observed. Through this sharing, a better and more concrete understanding of the dynamics of the relationship problems is reached and productive and appropriate ways to intervene is found.

The other way to assess and intervene is the method of focused therapy sessions. The pair of family therapists usually meets the family three times, once during the preadmission phase and twice on the ward. The applied method is a reflective model, where the pair of therapists openly discuss their thoughts and ideas in front of the family during the session and the family reflects and evaluates their discussion. Understanding the function of the symptoms in the systemic context of the family, exploring the family relationship history, and evaluating the family’s current situation from the viewpoint of family’s developmental phase are examples of the focuses of family therapy on the ward.

In this way it is possible to work simultaneously at different levels, on the concrete level using direct guidance, support and assistance of parental functioning based on behavioral therapeutic approaches, and on the more representational level through family therapeutic discussions.

Circular process and reflection – How the team and family work

Once a week all the information gathered and the evaluations made by different workers are discussed by the whole team in a case conference. This multiple information is integrated into a holistic and comprehensive understanding of the current situation of the referred child and the whole family. The problems and strengths of the child and the family are also defined. Based on this evaluation, the focus of interventions and the best interventions techniques are chosen.

The first case conference concentrates (1) on the diagnostic assessment and hypotheses, (2) on defining the focuses of the interventions, and (3) on choosing the intervention techniques to be used on the ward. In the second case conference (1) diagnostic hypotheses are re-evaluated, (2) diagnoses, when appropriate, are given for the referred child or for the family relationship pattern, (3) interventions and methods used are evaluated, and (4) further interventions are planned. In the last case conference (1) further treatment or support are planned, and (2) treatment period is evaluated. The hypotheses, ideas, and suggestions from the weekly case conferences are immediately shared with the family and worked on by means of a more open dialogue than has earlier been possible in the outpatient or inpatient context. Through this continuous sharing and dialogue, the family is involved in the intensive process of evaluation and intervention. The components of the family ward treatment period form an intensive process, which is characterized by continuous therapeutic reflection, circular proceeding, and the use of the multidisciplinary team (Fig. 2).

Information transfer meetings

In addition to being an intensive relationship intervention, the 3-week period gives the family and professionals a huge amount of new insight, understanding, and ideas to be used, if needed, in the further treatment of the family.

At the end of the 3-week period, need for further treatment or support is discussed with the family. The professionals, who will continue to follow-up and work with the family, are invited to one or two meetings. In these information transfer meetings, the knowledge, understanding, and experience is shared by the family and the staff with the visiting professionals. With multi-problem families, the final meetings are large network meetings with professionals from many different sectors of health-care, social, and educational organizations. The agreement and definition of responsibilities are important tasks in these meetings to help and further support the family in a meaningful and appropriate way.

Follow-up – later reflection

Six months after the treatment the family is interviewed by telephone or by mail. The family’s experiences, opinions, and evaluations of their treatment are ascertained. How did the family feel about their stay at the ward? What is their opinion now about achieving the aims and objectives of their treatment? Has something changed? What kind of changes do they see in their daily life? The child’s current situation is evaluated by a standardized questionnaire. The therapeutic aim of the follow-up interview is the improvement of the family’s ability for self-assessment and the promotion of the family’s ability for self-reflection. One aim is also to strengthen realistically the family’s confidence in their ability to change.

Experiences of the Work Done So Far

The family ward has so far offered 165 family treatment periods for 113 different families. The amount of second or repeated treatment periods (interval periods) for severely disturbed or multi-problem families has been increasing during these five years and it is now 31% (52 of 165) of the total of treatment periods. About half of the treatment periods have been used by single-parent families. Except for the majority of small
single-parent families, the variation in family size has been wide, up to families with eight members. The educational level of parents has varied from very low to academic, the social status has also varied greatly.

The referred child has been a boy in 66% (109 of 165) of the treatment periods, so boys have been over represented in the number of identified patients, which is a common situation in child psychiatry. The age distribution of the referred children during these five years has changed toward younger age groups (Table 1), which has been one aim of the new treatment model. Interestingly, the majority of referred boys have been preschool age (4–6 years in Finland) while most girls have been younger, infants and toddlers (Table 1). The

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**Table 1** The Distribution of Age and Gender of Identified Patients Since The Opening of The Family Ward

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problems of the referred children have varied from a symptomless situation (about one fifth of the referred children) to an adjustment disorder or further to psychotic or autistic symptoms, severe psychosocial deprivation, or sexual abuse. The main diagnoses given to the identified patients (referred children) are presented in Table 2, according to the diagnostic classifications ICD-10 and DSM-IV.

All families who have used our family ward have also had more or less severe problems in the whole family connected with problems of the referred child. So far, in our medical records only the main diagnosis is easily available, and the family problems are seen in records only if the referred child has no separate main diagnosis. In 24% of the treatment periods the main diagnoses have been the DSM-IV Axis IV diagnoses revealing family relationship disturbances or psychosocial problems of the family, severe problems in child rearing and parenting or family crises and negative life events.

**Mentally ill parents**

In 36% (41/113) of the families treated in our family ward one or both parents have had a psychiatric diagnoses and separate treatment before coming to the family ward. In addition to this in 13% (15/113) of the families one or both parents have been given a new referral to adult psychiatric treatment during the family ward treatment by a consulting adult psychiatrist. Since these mentally ill families have often been severely disturbed they have most often been given a new interval treatment period or several periods likewise in our family ward. So, altogether in 63% (104/165) of the total treatment periods one or both parents have had mental illness. Mentally ill parents have indeed been a specific challenge to our treatment model.

In our experiences there are two main issues that need to be seriously taken care of when working with the mentally ill families. First, one should have a special focus on the referred child (or children). During the family treatment period one of the main tasks is to raise and emphasize the viewpoint and developmental needs of the referred child and also other children in the family. Assisting, supporting and guiding deficient parenting in concrete everyday situations during functional sessions is important but not enough if it is not connected with a parent’s deeper understanding and an improved motivation to see the child.

In mentally ill families children’s problems are often almost “psychotically” denied because of unbearable anxiety and guilt, but when the whole family is in intensive care and in a holding environment parents are more able to face these painful questions. Also, clarifying structures and boundaries of the family, especially between adults and children, is helpful. Asymmetrical sharing of parental responsibilities during the symptom
episodes of the sick parent is often needed.

The other issue that should be focused on, is to support the adult treatment of the mentally ill parent. Regular psychiatric consultation and co-operation with the adult psychiatric unit responsible for the treatment of the sick parent must be continuous and well-functioning. We have found it helpful if adult psychiatrists have used a psychoeducative working model with psychotic families as a part of adult psychiatric treatment.16

Custody disputes and allegations of sexual abuse

Another challenge for our treatment model has been families with serious disputes between divorced parents over the custody of the child (or children), combined with accusations of sexual abuse of the child by one of the parents (15% that is 24 of the 165 treatment periods). In these families a continuous, cruel fight between parents and legal processes lasting for years with demands for repeated new assessments put the child (or children) in a difficult and traumatizing position. For these families we have offered a separate assessment and treatment period for the mother with the children and the father with the children. In order to avoid a split and coalitions, which are obvious around the child and even around the family, within the team it is important that the same people will be responsible for both treatment periods.

In to our experiences with these families it is necessary first to ensure the safety and well-being of the child in co-operation with the child protection services. Then we try very carefully to listen and see what the child him- or herself is telling when being with the mother, with the father and alone. As a whole it is important to bring all parties concerned to the same negotiation table and to emphasize the treatment needs of the traumatised child (or children).

We have also had some physically abusing families in our ward and so far our experiences with these families have been positive. If the family is able to speak openly about their problem and is motivated for this treatment program, the results seem to be good. Quite often the family is relieved that they are allowed to speak and that some one is really trying to help and support them to find better interactional patterns.

Conclusion

The family ward has existed now for five years, which is a quite short time when one is evaluating effectiveness of a treatment model, especially with young children and with a developmental viewpoint. However, preliminary outcome results are encouraging. The model seems to be both curative and probably markedly preventive. The treatment model is well accepted by families in need and also by referral organizations up to the point that our family ward now has a year long queue and therefore we are planning to increase our capacity and resources for this work.

The feedback from families has been personal and diverse, relating to the individuality of families and uniquely tailored treatments. The majority of positive comments have concerned the improvement of family relationships and the practical support and advice that the family has received. Negative comments have been fewer and even more varied concentrating, however, to some extent on the intensiveness and exhaustiveness of the treatment period.

The most urgent challenge for our treatment model is to further improve the assessment and support of parenthood and parenting patterns in multi-problem families. Treating families with serious impairments in parenthood and parenting has guided us to develop a long-term treatment model, where we use interval treatment periods based on developmental viewpoint. Also, we must be ready when needed to make serious decisions advising child protection services to take the child (or children) into custody early enough to be preventive. At the moment we are developing a specific Family Assessment Program for Parenthood (FAPP) method for evaluation purposes. Still another challenge, also in progress, is to develop an outpatient family treatment model with home hospitalization to be used flexibly in parallel with the present model.

References

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