

Multiple Riskfactors in Multiproblem Families? A Retrospective File Study

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Received date: Mar 15, 2015; Accepted date: Oct 22, 2015; Published date: Oct 29, 2015

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Abstract

Objective: The accumulation of risk factors in multiproblem families increases the risk of developing psychopathology in children. This study describes the risk factors and characteristics of a sample of families in an intensive outreach care programme for multiproblem families with children aged 12 or younger, and in which the parent and/or child has psychiatric problems.

Methods: In this study we used a self-developed questionnaire that measures the presence of risk factors at the level of the mother, any cohabiting partner and the family. It is a retrospective file study covering a period of two years and describing 48 families.

Results: We find that psychosocial problems, more prevalent in large cities, appear to accumulate in the group of clients being treated. There is an accumulation of risk factors that jeopardise the proper psychosocial and physical development of children. In this population, an average of seven risk factors per family were found, alongside a high percentage of domestic violence, inadequate basic care, inadequate physical safety and a lack of parenting skills.

Conclusions: A well-designed intensive outreach care programme that pays attention to these risk factors seems to be indicated for this group of clients.

Keywords: Child mental health care; Home treatment; Multiproblem families; Psychosocial; Risk factors

Introduction

Several studies indicate a number of risk factors for the psychosocial and somatic development of a child. It has been established that the development of children is more at risk when they grow up in a family with social or financial problems, with domestic violence, in which the parents have a psychiatric disorder, inadequate parenting skills or negative parental behaviour, or in a poor neighbourhood [1]. In multiproblem families, by definition, a variety of risk factors is present at the same time. This has consequences well into adulthood [2-4]. The accumulation of parental and contextual risk factors in multiproblem families increases the risk of the development of psychopathology [1,5-7]. Although the phrase multiproblem families is widely used, a clear definition is not available [1]. Based on clinical experience we suggest that at least three risk factors must be present to justify the use of the term 'multiproblem family'.

In addition to the multitude of problems children in these families have to face, their problems are often under-treated [8]. This may contribute to even more severe and longer-lasting disorders, as well as an increased risk of relapse [9].

In Amsterdam, the Netherlands, we offer multiproblem families with children aged twelve and younger a psychiatric, intensive, outreach treatment programme for a year via family care services [10]. The target group of this intensive outreach treatment programme is

multiproblem families with more than three risk factors at the same time. At least one of the parents or one of the children of the family must suffer from suspected or assessed psychopathology. Besides, previous interventions for the children have proved to be inadequate.

In this study, we examined all the risk factors in the multiproblem families who entered our treatment program. As far as we know there is only a limited number of studies describing these psychosocial risk factors in multiproblem families with young children. Our main research questions were:

- Which risk factors are present in a typical sample of multiproblem families?
- What is the number of risk factors in a typical multiproblem family?

Moreover we also describe some demographic and discerning treatment characteristics of these multiproblem families.

Methods

All children who were referred to our care programme over a period of 2 years were included in this study. In conformance with current Dutch legal requirements, patients were informed that anonymized routine clinical data might be used for the purpose of research and given the choice to opt out, in which case data were not used. In total we retrospectively assessed 48 listed children from multiproblem families. For all patients we filled in the 'Questionnaire for Psychosocial Risk Factors' retrospectively. This questionnaire assesses

the presence of risk factors for psychopathology and was completed by the family therapist based on case notes.

The ‘Questionnaire for Psychosocial Risk Factors’ was developed by this research group and is based on a literature review [1]. It holds all risk factors for which there is convincing evidence that it increases the risk for the development of psychopathology in children. This questionnaire identifies a number of risk factors affecting the mother, experienced stress by the mother in relation to any (cohabiting) partner, and factors at the family level. The total number of risk factors is 19.

A distinction is made between objective and subjective risk factors. The objective risk factors are related to mothers, any cohabiting partner or at the family level. The subjective experienced stress items are: stress due to problems with a (cohabiting or former) partner of the mother, housing, chronic physical complaints (of the mother herself or cohabiting partner) or related to unemployment. There has been much less research looking at the role of fathers on the development of psychopathology, reason to exclude them from our questionnaire. However, there are indications that fathers can also have an effect [11,12].

The subjective risk factors are described using a five-point scale in which only the two highest scores are indicative of risk. The assessment of the neighbourhood was conducted on the basis of quality of life criteria using the “Living Barometer” (at the postal code level), an instrument devised for that purpose by the Ministry of Home Affairs. It handles six dimensions (housing supply, public space, social facilities, demographics, social cohesion and safety) [13]. To assess the psychopathology of parents and/or children we made use of existing diagnosis provided by an outpatient clinic. This study did not include any standardised diagnostic questionnaire or interview. Alongside the risk questionnaire, the family therapist evaluated some treatment characteristics like domestic arrangements, parenting skills, affective care, physical and basic safety and completion of treatment.

Results

Our centre received the referrals of 48 children in the inclusion period of two years. All of them fulfilled the inclusion criteria described in the Methods section and were included in this study.

Mean age of the children at the time of referral was 7.6 years (SD=2.8), and 23% was younger than 6 years of age. In almost half of the children, a “parent-child relationship problem” was the psychiatric diagnosis; 21% had an internalising disorder, and the same percentage had an externalising disorder. Of the mothers, 96% suffered from a psychopathological disorder. Generally, the mothers suffered from a disorder in the affective spectrum (35%), or from a personality disorder (35%). Parents were relatively young. Average age of the mothers was 35.9 years (SD=7.9).

In 73% of the families, the relationship between the biological parents had broken and 27% of the children in these families did not see their father at all any more. The average number of children in the families studied was 2.3 (SD=2.3), ranging from one to five children per family. Of the mothers, 17% had a Moroccan background, 13% a Turkish background, and 13% a Surinam or Antillean background. A mixed ethnic/non-ethnic background was found in 17% of the parents. Table 1 lists a number of socio-economic and illness characteristics of the multiproblem families.

Mother has been unemployed in the last six months, N (%)	41 (89.1)
Mother has problems with partner/former partner, N (%)	37(82.2)
Family is entirely dependent upon social benefits, N (%)	37(80.4)
Mother has a non-western cultural background, N (%)	32(69.6)
Father has a non-western cultural background, N (%)	30(66.7)
Mother has had chronic somatic complaints in the last six months, N (%)	27(58.7)
Mother has had housing problems in the last six months, N (%)	23(48.9)
Father needs an interpreter, N (%)	10(28.6)
Mother needs an interpreter, N (%)	7 (15.9)
Mother has no contact at all with her partner/former partner, N (%)	3(6.5)
Average duration of mental health treatment in weeks for mother in the last six months, Mean (SD)	14.1 (11.3)
Estimated family debts in Euro, not including mortgage, mean (SD)	4378 (7833)
Average age of mother upon presentation for treatment, mean (SD)	35.9 (7.9)
Average age of child upon presentation for treatment, mean (SD)	7.6 (2.8)
Average age of mother at birth of 1st child, mean (SD)	26.6 (7.2)
Total number of cases was 48. If data were missing, proportions in this table represent valid percentages. For all variables data were available for 43 to 48 cases, with the exception of “Father needs an interpreter” for which data of 35 cases were available.	

Table 1: General socio-economic and illness characteristics.

	N (%) ¹
Maternal risk factor	
Mother has had a chronic psychological problem in the last six months	43 (95.6)
Level of education of mother less than completed secondary education (HAVO/MBO)	34 (77.3)
Mother younger than 25 years of age at time of birth of 1st child	23 (48.9)
Mother over 16 years of age at time of immigration to the Netherlands	10 (27.8)
Mother has had problems with alcohol and/or drugs in the last six months	8 (17.8)
Mother needs an interpreter	7 (15.9)
Mother has had contacts with the judicial authorities in the last six months relating to criminal matters	5 (11.1)
Risk factor in mother's partner	
Any cohabiting partner has had contacts with the judicial authorities in the last six months relating to criminal matters	3 (6.7)
Any cohabiting partner has had problems with alcohol and/or drugs in the last six months	1 (2.3)

Risk factor at family level	
Family income is less than € 1200	34 (75.6)
Family is not traditional (with a biological father and mother)	33 (70.2)
Family has debts (not including mortgage)	28 (63.6)
Family lives in a neighbourhood with moderate or negative quality of life criteria according to the "Living Barometer"	27 (56.3)
Family has a total of 1, or more than 3 children	14 (29.2)
¹ Total number of cases was 48. If data were missing, proportions in this table represent valid percentages. For all variables data were available for 43 to 48 cases, with the exception of "Mother over 16 years of age at time of immigration to Netherlands" for which data of 36 cases were available.	

Table 2: Objective risk factors (N=48).

The majority of the mothers were unemployed and depended on social benefits. The average income is relatively low, often in combination with debts. Apart from a mortgage, 64% of patients had a severe debt with an average of €4378. Approximately half of the families live in poor/deprived neighbourhoods. Most mothers (70%) had a non-western cultural background sometimes with poor understanding of the Dutch language (16%). The majority of mothers (96%) suffer from chronic psychological problems. Often, by the time they enter our programme, the biological parents were not together anymore and 77% of mothers had a problem with their partner or ex-partner. On average mothers were 27 years of age when they had their first child but half of the mothers started having children relatively young.

Risk factor	N (%) ¹
Mother has experienced high or extremely high levels of stress in the relationship with her partner/former partner during the last six months	26 (57.8)
Mother has experienced high or extremely high levels of stress as a result of housing problems	17 (36.2)
Mother has felt chronic physical complaints to be a severe or very severe problem	13 (28.9)
Mother has experienced high or extremely high levels of stress as a result of unemployment	6 (13.3)
Mother has felt chronic physical complaints of any cohabiting partner to be a severe or very severe problem	1 (2.3)
¹ Total number of cases were 48. If data was missing, proportions in this table represent valid percentages. For all variables data were available for 43 to 48 cases.	

Table 3: Subjective risk factors (N = 48).

Table 3 sets out the risk factors for the multiproblem families that can be identified on a more subjective basis by the family therapist.

Out of all mothers, 79% experienced severe to very severe levels of stress on at least one of the factors mentioned in Table 3. The most common occurring cause of stress was quarrels with (ex) partner(s). Two other important causes of stress were housing problems and chronic physical problems.

Tables 2 and 3 show a total of 19 risk variables for which there is convincing evidence that they increase the risk for psychopathology in

children. Bearing this in mind, children in our sample face a high number of risk factors. The average number of risk factors in our sample was 7.4 (SD=2.4 with a distribution of 3-11).

The main referrers for this care programme are Child Care Services (35%), paediatric psychiatry (23%) and adult psychiatry (17%). During treatment, extensive psychiatric or psychological examinations were conducted in 27% of the children. In almost 30%, the domestic arrangements were so chaotic that care focused on this area. During treatment, parenting skills were found to be inadequate in 90% of the families and 50% were offered a parenting course. Other important focus areas were inadequate affective care (in 44% of the families), inadequate physical safety (38%) and inadequate basic care. Domestic violence was a feature in 48% of the families. In almost 80% of the cases, completion of the entire course of treatment proved possible.

Discussion

Target group

In the literature, the concept of the 'multiproblem family' is vague and, like the care provided, it can be wide-ranging. However, psychiatric care should preferably be delivered to carefully defined clients with indications and comprise precisely defined treatment methods. The intensive outreach care programme described here attempts to do this for multiproblem families.

This retrospective study showed that the target group for our care programme often comprises single mothers who have had little education and who suffered from chronic psychiatric and physical problems. Of course, this is related to the inclusion criteria for our care programme. In addition, income is often limited and people usually rely exclusively on benefits and they are in debt. The mothers are usually unemployed but they do not generally feel this to be a major concern. Although they are often single, the mothers have severe problems with their current or former partners. Both the mothers and the fathers usually have a non-western cultural background. Families from this care programme live more often in the more problematic areas of the city. These results coincide with the most vulnerable group Lanza et al. [14] described.

The client population comes from a large city with the associated specific demographic characteristics. These can differ from the demographic characteristics in the rest of the Netherlands. In Amsterdam, approximately 16-28% of families with children (aged 0-18 years) live on benefits or from a minimum income. Most of them are families with Moroccan roots. The corresponding percentage for the Netherlands as a whole is only 6% [15,16]. In our study, 76% of the families live off less than 1200 Euros. In addition, in major cities such as Rotterdam and Amsterdam, slightly more than half of the children have a non-western ethnic background, compared to the national percentage of 25% [15,16]. In our study, 67% of the mothers have a non-western ethnic background.

In children generally, but particularly in children from minority groups, there is under-diagnosis of psychiatric problems by general practitioners, schools, childcare services and juvenile judicial organisations [8]. This may be the reason why, despite assistance received elsewhere in the past, further psychiatric or psychological examination was considered to be desirable in the children of a quarter of the families studied. The majority of children had a psychiatric disorder, half of which were a parent-child relational problem. Although this may not be as severe as expected, it only reflects the

situation during referral to our team. It does not exclude the development of more severe psychopathology in the future. We believe that, particularly in these children who face multiple risk factors for the development of a psychiatric disorder, the application of interventions are necessary to prevent or limit the development of psychiatric disorders.

Risk factors

The results of our Questionnaire for Psychosocial Risk Factors demonstrate that our population is characterised by the presence of a relatively large number of factors that previous research [1] has linked to a heightened risk of child pathology. Many risk factors are found at the mother and family levels. These are usually single-parent families and so there are few cohabiting partners who can constitute a risk factor. A striking feature is the high level of stress caused by former partners or new partners as perceived by more than half of the mothers.

As expected, at least three risk factors are present in the families studied. In our population, the average number is seven, with extremes of eleven risk factors. Research has shown that risk factors for the development of psychopathology each make a modest contribution of their own to the actual development of that pathology. However, an accumulation of risk factors makes the risk much higher in a disproportional way. Flouri et al. [17,18] find that an accumulation of risk factors is the most significant determinant of variance in child development. Until now, there have been a limited number of studies looking at risk factors [3,14,19-22]. The various studies use different risk factors and are therefore difficult to compare. The Questionnaire for Psychosocial Risk Factors is broad in the sense that it can be used to score any possible risk factor, excluding possible relating of factors. It is a cause for concern that our study showed several children who face an extreme high number of risk factors. Needless to say, this is in part attributable to our selection criteria based on possible parental psychopathology and the presence of psychosocial problems. On the basis of the indication criteria for the care programme, we certainly expected a high percentage of chronic psychiatric problems in the mothers, low family income, debts, unemployment and housing problems. It is striking that not all mothers with chronic psychiatric complaints did receive treatment. However, this study shows that other risk factors, such as a low educational level of the mother, the young age at which mothers first become pregnant, the high level of stress perceived by mothers in relation to their partners/former partners, the non-traditional family arrangements, and the more problematic neighbourhoods where they live, are important considering the enhancing risk of the children in multiproblem families developing psychopathology.

We made a distinction between objective risk factors and subjective risk factors determined by the family therapist. It is possible that these subjective risk factors were overestimated retrospectively. On the other hand, it is possible that the retrospective assessment resulted in more known risk factors because the family therapist knew the family better and was able to discuss more problematic issues as a result of an increase in trust. The mothers themselves could have completed the questionnaire.

Of course, various factors may be related to one another. A level of education for instance is likely to be related to income and debt, which may relate to housing conditions. This may also have resulted in an over-estimate of the number of risk factors. Unfortunately we were not able to study differences in the number of risk factors as determined

with the questionnaire between our population, a mental health care outpatient clinic, and a normal population.

Treatment

During the treatment, it was found that virtually all parents had inadequate parenting skills (this was the case in 90% of the families), and that almost half provided inadequate affective care (44%) and physical safety (38%). Olds et al. [23] adopted the number of completed house visits and completed treatment courses as a success criterion for a given treatment programme. On the basis of this criterion, we conclude that our care programme was successful. Out of all families 80% completed the treatment programme of one year. We did not examine the efficacy of specific elements of our care programme.

Conclusions

In the multiproblem families of our intensive treatment program, there is a substantial accumulation of risk factors that jeopardise the proper psychosocial and physical development of children. In our population, we find an average of seven risk factors per family, alongside a high percentage of domestic violence, inadequate basic care, inadequate physical safety and a lack of parenting skills.

In accordance with Ezpeleta et al. [24] we find that every risk factor should, if possible, be prevented. Therefore care services should provide intensive outreach psychiatric care and engage in further scientific study of this group of children in order to prevent severe or chronic pathology.

Acknowledgements

We wish to thank the family therapists of the intensive outreach care programme (Project aan Huis, Amsterdam, the Netherlands) for their support and collection of the research data.

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