Research for practice based evidence in family therapy

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Bergen 28th August 2008

Why psychotherapy research?

- Large discipline
- - natural sciences – medicine – positivism
- - human sciences – processes - hermeneutics
- The knowledge we use is produced by our selves
- From global to local knowledge
- “Evidence” mostly for us – against academic colonialism

- “Change of administrative culture calls for evidence based research for guiding the practice”
- Seikkula, J. & Arnkil, TE Dialogical meetings in social networks. London: Karnac

Knowledge for whom?

The main stream at the moment:

- 1) Academic world – “Evidence Based Medicine”
- 2) Administration and Producers of the services
- 3) Clients and others
- Focus on experiments – methods – manualized treatments

Knowledge for us

The revised order:

- 1) Our selves and clients
- 2) Politicians and administration
- 3) Academic world

- Focus on studying the every day practice

EBM – Cochrane library

- Treatment of excellence recommensdation
- Generalizability fromone context to another
- Meta-analyses
- - at least 2 RCT
- - meta-analysis
- - systematic review
- - recommendations

Internal validity

- Control group
- - randomized trial as a standard
- Follow-up
- - the entire group – “intention to treat group”
- Independent observer
- - Therapist is not evaluating his own job

Lacking external validity

- Is the sample representative?
- Is the treatment valid for all
- Are the measurements valid for useable information
- These are not controlled!!!
- THUS:
- Poor external validity is the biggest problem in EBM

Examples of poor external validity

- Medicine studies – placebo trials
- Comparison og group means – 70% of cases in different group can be within the same variation

Clinicians as researchers

We know best:

- - the circumstances where knowledge is applied
- - the content of problems and treatments
- Not either positivistic or hermeneutic but both and
- Interactional, dialogical contexts as well as manualized therapies (if you like them)

Psychotherapy studies

Process studies

- - case studies in different forms – 1 step
- - ethnomethodology – Discourse Analysis - transcripts
- - narrative and dialogical analysis
- - analysis of interviews – Grounded Theory, content analysis, narratives (positioning, voices)

Processes of change studies

- - Psychotherapy Q-Sort – A. Johnson
- - Assimilation analysis – B. Stiles

Outcome studies

- - Effectiveness – efficacy

Outcome AND process studies

- - analysing processes after we know the outcome

Progress research

- - each session rating – “on line”

Studies on psychotherapist/counselor

Denominators for contemporary research

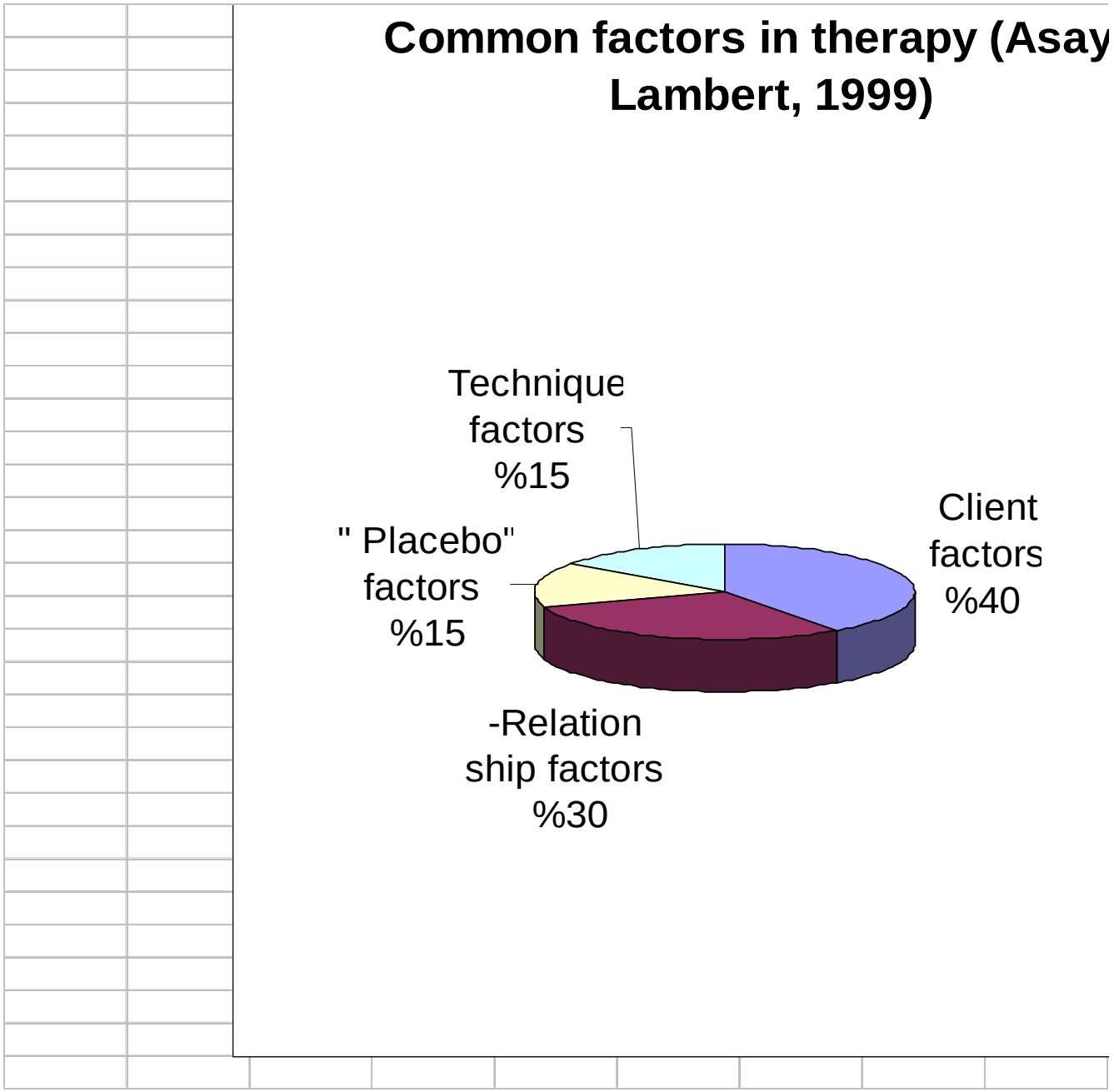
Common Factors – MJ Lambert & Asay

- - change is based more on common than specific factors for all therapies

Contextual model – J. Frank, B. Wampold

- More differences in outcomes within one therapy school than between schools

- Commitment to own believes more important than adherence to the specific psychotherapy


Common factors in therapy (Asay
Lambert, 1999)
Technique factors %15
Client factors %40
" Placebo" factors %15
-Relation ship factors %30

COMMON FACTORS AS AN INADEQUATE FOUNDTION FOR MFT

•Thomas L Sexton, PhD, Charles, R. Ridley, PhD, and Amy J. Kleiner,
BEYOND COMMON FACTORS: MULTILEVEL-PROCESS MODELS OF THERAPEUTIC CHANGE IN MARRIAGE AND FAMILY THERAPY
2004,Vol. 30, No. 2, 1–12
JOURNAL OF MARITAL AND FAMILY THERAPY 131

- *1. Is There Research Support For Common Factors?*

Thus, the outcome of a meta-analysis is limited to those variables identified and coded and to the operational definition of the coded variables. To date, no meta-analysis has coded for anything other than broad and general approaches to therapy (e.g., structural family therapy).

- *2. Do Common Factors Integrate Research Into Practice?*

First, common factors are not conceptually clear, operationally defined, or contextualized within a clinical process enough to make them either researchable or understandable.

3. Do Common Factors Provide an Adequate Theoretical or Conceptual Foundation to Explain the Processes or Mechanisms of Change?

Despite the contributions of the common factors perspective, it does not explain the complexity of change or the process through which change takes place.

4. Do Common Factors Advance Theory Development?

Unfortunately, the current articulation of the common factors perspective is seriously lacking as a comprehensive theoretical foundation to MFT

5. Does it Provide the Guidance Necessary for Successful Clinical Work?

Thus, common factors do not explain the process of change and therefore leave the clinician at a loss for guidance in the most basic need to know what first, what second, and what third.

6. Can Common Factors Serve as the Basis of Clinical Training?

Critics to Common Factors/2

- Psychotherapy or other experiences of discussions of you own life is much more than change in variables, ratings scales or family interaction

Challenges in “real world”

- Descriptive models, not single variable explanations
- Aim to illustrate (develop) specific practice – not on generalizeable knowledge
- Comparison vs. control groups
- The problem of group means: e.g. neurobiological explanations for schizophrenia
- Triangulation: Case analysis involved in each group comparison to increase validity

5 years follow-up of Open Dialogue in Acute psychosis

- 01.04.1992 – 31.03.1997 in Western Lapland, 72 000 inhabitants
- Starting as a part of a Finnish National Integrated Treatment of Acute Psychosis –project
- Aim 1: To increase treatment outside hospital in home settings
- Aim 2: To increase knowledge of the place of medication – not to start neuroleptic medication in the beginning of treatment but to focus on an active psychosocial treatment
- N = 90 at the outset; n=80 at 2 year; n= 76 at 5 years f-u
- Follow-up interviews as learning forums

COMPARISON OF 5-YEARS FOLLOW-UPS IN WESTERN LAPLAND AND STOCKHOLM

	ODAP Western Lapland 1992-1997 N = 72	Stockholm* 1991-1992 N=71
Diagnosis:		
Schizophrenia	59 %	54 %
Other non-affective psychosis	41 %	46 %
Mean age years		
female	26.5	30
male	27.5	29
Hospitalization days/mean	31	110
Neuroleptic used	33 %	93 %
- ongoing	17 %	75 %
GAF at f-u	66	55
Disability allowance or sick leave	19 %	62 %

- *Svedberg, B., Mesterton, A. & Cullberg, J. (2001). First-episode non-affective psychosis in a total urban population: a 5-year follow-up. Social Psychiatry, 36:332-337.

Dialogical and Narrative Processes in Couple Therapy for Depression – University of Jyväskylä

- A real world design – integrating analysis of outcome, processes and processes of change

- Multicentre study – randomized control groups
- Controls both to “treatment as usual” and within the experiment group

Sample & design

- Depressed patients (F32 and F33 in ICD-10) living in a couple relation, N=32
- Couple- or family therapy by co-therapist pair vs. individual treatment as usual
- Medication is used in both groups if necessary

Statistical Data

- Assessments before treatment, 6, 12,18 and 24 months after the beginning of the treatment
- - Social status – employment, disability days, use of services and relapses
- - Hamilton Depression Scale and Beck's Depression Inventory
  - Symptoms Check List – SCL-90
  - General Assessment of Functioning - GAF
  - Use of alcohol
  - Domestic Violence
  - Dyadic Adjustment Scale for couples -DAS

Qualitative Data

- Video recordings of the family sessions
- Outcome Rating Scale and Session Rating Scale (by Miller and Duncan) in every session
- Co-research interviews 3 months after the treatment for both the family members and the therapists present
- Psychotherapy process change analysis – PPQ –Sort
- Narrative process and dialogue analysis of extreme cases

Questions

- Significant group differences a challenge – how to combine with process analysis?
- How to plan process analyses in relation to the entire project
- How to take use of each session ratings?

  (Variation huge from 2 to 30-40 sessions)
- How to describe the therapies when no manual exists?

Looking at therapists

Blow, Sprenkle & Davis, 2007 IS WHO DELIVERS THE TREATMENT MORE IMPORTANT THAN THE TREATMENT ITSELF? THE ROLE OF THE THERAPIST IN COMMON FACTORS .Journal of Marital and Family Therapy , 33, 298–317

(a) Observable traits (fixed characteristics that could be coded by an external coder and that describe the therapist independent of his or her role as a therapist) like gender, race, and age;

(b) observable states (potentially changeable characteristics, specifically related to the role of therapist, that do not need to be inferred—that is, they could be potentially identified by procedures independent of the therapist) like therapist training and experience;

(c) **inferred traits** (relatively stable characteristics that can only be inferred from information provided by the therapist but that transcend the therapist's role as a therapist) like personality, well-being, and values; and

(d) inferred states (relatively changeable therapist variables that can only be inferred by information from the therapist) like the therapist's view of the therapeutic relationship.

What to do

- Starting systematic analysis of own practice – part of every day practice
- - Session ratings – many alternatives
- Co-operation between clinics and universities and other institutions
- - Research – Action Research
- - Training

Example: Jyväskylä multidisciplinary doctorate program for Psychotherapy Research

- One program for all therapists – individual psychotherapies, family therapy, psychodrama, music therapy
- Philosophers, social workers, ministries, GP:s as well
- 4 years by job training – seminars, supervision, workshops, pair support