Utilization of Individual versus Family Therapy Among Adolescents with Severe Emotional Disturbance

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Abstract

The present study investigated service utilization of individual and family therapy services among children with severe emotional and/or behavioral disturbances. Participants included 89 children and families, interviewed at two time points across a 6-month period. Results indicated that children received a greater number of individual therapy sessions than family therapy sessions. Paired samples *t*-tests indicated that children significantly decreased their levels of internalizing and externalizing behaviors across 6-months. Hierarchical multiple regressions indicated that family therapy was associated with decreases in internalizing behaviors when children reported outcomes. Individual therapy was not associated with changes in either internalizing or externalizing behaviors regardless of reporter. Additionally, caregivers did not report significant change in their own levels of depression or empowerment across the 6-months. Recommendations and implications for future work are offered.

Introduction/Background

Individual Therapy

- Individual-based treatments encompass treatment modalities that focus on the targeted youth for therapeutic change
- Youth psychotherapies produce both specific improvements directly related to the presenting problems as well as global improvements on development over time (Weiss et al., 1987, 1995), with effect sizes ranging from .71 to .79, with the average treated child functioning better than 75% of control group children
- Only about 5%-10% of children and their families utilize outpatient individual-based therapy services (Burns, Hoagwood, & Mzazek, 1999)

Family Therapy

- Family-based treatments include "any modality involving parents as essential participants in treatment" (Diamond & Josephson, 2005, p. 874).
- There is "a stunning lack of research on what has classically been defined as family therapy in regard to childhood disorders" (Estrada & Pinsof, 1995, p. 433)
- Family therapy proven effective and produces results that are *at least* comparable to child-based interventions, with overall effect sizes around 0.53 (Rutter et al., 1976; Stanton & Shadish, 1997)

Family Outcomes

- Child-focused therapy leads to improvements in parental symptomology and family functioning (Kazdin & Wassel, 2000)
- Family therapy might lead to improvements in child symptomology *as well as* parental symptomology

Purpose of Present Study

The current study examines service utilization of individual and family therapy, as well as how these services relate to changes in both child variables (i.e., internalizing and externalizing behaviors) and family variables (i.e., caregiver depression and family empowerment).

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Hypotheses

1) Children would be more likely to receive individual therapy than family therapy.
2) Children would benefit more when they receive a combination of family and child therapy compared to child therapy alone.
3) Caregivers who participated in family therapy also would achieve treatment gains in terms of a decrease in depressive symptoms and an increase in empowerment.

Method

Participants

- Youth and primary caregivers ($N = 89$) (75% boys; 25% girls)
- All youth were identified as highly "at-risk" (DSM-IV diagnoses, functional impairment, out-of-home placements)
- Youth age at intake: ($M = 11.83$, $SD = 2.40$), range 6-to 17-years-old
- Ethnicity (42% African-American, 58% European-American)
- Family income: 43% (< $15,000); 57% (> $15,000)

Procedure

- Clinical sample referred to their local community mental health agency
- 2-hour In-Home interviews were conducted with the caregiver; 1-hour In-Home interviews were conducted with youth
- Caregivers were paid $25 for baseline interviews, and $30 for follow-up interviews
- Interviewed at two separate time points, 6-months apart

Measures

Demographics – Primary Caregiver Report

- Descriptive Information Questionnaire (DIQ; CMHS, 1997)
  - Child and family characteristics such as age, race, ethnicity, risk factors, family structure, custody status, and referral source

Individual and Family Therapy Estimates

- Multi-Sector Service Contrast (MSSC; CMHS, 2000)
  - "Did your child receive medication treatment?" (as a control variable; dichotomous variable); "How many individual therapy sessions did he/she receive during the last six months?"; and "How many family therapy sessions did you receive during the last six months?"

Internalizing and Externalizing Behaviors – Caregiver Report

- Child Behavior Checklist (CBCL; Achenbach, 1991)
  - Utilized *T*-scores from the Internalizing subscale and Externalizing subscale
  - All α's >.82

Internalizing and Externalizing Behaviors – Child Report

- Youth Self-Report (YSR; Achenbach, 1991)
  - Utilized *T*-scores from the Internalizing subscale and Externalizing subscale
  - All α's >.82

Caregiver Depression

- Center for Epidemiological Studies-Depression (CES-D; Radloff, 1977)
  - 14 items (e.g., "how often have you been sad?")
  - 3-point scale
  - α = .78 at T1; .84 at T2

Family Empowerment

- Family Empowerment Scale (FES; Koren, DeChillo, & Friesen, 1992)
  - 34 items
  - 5-point scale
  - α = .90 at T1; .95 at T2

Results

Paired Samples t-Tests Examining Change Across 6-Months.

Comparisons	*t*	*df*	*p* value	Index	B-H critical
Child-Reported Internalizing	4.63	55	.001	1	**.025***
Caregiver-Reported Internalizing	3.52	88	.001	2	**.021***
Child-Reported Externalizing	3.09	55	.002	3	**.017***
Caregiver-Reported Externalizing	4.86	88	.001	4	**.013***
Caregiver Depression	.118	70	.453	5	.008
Family Empowerment	-1.84	70	.035	6	.004

***Note.* * Indicate comparisons for which the direction of the difference is confidently interpreted at the $\alpha/2$ level using the Benjamini-Hochberg method**

Preliminary Analyses – Do Youth Need to Be Examined Separately?

- MANOVA using a 2 (primary internalizing diagnosis or primary externalizing diagnosis) X 4 (neither IT nor FT, only IT, only FT, both IT and FT) design to predict the two outcome variables (internalizing symptoms, externalizing symptoms)
- Multivariate *F*-test was non-significant across groups, $F(1, 86) = 1.64$, *ns*.
- All youth with SED were examined together.
- ANOVA - clinical severity of children's internalizing and externalizing symptoms as measured by the CBCL and YSR were not related to group status (neither IT nor FT, only IT, only FT, both IT and FT).
- *Symptom severity did not predict whether a child received individual therapy only, family therapy only, or a combination of individual and family therapy.*

Hypothesis One Testing

- Paired sample *t*-test showed that children received a higher number of individual therapy sessions ($M = 11.44$, $SD = 16.58$) than family therapy sessions ($M = 5.43$, $SD = 12.86$) over a 6-month period, $t(88) = 3.31$, $p < .01$ (B-H corrected alpha level of .02).

Hypothesis Two Testing

Series of Hierarchical Multiple Regression

Step One: Ethnicity (control variable)
Medication use (control variable)
Internalizing/Externalizing Behaviors at Time One (T1)
# of Individual Therapy (IT) Sessions
# of Family Therapy (FT) Sessions

Step Two: IT X FT

DV's: Internalizing Behaviors at Time Two (T2); Externalizing Behaviors at T2

Regression One - Externalizing Behaviors

Main Effects

- Child-reported externalizing at T1, $t(55) = 6.90$, α=.017, ß = .71, ↑ externalizing at T1, ↑ externalizing at T2
- Caregiver-reported externalizing behaviors at T1, $t(88) = 4.04$, α=.017, ß = .46, ↑ externalizing at T1, ↑ externalizing at T2
- Neither IT nor FT was related to change in externalizing behaviors regardless of who reported externalizing behaviors (child or caregiver report).

Regression Two - Internalizing Behaviors

Main Effects

- Child-reported internalizing at T1, $t(55) = 5.14$, α=.017, ß = .78, ↑ internalizing at T1, ↑ internalizing at T2
- Caregiver-reported internalizing behaviors at T1, $t(88) = 4.28$, α=.017, ß = .47, ↑ internalizing at T1, ↑ internalizing at T2
- Neither individual nor family therapy was related to change in internalizing behaviors when caregivers reported internalizing behaviors
- For child-reported internalizing, main effect of FT, $t(55) = -2.60$, α=.008, ß = -.28, ↑ FT, ↓internalizing at T2
- Hypothesis two partially supported for internalizing disorders when child reports were considered, but did not receive support when caregiver reports were the focus.

Hypothesis Three Testing

- Because there were no significant changes in the family-level variables of caregiver depression or empowerment from T1 to T2, further analyses investigating the links between individual versus family therapy and change in family-level variables were not conducted.

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Discussion

- Consistent with the recommendation by Weisz and colleagues (2005), the findings work toward developing a deployment and dissemination model by assessing the degree to which individual and family therapy occurs in a community sample as well as how the use of these therapies related to change in functioning.

- Children received more IT than FT - Given the research indicating family therapy in the treatment of severe internalizing and externalizing problems, it appears that family therapy was under-utilized in this sample. Why?
  - Perhaps it is more challenging to engage families in treatment compared to one individual.
  - Clinicians may have had less training in family therapy or a predilection toward using individual therapy, and systems may have been less supportive of family interventions.

- IT alone was not linked with changes in either child externalizing and internalizing behaviors, while FT alone was associated with decreases in internalizing behaviors when children reported their own symptoms.
  - Focusing solely on the "child's problem" in individual therapy seemed to be ineffective at alleviating emotional problems, at least within this sample.
  - Or, perhaps children were not receiving enough individual therapy sessions to be effective over a 6-month period; children received approximately 11 sessions over six months, averaging to less than two sessions per month.

- Support was not found for the third hypothesis that caregivers would achieve treatment gains in terms of a decrease in depressive symptoms and an increase in empowerment. Instead, these levels remained relatively stable.
  - Caregivers reported no changes in their own symptoms and less change in their children's symptoms (compared to children's reports of their own symptoms). Possible reporter differences due to perceptions, sensitivity to change, or timeframe?

- Future studies on how to integrate individual and family therapy among samples of youth with SED would be beneficial to the delivery of mental health services, including assessment of whether demographic variables such as income, transportation, or other resources make the combination of multiple services less likely.

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