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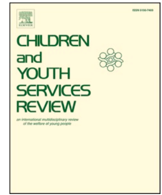

# Elements of care that matter: Perspectives of families with multiple problems

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ABSTRACT

The severe and often persistent problems of families with multiple problems (FMP) call for better understanding of how interventions can improve outcomes in these families. Perspectives of FMP on the crucial elements of interventions may strongly support improvement by providing cues on how to realize positive change. We therefore explored the views of parents and children in FMP regarding helpful and less helpful elements of various interventions. We interviewed 24 parents and 4 children about their perspectives, using a semi-structured interview guide comprising themes that were chosen by the target group. Participants reported 11 elements that contribute to the effectiveness of care, categorized under three main themes: the *characteristics of the practitioner*, the *content of interventions,* and the *structure of interventions*. The perspectives of FMP show the following activities to be promising: routine reflection on the non-judgmental and positive approach of practitioners, more direct focus on children, focus on the underlying cause of behavior, activation of families' social network, the school and other professionals around the family, and creation of more possibilities for long-term and flexible support. Perspectives of FMP on the content and provision of care should be better embedded in interventions. This may help to tailor interventions to their wishes and needs, which in turn can contribute to more positive outcomes of care.

## 1. Introduction

Problems of families with multiple problems (FMP) are typically severe and persistent, indicating a need for effective interventions and for understanding of how these interventions can lead to positive change within these families. FMP face a wide range of complex problems in different areas of life, (Bodden & Deković, 2016; Tausendfreund et al., 2016) such as financial, psychiatric, parenting, relationship, health, and social network problems (Bodden & Deković, 2016). These problems are often intergenerational (Pannebakker et al., 2018). The complexity of these problems and their transfer from older to younger generations contribute to an intensive use of care and the involvement of multiple organizations over longer periods of time (Spratt, 2011). Moreover, according to the Cumulative Risk Theory, children growing up in FMP are exposed to a high number of risk factors from early childhood on, which increases their chance of serious problems later in life (Appleyard et al., 2005; Evans et al., 2013).

The complex and persistent problems of FMP pose a serious challenge for the development and long-term effectiveness of interventions for these families. Studies indeed showed that the sustainability of the effects of interventions for FMP is low (Al et al., 2012) and that considerable problems remain after closure of the intervention (Van Assen et al., 2020). Moreover, the fact that each FMP has its own unique mix of problems requires that interventions can be adjusted to the specific needs of a family. This complicates the development of interventions, because they need to be all-encompassing but is also a challenge for the assessment of the effectiveness of these interventions, since the content of each intervention in a specific family is unique. This differing content might be one of the reasons for the heterogeneous findings of studies on the effectiveness of interventions for FMP (Evenboer et al., 2018).

The increasing focus on interventions for FMP has led to the development of a wide range of interventions with also growing evidence for their effectiveness. A systematic review of 30 interventions for FMP found that eight interventions had an effect size of at least 0.5, that is moderate, on core outcomes such as problem behavior of the child or parenting stress (Evenboer et al., 2018). These interventions were Multisystemic Therapy (MST), Multidimensional Family Therapy

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(MDFT), Intensive Family Treatment (IFT), Families First (FF), Family Central (FC), Parent Management Training Oregon (PMTO), 10 for the Future (10Ftf), and Triple P 4–5. These are all intensive family interventions, taking place in the home environment of the child, characterized by a high intensity of care contacts, and systemic, meaning that they focus on the child and its surroundings. Most of these interventions are well-known nationally and internationally, as interventions for FMP.

While knowledge regarding the effectiveness of these interventions for FMP is increasing, little is known about which elements are most pivotal for positive outcomes (Michie et al., 2009). These elements could be related to the content of interventions, labeled as practice elements, or to the structure in which the interventions are provided, labeled as program elements (Lee et al., 2014). A recently conducted study showed that there is great overlap between the contents of these eight interventions for FMP (Visscher et al., 2020a). In addition, studies have shown that interventions for FMP focused mainly on parents, but much less on the child, siblings, and the social network (Tausendfreund et al., 2015; Visscher et al., 2020b). Interventions aimed mainly at working on behavioral change and collecting information about family members and their problems (Tausendfreund et al., 2015). Moreover, their content was provided mainly through psycho-education (i.e., discussing information about problems of the family and offering tools for dealing with those problems) and instruction (i.e., giving a verbal instruction or advice concerning desired behavior) (Visscher et al., 2020b). Finally, interventions for FMP were of high intensity (Tausendfreund et al., 2015), but toward the end of the intervention the number of visits decreased (Visscher et al., 2020b). These studies gave insight into the content and structure of care provided to FMP, but not its effectiveness.

Individual perspectives of children and parents from FMP, in this paper shortly named as FMP, regarding elements of interventions that matter can increase our understanding of the effectiveness of care. However, insight into the perspectives of FMP on interventions received is scarce: it is as yet unknown how FMP value the specific content (i.e., practice elements) and structure (i.e., program elements) of different interventions for FMP, and how these contents relate to positive change. The scarce evidence focuses mainly on experiences of FMP with specific interventions (e.g., Multisystemic Therapy or Multidimensional Family Therapy) (Kaur et al., 2017; Paradisopoulos et al., 2015; Tighe et al., 2012) or other forms of intensive family treatments (Kauffman, 2007; Lietz, 2009; McWey, 2008; Sheridan et al., 2010). Some of these studies do report on attributes of these interventions that, according to families, contribute to (sustaining) positive change, such as the relationship with the practitioner (e.g., good alliance with and specific characteristics of the practitioner, such as being non-judgmental) (Kaur et al., 2017; McWey, 2008) and the way in which care has been organized (e.g., wish for more long-term support, and negative experiences with terminating care without possibilities for some form of follow-up) (McWey, 2008). More general perspectives, such as a good match of the interventions with specific needs of families, were also reported (Kauffman, 2007). However, detailed knowledge on specific helpful elements in various interventions is lacking. This is important because each family has its own unique combination of problems, so including perspectives from children and parents who received different interventions enables to broaden our understanding of intervention elements that are important for these families.

It is important to determine whether elements of the content and structure of care as mentioned by the families align with the content and structure of current practice. This may indicate which elements are important, how interventions should be provided to be helpful to FMP, and thus, what is needed to establish effective care. Based on previous studies of experiences of families with specific interventions, and of factors affecting the effectiveness of youth care interventions, (Karver et al., 2006; Van Yperen et al., 2010) we expect that FMP will mention elements regarding not only the content and structure of care, but also regarding the practitioner and the relationship with the practitioner. To determine whether interventions for FMP indeed match their needs, we explored the perspectives of both parents and children regarding helpful and less helpful elements of various interventions.

## 2. Methods

### 2.1. Study design

We conducted semi-structured interviews, on themes that were established in a focus group with five children, one parent and one social worker. The interviews were conducted by trained interviewers and aimed to explore perspectives of FMP on helpful and unhelpful elements of interventions. We report our methods according to the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007) (Supplemental Table 1).

### 2.2. Study sample

We selected children or parents from FMP via our quantitative study on eight interventions targeting FMP (Visscher et al., 2020b). In this quantitative study, FMP were defined as families that had received Multisystemic Therapy (MST), Multidimensional Family Therapy (MDFT), Intensive Family Treatment (IFT), Families First (FF), Family Central (FC), Parent Management Training Oregon (PMTO), 10 for the Future (10Ftf), or Triple P 4–5, because of their problems in multiple domains. This database consisted of 499 families who received one of these eight interventions. More information on the included interventions can be found elsewhere (Visscher et al., 2020a).

Of the participants in the quantitative study, we selected those who filled in the questionnaire at the end of the intervention before January 2019 and indicated in this last questionnaire that they were available for an interview about their perspectives on the intervention (41 parents and 7 children). To obtain a diverse study sample, we composed a stratified sample of parents or children of 12 years or older from families in which the intervention was more successful and families in which the intervention was less successful, based on the percentages of intervention goals reached according to the participants. The degree to which intervention goals had been reached was assessed by a participants' questionnaire at the end of the intervention: "What percentage of the goals set in the care plan have been achieved on a scale from 0 to 100%?" Selected participants were approached by telephone or by email. For children below 16 years of age, their parents were first phoned for permission to approach the child, yielding 100% consent. Participants then received an information letter and an informed consent form at their home address, along with an invitation for an appointment. Further information regarding the selection process and the number of children and parents that were included can be found in Fig. 1. Information on the characteristics of participants can be found in Table 2. The Medical Ethics Committee of the University Medical Center Groningen in the Netherlands provided a waiver for ethical approval for this study (reference number METc2016.005 dated March 7, 2016).

### 2.3. Interview guide

We developed a semi-structured interview guide, consisting of questions and topic cards, in several steps. We first invited children and parents who had experience in child and youth social care to participate in a focus group. Five children (12 years or older), one parent who had previously used child and youth social care, and one social worker agreed to participate. The social worker took part because he was a supervisor of the children that participated in the focus group. In this focus group we asked which topics to address to discover what constitutes good care for FMP, and which questions we should ask to get more information about these topics. We explained that we aimed to interview both children and parents of FMP. The focus group discussion yielded the following five topics, which formed the basis of the interview guide:

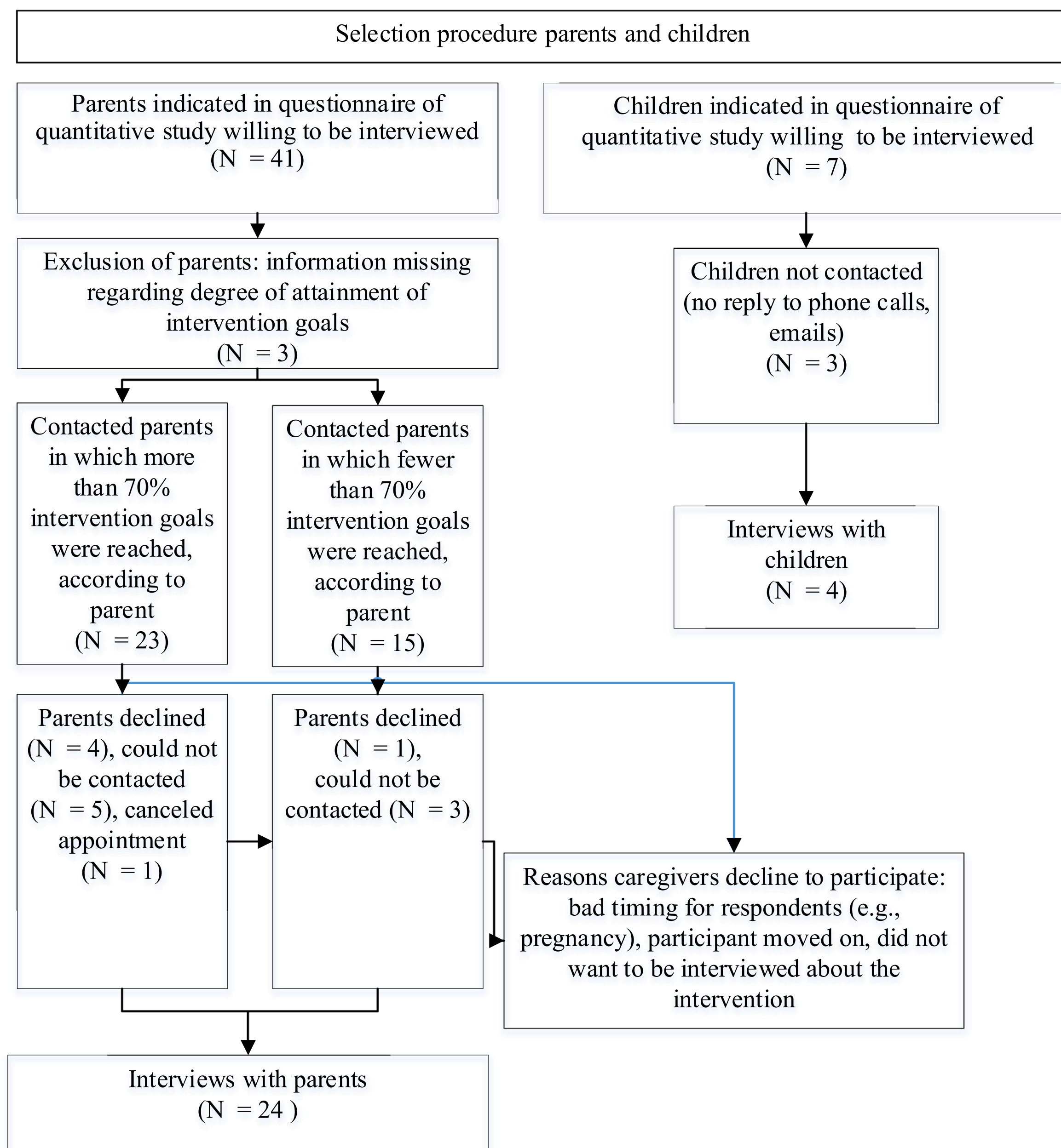


**Fig. 1.** Selection procedure of participants.

1. To what extent practitioners explored the client's expectations of the intervention;
2. How practitioners approached the client and how the relationship between the practitioner and the client was evaluated;
3. To what extent practitioners respected and included the ideas and wishes of the client in care;
4. Content of care, for example to what extent practitioners discussed clients' thoughts and feelings, or activated their social network;
5. Outcomes of care, for example what was the situation at the end of care, and the situation some months later.

Second, we developed topic cards to guide participants through the content of the intervention they had received (theme four). This was done because parents and children in the focus group suggested that asking parents and children about the contents of the care they received would be too general. Therefore, topic cards were developed to structure this part of the interview. The cards regarded topics that could have been addressed during the intervention that families had received. Topics were derived from the main categories of the Taxonomy of Interventions for FMP (TIFMP) (Visscher et al., 2018). The TIFMP is an instrument used to identify the content and structure of a wide range of interventions for FMP. It has been developed based on the manuals of the eight interventions, national guidelines for FMP, existing taxonomies and meetings with field experts. The TIFMP was found to be a reliable instrument for identifying the content of interventions for FMP (Visscher et al., 2018). Regarding the content of care, it includes 53 practice elements (techniques used by the practitioner to promote positive outcomes), thematically divided into 8 main categories. For each main category, one or two topic cards were developed. An example of a topic card was 'helping with daily tasks'. For both main categories, B (planning and evaluation) and C (working on change), two cards were developed, and for main category H (maintaining the practitioner-client relationship) no card was developed, since this topic was discussed during theme 2 of the interview guide. More detailed information on the

topic cards can be found in Table 1. In the interviews, participants were asked to select five cards that best reflected the content of their intervention. For each selected topic card, we asked the participant to tell something about how this was addressed within their family, and to elaborate on what was helpful or not helpful.

Third, to the interview guide we added questions regarding the personal situation of the family (e.g., what a normal day looks like, number of children living at home, living situation), and how it was before they received care (e.g., problems within the family, former care), and ended with questions regarding their ideas and expectations for the future. After finalizing the interview guide, we tested it in a pilot interview with one parent, and made a few minor adjustments in the wording of questions.

### 2.4. Procedure

Interviews took place in the home of the participant. Before the start of the interview, the interviewer explained its aims, emphasized that the researcher was independent of the care organization, and that the participant could stop the interview at any time, and guaranteed anonymity of the data. All participants gave written consent prior to the start of interview. Interviews were conducted between 2 and 21 months after ending the intervention, with a mean of 9.5 (parents) and 11.75 months (children) after ending the intervention. All interviews were audio-recorded and lasted 60 to 120 min. During most interviews no other individuals were present, except for interviews 7 and 8 (children were present), 18 and 20 (stepmother participated in the interview), and 22 (father was present). Participants received a token gift of €20 for their time.

**Table 1**
Topic cards regarding content of care.

| Main category of the Taxonomy of Interventions for FMP (TIFMP) | Topic cards used in interviews* |
|---|---|
| A) Assessment of problems<br>*Practice elements aimed at collecting and categorizing information about family and family problems* | Collecting information |
| B) Planning and evaluation<br>*Practice elements aimed at translating family problems into goals, and practice elements involving evaluation of these goals* | Discussing what my family thinks about the progress of care<br>Discussing what my family wants to reach |
| C) Working on change<br>*Practice elements aimed at realization of change* | Helping us to know how to get along with each other in the family<br>Helping to cope with thoughts and feelings |
| D) Learning parenting skills<br>*Practice elements aimed at improving parenting skills* | Helping with raising my children |
| E) Helping with concrete needs<br>*Practice elements aimed at easing burden of everyday challenges* | Helping with daily tasks |
| F) Activating the social network<br>*Practice elements aimed at engaging the family's social network to help and support the family* | Helping with contact with other people |
| G) Activating the professional network<br>*Practice elements aimed at enhancing goals, agreements, and procedures involving other practitioners who work with the family* | Helping with contact with school or other organizations |
| H) Maintaining practitioner-client collaboration<br>*Practice elements aimed at maintaining and promoting collaboration between practitioner and client* | No cards developed for this main category |

**Note.** After discussing the five cards selected by the participant, we discussed whether any other topic was addressed in the intervention, and whether the participant missed anything in the intervention.
*For main categories B and C two cards were developed: in main category B, planning and evaluation of care are two separate activities; in main category C, we decided to use two cards to summarize the elements in this category. On the one hand these elements refer to how the family gets along with each other (communication, authority relationships, daily routine, desired/undesired behavior), and on the other hand to internal processes (thoughts and feelings). This last category was also mentioned by the focus group as an important topic for the interviews. For main category H no cards were developed because the characteristics of the practitioner was a separate topic in the interviews.

### 2.5. Data handling, analysis and reporting

All recorded interviews were transcribed verbatim and analyzed thematically with the aid of Atlas.TI 8.4. The interviewer involved reviewed the transcripts of all interviews for completeness and accuracy.

Braun and Clarke's 6-step guide (Braun & Clarke, 2006) was used to analyze the interviews thematically and identify emerging themes. We first made a codebook to summarize the entire dataset. To do this we used a combination of thematic codes deduced from the interview guide, and open codes that we applied to newly emerging themes within the interviews. To start setting up a codebook we formulated thematic codes based on the topics in the interview guide, and briefly defined each thematic code. Using the codebook, the interviewers (first author and two project-assistants) independently coded the first two interviews, and discussed them thoroughly. All interviewers were trained and experienced in interviewing and performing analyses in qualitative research. After their discussions, they adjusted some definitions of thematic codes, and added codes newly emerging from the two interviews (open codes) to the codebook. One of the interviewers coded the next six interviews, and the other controlled the coding of these interviews. In case of disagreement about whether or not a code applied, the interviewer that coded the interview and the interviewer that controlled this coding discussed this to reach consensus. The other interviews were coded by the first author and randomly checked by a colleague researcher experienced in qualitative research. During the entire further coding process, newly emerging codes based on participants' verbatim statements were added to the code book (open codes). After coding all interviews, separately for each code, the first author checked the accuracy of the interview quotes that were included under a certain code. If necessary, interview quotes were recoded, or codes relabeled or regrouped.

After coding all interviews, we grouped codes into themes based on common threads throughout the data. This grouping of codes was reviewed by the last but one coauthor to ensure consistent interpretation of data and organization of codes. Any disagreements were discussed between the two researchers until consensus was reached. The code tree can be found in Supplemental Table 2.

We will first report the background characteristics of the participants. Next, we will present those elements of interventions that participants found most and least helpful, divided into three overarching themes.

## 3. Results

### 3.1. Background characteristics

The sample consisted of 24 parents and 4 children (see Table 2 for more information on the results of the selection procedure). The parents interviewed received the following interventions: IFT (6), MST (9), MDFT (4), PMTO (3), FF (1) and FC (1). The children interviewed received MST (1), MDFT (1), IFT (1) and FC (1). In three families both the child and the parents were interviewed. In one family, only the child was interviewed, and in the other interviews only the parent was interviewed. More detailed background information on the participants can be found in Table 2.

**Table 2**
Characteristics of participants ($n = 28$).

| Interview number[1] | Intervention received | Duration of intervention (in months) | % of goals reached according to participant | Time between end of intervention and interview (in months) | Gender of participant(s) | Age of child | Gender child | Educational level parent[4] | Foreign background parent[5] | Marital status parent |
|---|---|---|---|---|---|---|---|---|---|---|
| **Parents ($n = 24$)** | | | | | | | | | | |
| 1 | IFT | 6 | 88% | 5 | Female | 6 | Female | Low | Industrialized | Married |
| 2 | FF | 1 | 15% | 10 | Male | 17 | # | # | # | # |
| 3 | MDFT | 16 | 95% | 3 | Female | 15 | Male | Low | Industrialized | Divorced/ not living together |
| 4 | MST | 5 | 100% | 6 | Male | 16 | Female | Medium | Industrialized | Married |
| 5 | MST | 5 | 100% | 10 | Female | 16 | Female | Medium | Industrialized | Married |
| 6 | MDFT | 8 | 10% | 7 | Female | 15 | Female | # | Industrialized | Divorced/ not living together |
| 7[3] | MDFT | 5 | 100% | 11 | Female | 16 | Female | Low | Industrialized | Married |
| 8[3] | MST | 8 | 5% | 9 | Female | 14 | Female | High | Industrialized | Divorced/ not living together |
| 9 | MST | 5 | 40% | 9 | Male | 16 | Male | High | Industrialized | Married |
| 10 | MST | 4 | 95% | 5 | Female | 17 | Male | Medium | Industrialized | Divorced/ not living together |
| 11 | MST | 5 | 20% | 10 | Female | 12 | Male | Low | Industrialized | Divorced/ not living together |
| 12 | IFT | 2 | 45% | 20 | Female | 15 | Male | High | Industrialized | Divorced/ not living together |
| 13 | MDFT | 6 | 24% | 13 | Female | 14 | Male | Medium | Industrialized | Divorced/ not living together |
| 14 | IFT | 5 | 70% | 12 | Female | 14 | Female | Medium | Industrialized | Married |
| 15 | PMTO | 8 | 70% | 7 | Female | 11 | Male | Low | # | Married |
| 16 | Family Central | 8 | 90% | 8 | Female | 13 | Male | Medium | Industrialized | Divorced/ not living together |
| 17 | IFT | 11 | 90% | 4 | Female | 15 | Female | Low | Industrialized | Living together with partner (not married) |
| 18[2] | PMTO | 7 | 75% | 2 | Female | 5 | Male | Medium | Industrialized | Divorced/ not living together |
| 19 | IFT | 5 | 70% | 17 | Female | 9 | Male | Medium | # | Divorced/ not living together |
| 20[2] | MST | 5 | 80% | 14 | Male and female (stepmother) | 17 | Male | Father: High | Father: Industrialized | Father: Married |
| 21 | MST | 4 | 90% | 9 | Female | 15 | Male | Medium | Industrialized | Living together with partner (not married) |
| 22[2] | MST | 4 | 70% | 14 | Female | 13 | Female | High | Industrialized | Married |
| 23 | PMTO | 7 | 75% | 14 | Female | 5 | Male | Medium | Industrialized | Living together with partner (not married) |
| 24 | IFT | 13 | 74% | 9 | Female | 12 | Male | Medium | Industrialized | Divorced/ not living together |

Children ($n = 4$)

| Interview number[1] | Intervention received | Duration of intervention (in months) | % of goals reached according to participant | Time between end of intervention and interview (in months) | Gender of participant(s) | Age of child | Educational level child[4] | Foreign background child[5] |
|---|---|---|---|---|---|---|---|---|
| 25[6] | MST | 4 | 93% | 5 | Male | 17 | Low | Non-industrialized |
| 26[7] | MDFT | 6 | 87% | 13 | Male | 14 | # | # |

(*continued on next page*)

**Table 2** (*continued*)

| Children (*n* = 4) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Interview number[1] | Intervention received | Duration of intervention (in months) | % of goals reached according to participant | Time between end of intervention and interview (in months) | Gender of participant(s) | Age of child | Educational level child[4] | Foreign background child[5] |
| 27[8] | FC | 8 | 89% | 8 | Male | 13 | # | # |
| 28 | IFT | 4 | 100% | 21 | Male | 12 | Low | Industrialized |

[1]Interview numbers assigned according to date of interview.
[2]Partner of participant took part in interview.
[3]Children present during interview.
[4]Educational level was classified into: "low" (none to maximum lower general secondary education), "medium" (intermediate vocational education or apprenticeship to pre-university secondary education), and "high" (higher vocational education or university.
[5]Foreign background was classified into non-industrialized or industrialized [i.e., born in Europe [excluding Turkey], North America, Oceania, Indonesia and Japan).
[6]Child of parent number 10.
[7]Child of parent number 13.
[8]Child of parent number 16.

### 3.2. Helpful and less helpful elements of various interventions from a family's point of view

Our analyses resulted in eleven elements that participants found helpful, based on their experiences with the intervention. We divided these elements under three main themes: characteristics of the practitioner (three elements), content of the intervention (five elements), and structure of the intervention (three elements). Per theme we will provide illustrative quotes from the interviews. Each quote appears with the number of the interview from which it came, and is followed by a letter showing whether the quote was from a parent (p) or a child (c) (see Table 2).

### 3.3. Characteristics of the practitioner

Regarding the characteristics of the practitioner, participants mentioned three elements that they found helpful: a non-judgmental approach, being taken seriously, and a positive approach.

***A non-judgmental approach.*** Participants reported a non-judgmental approach of the practitioner and having confidence in this practitioner to be helpful, in particular to reach a good alliance. Participants mentioned that when they trusted the practitioner, they felt that they could *"share secrets with the practitioner" (c28),* or share their story without being judged or embarrassing themselves or their child. One participant explained: *"I could say everything to her, the good and the bad things. Just because I really felt I could trust her. Maybe that's why I was very open and honest" (p16).* When they trusted the practitioner, they also dared to discuss things that were not going well, because they felt that they would not be blamed. One participant explained:

> *She didn't come to give a verdict. Because [another practitioner] said, like, 'Is it safe enough here? And are you doing it right?' And she wasn't. With her it was just: okay, what's going on? It's pretty complicated, and how can we deal with it better? (p8)*

***Being taken seriously.*** Participants found it helpful when they felt that the practitioner was taking them seriously and really wanted to help. Some said that this feeling increased when practitioners indicated having had specific experience with a disorder or problem now facing their child. One participant explained:

> *I like to see and notice expertise. I don't need to see a diploma but I do need to somehow notice that they have something to offer me. […] And I had something like that with J. pretty soon; this is someone who takes very concrete, very clear steps" (p22).*

Another issue related to this is that practitioners indicated sincere interest by responding adequately and immediately, for example via WhatsApp. Participants experienced that this "*gave guidance*" *(p4)* and gave them the feeling that they "*[were] not alone in this situation*" *(p17).* Lastly, participants felt that they were being taken seriously when the practitioner listened to their wishes and ideas:

> *There was always consultation and nothing was forced. Come up with ideas, what do you want to work on, and how do you think you are going to do that, and how are we going to do that then. […] So it always came from ourselves. And they gave us guidance (p10).*

Another participant said that this approach motivated her *"to have a certain difficult conflict with your own family, that you then dared to solve" (p17).* In contrast to parents, two children said that they had not had a clear idea of the care they were going to receive before care was started; one said: *"For me it is important to know what kind of care I will get" (c27).*

***A positive approach.*** Participants found a positive approach very helpful:

> *I liked the positive approach very much, because you come from such a dust bin of negativity […] that you can hardly see or find the positivity again […] Not pointing a blaming finger, like you really didn't do that well (p8).*

One participant explained: "*She saw that my mother and I could have fun together. And that we didn't just fight. […] We argued sometimes, but then it was just a little more intense" (c26).* According to participants, a positive approach could also be communicated through compliments and encouraging words, and a practitioner who *"Can just bring it with humor. […] And yet be serious when it's needed" (p6).*

### 3.4. Content of the intervention

Concerning the content of interventions, participants found several elements helpful: a focus on the underlying cause of behavior, involving the child in care, provision of flexible, practical and structured methods within care, and activation of the social network, the school and other professionals around the family.

***Focus on the underlying cause of behavior.*** Participants thought it would be helpful if practitioners put more effort into investigating the cause of the behavior before starting treatment. According to participants, effects of the intervention on the child's future life would not be sufficient if the focus was on setting rules or declaring consequences to reduce external behavior, while disregarding the underlying cause. One explained:

*What I didn't understand […] is that she focused straight on behavior but at the same time didn't try to find out what was happening in her head to make it go wrong. So we first did systemic therapy without understanding the origin of the behavior (p22).*

Partly in line with this topic, one participant described how the practitioner helped her to deal with thoughts and feelings: "*Because if that's all you've got in your head, it just keeps going around. If you talk about it out loud, you kind of let it go; it just feels good" (c26).*

***Involving the child.*** Participants mentioned that involving the child in the intervention is important, because it allows the child to feel heard, and to have its ideas taken seriously for possible solutions. According to participants, this does not necessarily mean that children must be present during every meeting, but perhaps the practitioner could sometimes play a game with the child, or involve the child in discussions about the progress of the family. One participant explained: "*we had to do it together, but to burden the child even more with therapy was not really an option" (p19)*. Other participants said that it seemed to them that the child suddenly showed problem behavior, and the parents found it strange that the intervention was focused mainly on themselves. One participant said:

> *Because if you have a kid who went off track in just a week, it has nothing to do with your childhood. […] It should have been directed more at her [daughter]. […] It's your child who is derailed" (p5)*. Another participant said*: "You also have to understand that people, where things would usually be normal […] that there is also something going on with that child, and that you have to look there (p22).*

***Provision of flexible, practical and structured methods within interventions.*** Participants mentioned that flexibility in the content of interventions is helpful: "*what works for one, might work for the other in a different way*" *(p21)*. Participants suggested that professionals should take a good look at the specific needs of the child or family, and adapt the content of the intervention accordingly, for example not use a reward system with a child who is not sensitive to punishment or rewards. They emphasized their positive experiences with the use of playful methods, for example playing a family game to learn how to talk with each other. Furthermore, participants experienced that they benefited most from methods that were practical, concrete, and easy to use at home (i.e., a sticker-sheet to give rewards). Children themselves also mentioned that they experienced this as helpful, for example making a plan for day activities, or practicing how to say no to people. One parent explained:

> *I was practicing with her. […] She'd be a mother and I'd be the child. And then I'd have to do things, not listen. […] I had to give feedback about how I could do that with my own children. […] As that therapy progressed it did help me to practice with her a number of times before I applied it at home (p15).*

Participants regarded as helpful a method that gives a structured overview into what is going well and what can be improved (e.g., which problems need to be addressed). Such methods helped participants to gain an overview of problems that needed to be addressed, the triggers of these problems, and what they could do when certain situations arose. This overview was also valued as a tool for evaluating the process of care, and helpful to read again upon conclusion of the intervention. One such method is a fit circle that is used in MST, in which the factors are examined from the various systems around the child and the family that drive or maintain problem behavior. This circle is drawn on paper. The 'fit' that arises is the problem analysis on the basis of which hypotheses and goals are formulated (Henggeler et al., 2009). One parent illustrated:

> *She had such a nice circle. And then we looked at where we were, how far along we were and what had gone well and what hadn't gone well. […] And how do we proceed? […] And then you can also look […] what points do we still have to work on. […] What you're dissatisfied with, that's paramount. While they also say hey, you've done all this (p8).*

***Activating the social network.*** Participants found it helpful to have support from others such as their partner, ex-partner, family members, or others around the family and active involvement of the social network within the intervention. Some participants also found it useful to make an inventory of their social network by writing down who they could talk to about their problems and who could relieve them of caring responsibilities for a while; this made them "*aware of the people who are there" (p10)*. In addition, several participants found it helpful to have their network informed about the situation of the family and why help was being provided, and to assess whether the network could do something to help. One participant for whom such a network meeting was organized explained:

> *Also the family members didn't know exactly how much help we actually needed. That it wasn't just a matter of babysitting, but that it was just […] to fold the laundry together, because it was getting too much for me. […] it was just a listening ear, just giving one child some extra attention. […] If my partner is far too tired or if I am far too tired, now I dare to ask for help (p17).*

Although many participants valued support from the social network, some also stressed that this is not always sufficient. Sometimes they wanted professional support because professionals can look at the situation more objectively.

***Activating the school and other professionals around the family.*** Participants mentioned that it is helpful if the practitioner activates the school and other professionals around the family. For example, in contact with school, the practitioner can "*support during meetings and can better explain and translate*" *(p17)* why the child shows certain behavior and what the child needs at home and at school: "*She can ask for concrete help: can you start up a performance anxiety training or do we need to do that?" (p14)*. Practitioners could also confirm that the help at school was in line with the intervention being provided at home. To realize this, having a steady contact person at school was experienced as helpful: *"Any worries there are, I'll mail them to that woman and they'll be solved. […] They're on top of it. That gives parents a lot of peace" (p24)*. Participants also mentioned that it is helpful when the practitioner coordinates various kinds of care for families: "*She was always in contact with other professionals. How it went and if follow up care was needed. I liked that very much" (p12).*

### 3.5. *Structure of the interventions*

The structure of an intervention refers to the frame in which the intervention is provided. Regarding the structure of interventions, participants found three characteristics particularly helpful: care provided in the home of the family, a declining intensity of visits during the intervention, and support after care has ended.

***Care provided in the home of the family*** Participants emphasized that receiving care in their home was helpful for several reasons: it was easier to organize, participants felt more at ease at home, and the practitioner could experience what it was really like in the family, and focus on that behavior during the intervention. Parents explained that when the practitioner is not providing care in the home of the family, the risk is that the child *"doesn't link it to his life" (p24)*. One parent further explained:

> *Because she came to our home and saw it too. S. was always sweet, nice and kind in the beginning, but there comes a moment, when someone keeps coming, that the child gets a bit used to it, and then he goes on the rampage. […] Then she also knows: oh, wait a minute, what does the mother do? How does the child react? How does she handle it? How can I support her? And someone who is working with me on this from outside doesn't see that. (p24).*

***Declining intensity of visits during the intervention.*** Participants also found it helpful to have a decreasing frequency of contacts toward the end of the intervention. They experienced that this stimulated them to apply for themselves the skills they had learned, and convinced them that the practitioner also thought that the problems were under control. However, to avoid startling parents by sudden termination of the intervention, clear communication about the declining number of visits and the end date of care was important to participants. One commented:

*I think twice a week and at the end eh once a week. […] And then it ended all at once […] now I have to do it all by myself. But that was not bad after all, but it caught me off guard a bit, can I do all that on my own? (p10).*

***Support after care has ended.*** Participants often expressed the need for support after the intervention had ended, remarking that such support would have been helpful. They mentioned that what they had learned during the intervention was not always applicable, because new problems arose, or existing problems were expressed differently, due for example to a child's transition to adulthood or a divorce of the parents. In such situations, participants explained that it was helpful to have on paper an overview of learned skills and solutions, and to have the opportunity to contact the practitioner (i.e., by phone or WhatsApp) about what they could do to cope with new situations: *"What would be your advice? […] That's nice that you can fall back on that" (p10).* Many participants regretted that no (guidance to) follow-up care was provided after termination of the intervention, and were not sure who could further help the family. One participant who asked for follow-up care explained:

*I got a pretty clear mail to the effect that it was just over […] And look, I got it. I just didn't get that you were supposed to let it go. […] If only there had been someone who said, now we know this. And now we're going to see what kind of solution is the best […] that would have been nice. […] I'm really sorry about that. Because in itself, I think it was a pretty good trajectory (p8).*

One participant was part of a pilot in which she was able to ask for help until her child became 18 years old. She explained:

*And I always have moments, of course, it's going to be hard. […] But just that I can always fall back on [the organization], that's just really nice. […] I still have regular conversations. […] The intention is actually once or twice a month. That I get a little help anyway and that I keep going the right way (p16).*

## 4. Discussion

As far as we know, this is the first study on the perspectives of families with multiple problems (FMP) regarding specific elements in a wide range of interventions. We aimed to explore the elements of these interventions which parents and children within FMP found most or least helpful. Based on their experiences with the interventions, participants mentioned 11 elements that they considered helpful. We categorized these 11 elements under 3 main themes: the characteristics of the practitioner, the content of the interventions, and the structure of the interventions.

Participants reported that a practitioner should be non-judgmental, have a positive approach, and take the family seriously. This aligns with findings of several studies on experiences of families with intensive home treatments, showing the importance of a non-judgmental and positive practitioner (Garcia et al., 2018; Kaur et al., 2017; McWey, 2008; Sheridan et al., 2010; Tighe et al., 2012). In our study, FMP explained that a non-positive and judgmental approach results in a poor relationship with the professional, one in which they are not open about their problems due to fear of being judged. In such instances, the family is likely not to become engaged and open to change, thus preventing the intervention from having the desired impact (Kaur et al., 2017; Tighe et al., 2012). A non-judgmental and positive approach on the part of practitioners, and the feeling that these practitioners take the family seriously, may therefore, regardless of the content and structure of care, be a prerequisite for achieving positive change within these families (Ackerman & Hilsenroth, 2003; Martin et al., 2000; Shirk & Karver, 2003; Tighe et al., 2012).

Participants mentioned several elements of the content of care, labeled as practice elements that they thought would be helpful but, according to previous studies are not included in interventions. These elements included involvement of the child in the intervention, activation of the social network, the school and other professionals around the family, and attention for underlying problems. These contrast with the content of care as offered, since usually only the parents and not the child are addressed, and activation of the further network lies beyond the scope of the intervention ( Tausendfreund et al., 2015; Tausendfreund et al., 2014; Tausendfreund & Knot-Dickscheit, 2016). In addition, current interventions for FMP aim more at reducing children's problems by changing the behavior of parents, and less on treating the underlying causes of the behavior of the child itself (Tausendfreund & Knot-Dickscheit, 2016). This suggests that the contents of care could be better matched to the needs of families.

The mismatch between content of care as offered and the needs of families may stem from three factors. First, the elements that FMP find important may not be included in the interventions as described in the intervention manual, and therefore not offered by practitioners. Second, the elements may be part of the interventions but practitioners may not provide them. And third, although practitioners may provide elements that FMP need, these may not be recognized by the FMP, possibly because of insufficient communication between practitioners and families. In any case, recognizing and including the perspectives of FMP on the content of care could solve this problem. Further research on this mismatch and its causes is needed to better cope with this barrier in care, and to achieve sustainable improvement.

According to FMP, important elements in the structure of care are a declining intensity of visits, provision of care in the home of the family, and possibilities for follow-up care. The wish for a declining frequency of visits toward the end of the intervention corresponds with current practice in routine care, which is aimed at gradually preparing the family for termination of care. However, most interventions are provided within a limited time frame (Visscher et al., 2020a) and do not always offer the possibility to receive long-term and flexible follow-up care. Furthermore, not all interventions for FMP take place in the home of families (Visscher et al., 2020a). To better meet persistent needs and problems of FMP we should invest in providing interventions, as much as possible, in the home of families. Also a more fluent transition to after-care, or more longer-term support, may result in more sustainable improvements.

### 4.1. Strengths and limitations

A major strength of this study is that we focused on experiences of FMP themselves, giving voice to what they need when receiving care. A second strength is the use of a topic list, developed in a focus group with substantial involvement of children and parents, providing themes that they found important to discuss during the interviews. A third strength of our study is that we included children and parents who had experienced a wide range of interventions for FMP, enabling to identify experiences with these different interventions for FMP.

A limitation of our study may be that during the focus group in which we developed the topic guide for the interviews, only one parent participated. Although we are convinced that children can also give valuable information on topics of interest (Heijerman-Holtfrege et al., 2021), this may have led to missing topics that were important to parents. However, in the interviews we included more parents than children, thus we are quite sure that the perspectives of both children and parents on topics that were important to them have sufficiently been included. Moreover, during the interviews, children and parents were given the opportunity to bring up topics that were not yet discussed during the interview. This rarely happened, which indicates that our interview guide may have been quite complete.

A second limitation may be that we included only four children in our study. This was due to the fact that only seven children wanted to participate, three of which we could not reach. Consequently, we may not have captured all elements that are important for children. We do,

however, think that we reached data-saturation because the perspectives of children did not lead to new themes, on top of the themes that resulted from the interviews with parents.

Third, in some families the time between the end of the intervention and the interview was quite long (ranging from 2 to 21 months, with a mean of 9.5 for the interviews with parents and a mean of 11.75 months for the interviews with children). This may have led to recall bias, but may also have added to the range of perspectives collected, giving the variation in time to reflect on the care as received. Nevertheless, we believe that we were able accurately to capture their experiences with the intervention: we were able to demarcate clearly the intervention we were interested in, who provided it, and during which time period. We derived this information from our quantitative data, and participants clearly remembered the content of the care they had received. Moreover, we did not notice differences between interviews about interventions that were concluded recently compared to interventions that were concluded longer ago. A third possible weakness was that we did not discuss the outcomes of separate interviews with the participants. Accounting for their views on the outcomes might have enhanced the accuracy of the data analysis (Probst, 2015).

### *4.2. Implications*

Our findings have important implications for policy makers, researchers, developers of interventions, and practitioners regarding the content and provision of care for FMP. These recommendations may help to strengthen interventions for these families, and to tailor care to their needs and wishes, thereby contributing to better outcomes.

First, practitioners should reflect more often on whether their approach is non-judgmental and positive. Such reflection can contribute to a better alliance between practitioners and families, and thus contribute to positive change (Lange et al., 2017). This reflection may be addressed in the training of practitioners and could, for example, be included in intervision or supervision meetings. Also, a conversation with the family, beforehand, about their wishes, needs, and expectations regarding the approach of the practitioner, and evaluation of these factors during the intervention, could be helpful.

Second, more effort should be put in promoting a match between the content of interventions and the needs of families. That this is essential to reach positive outcomes (Jager et al., 2015; Kauffman, 2007; Kelly & Blythe, 2000; Lietz, 2009; Seccombe, 2000; Sheridan et al., 2010) was also illustrated by the positive outcomes of more personalized interventions for anxiety, depression, and behavior problems (Borntrager et al., 2015; Weisz et al., 2012). Practitioners should personalize protocolized care in consultation with clients. To achieve this, a more structural inclusion of the perspectives of FMP on the content of the care they receive is important (Cashmore, 2002), and can increase the potential for sustainable change within these families. Outcome-informed treatment might also be helpful, allowing a way to monitor families' progress and analyze what is needed to improve outcomes (Lambert et al., 2018).

Third, children could be more actively involved in interventions. This may be beneficial to achieve long-term change, because the goals of the child (e.g., behavioral change) will be more directly addressed (Tausendfreund & Knot-Dickscheit, 2016; Tausendfreund et al., 2014; Veerman et al., 2005; Holwerda et al., 2014). The introduction of dual care workers, one focusing on the child and one on the parents, might be a way to do this, and was found to be associated with more positive outcomes for FMP (Tausendfreund, 2015; Thoburn et al., 2013). Although children and parents find it important that children are involved and results on dual care workers are promising (Tausendfreund, 2015; Thoburn et al., 2013), future research should address if this involvement of children is needed and desirable in care for all FMPs.

Fourth, interventions should focus on underlying causes of behavior. Problem behavior of the child or parenting stress may emerge or be maintained as a result of unresolved underlying problems (Frick & Dickens, 2006; Hernandez et al., 2006), such as disorders (Tarver et al., 2019) or trauma (Grella et al., 2005). A thorough analysis of factors that underlie or sustain problem behavior may help practitioners to understand why the child shows a particular behavior and how underlying factors affect a family's response to care (Heyvaert et al., 2014; Van Aar et al., 2019). Care providers can then adapt the content of care to the needs of FMP, or develop additional modules to target factors that sustain problem behavior.

Fifth, the social network of FMP should be more involved in care. This may encourage FMP to ask the support of their network after the intervention has ended. In a previous study we found that, most interventions for FMP include elements concerning the activation of the social network, but that these are used too infrequently by practitioners (Visscher et al., 2020b). It might therefore be important to invest in the development of methods to activate the social network and to not only train practitioners in how to identify the (positive) network of FMP, but in how to activate this network. Moreover, it is advisable to explicitly address the activation of the social network of families in intervision and supervision meetings for practitioners.

Sixth, regarding the structure of interventions, we recommend providing longer and more flexible follow-up care. Tailored care trajectories offering flexible support over a long period of time could be promising (Tausendfreund et al., 2016; Van Assen et al., 2020). Such forms of care might better suit the persistent and quickly changing problems of FMP, compared to interventions with a demarcated duration. Although, such trajectories require financial support, as well as good collaboration between specialized and easy-access primary care for families, it can prevent escalation of problems and high societal costs due to this escalation.

The above recommendations have significant implications for the implementation of interventions for FMP. Some of these implications, such as including a dual-care worker or providing longer and more flexible follow-up care, may require many more resources to implement an intervention. As this may be hard to realize, a promising first step might be to optimize existing interventions based on our findings and ensure that these interventions can better meet the needs of FMP. Lastly, our findings also have important implications for researchers. The findings on elements of interventions that are important to children and parents ask for quantitative confirmation. Further research should find out if the inclusion of elements that are important to FMP also leads to more positive outcomes for these families. In addition, the effectiveness of these elements for specific subgroups, for example groups of families with younger versus older children, should be examined.

## 5. Conclusion

This study provided insight into helpful and less helpful elements of interventions for FMP, from the point of view of the families themselves. These perspectives of FMP indicate that to better meet their needs, care can be strengthened in the following ways: structurally reflect on the non-judgmental and positive approach of practitioners, focus more attention on children, focus on the underlying cause(s) of behavior, activate the social network, the school and other professionals around the family, and create possibilities for long-term and flexible support. Our findings suggest that perspectives of FMP on the content and provision of care should be better embedded in interventions. Interventions tailored to these wishes and needs will contribute to more positive outcomes.

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## Ethical approval

The Medical Ethics Committee of the University Medical Center Groningen in the Netherlands determined that ethical approval was not needed for this study (reference number METc2016.005 dated March 7, 2016).

## CRediT authorship contribution statement

**L. Visscher:** Writing – original draft, Formal analysis, Conceptualization, Data curation, Investigation. **D.E.M.C. Jansen:** Conceptualization, Writing – review & editing, Supervision, Funding acquisition. **R.H. J. Scholte:** Writing – review & editing, Supervision. **T.A. van Yperen:** Writing – review & editing. **K.E. Evenboer:** Writing – review & editing, Validation, Supervision. **S.A. Reijneveld:** Conceptualization, Writing – review & editing, Supervision, Funding acquisition.

## Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.


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