Nothing to Fear? Thoughts on the History of Family Therapy and the Potential Contribution of Research

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The aim of this plenary address is to advocate for the role that research can play in family therapy, with particular reference to our future as a field in Australia. I will argue: 1) that we have been in transition as a field in the past 15 years or so, from a fairly closed system, to one that is more amenable to holding itself to account through research; 2) that we hold a number of misconceptions about research that need to be explored if we are to continue; 3) that we need to develop a research agenda that is consistent with our values and 4) that there are a host of research methodologies that are consistent with our epistemologies and modes of practice.

Keywords: research, qualitative, research methods, family therapy

In making this address I would like to emphasise that I am coming from the perspective of a committed family therapist who has gradually made the transition to becoming a researcher. From 1996 to 2006 I conducted around five sessions of family therapy per day five days a week. Now I see few clients and focus mainly on supervising Doctoral students in their research in family therapy and clinical psychology. I used to have 15–25 cases on my books, now I have 15 research projects to supervise.

I hope that these perspectives help me today in trying to further the bridge between active, committed and innovative family therapists and the potential value and contribution of research. There remains a significant scientist-practitioner divide that I believe we need to address if we are to maintain our credibility as a field.

Four Themes Relating to Current Developments in Family Therapy

If you were raised as a family therapist before the end of the 1990s you will have been part of our own unique historical meta-narrative that starts with structural therapy and finishes with narrative. History seemed continuous, with thinkers and therapists making the gradual change to greater transparency, a better consideration...
of ethics in relationships, a gradual swing from right to left, etc. I can even remember how many of the conference ice-breaking conversations in the 1990s were along the lines of ‘what model do you use?’ as if you could only use one. Since then and certainly since the death of Michael White and Steven de Shazer, it can be very hard to get a handle on what has happened to that history. Is it over? Is there still this continuous thread? Is family therapy finished as a distinct field? What does the future hold?

From my own perspective, family therapy since the late 1990s has been defined by some very specific developments. While we are no longer defined by new paradigms and models there still seem to be some major themes driving our continued growth.

1. **A Re-engagement with Psychodynamic Thinking**
To some degree family therapy was developed in reaction to psychoanalysis. The perceived passivity of the therapist was replaced with active sculpting and re-enactments, strategy and interventive questions. The intrapsychic focus was replaced with the interpersonal. Now we realise that the relationship between family members is not the only focus, but that their relationship with us and our capacity to manage transference and counter-transference is critical (e.g.: Flaskas & Pocock, 2009). Psychodynamic thinking is giving us back some of the depth we may have lost in our early development (perhaps with the exception of Bowen), which, is being reconsidered in our re-evaluation of psychodynamics.

2. **A Shift to Integration**
It now seems standard practice to rely on a wide variety of models, not just in terms of a loose eclecticism, but a more sophisticated careful integration of practices based on the specifics of the case. There are many examples of integrative frameworks in the literature, including Metaframeworks, Integrative Problem-Centred Therapy, Multimodal Therapy, Integrative-Contextual Therapy, Biopsychosocial Therapy, Integrative Family Therapy (Smith & Southern, 2005). The latter authors go as far to say that integrative models may soon ‘consume, not replace, all unitary models, with few if any clinicians working from one pure approach’ (p. 397).

3. **A Developing Respect for Other Disciplines**
Much has now been written about the need for hospitality in our dealings with other professions rather than defining our self in opposition to them (e.g. Larner, 2001). There is, for example, a much stronger engagement with neurology, via attachment. Daniel Siegel (2003) calls for an interpersonal neurobiology: ‘The brain becomes literally constructed by interactions with others. . . . Our neural machinery . . . is, by evolution, designed to be altered by relationship experiences’ (p. 18). A great review of this work can be found in *Wired to Connect: Neuroscience, Relationships and Therapy* (Fishbane, 2007). The brain is becoming recognised as a context-influenced system much like the family and one which we need to understand more in our everyday work.

I have also noticed, for example, that the recent issue of *Family Therapy* magazine (*AAMFT*) is dedicated to the topic of Medical Family Therapy. There are also a number of Medical Family Therapy training institutes in the United States that include a strong emphasis on effective collaboration with the health care system. This
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The term was first coined by Mc-Daniel, Hepworth and Doherty (1992) to refer to the ‘biopsychosocial treatment of individuals and families who are dealing with medical problems’ (p. 2).

4. Accountability through Research
In the history of family therapy the push for accountability has occurred through epistemology. Our history has been defined, in many ways, by a struggle to become less deterministic, more collaborative and more respectful of the power we wield as therapists. While this has been critical we are starting to see that rigorous investigation is also important. Many of our ideas have now been operationalised and submitted to randomised control trials. Examples include the Maudsley model for anorexia nervosa (Lock, Le Grange, Agras & Dare, 2001), attachment-based family therapy (Diamond, Diamond & Hogue, 2007), multi-systemic family therapy (Henggeler & Schaeffer 2010) and How I Ran OCD Off My Land (Marsh & Mulle, 1998), all of which have been found to be effective.

These four developments have some parallels with findings from the most recent Delphi study into the future of therapy (Norcross, Hedges and Prochaska, 2011), where 62 leading mental health professionals from the widest possible range of disciplines and approaches identified the following emerging themes:

Efficiency is an economic theme that emphasizes the briefest therapies, the cheapest therapists, and the least expensive techniques. Evidence is a scientific theme that rewards research on the efficacy of treatments, therapists, and clinical interventions. Evolution is a theoretical theme that supports gradual change that builds on, rather than breaks with, historical trends in therapeutic theories and techniques. And Integration is a knowledge theme that seeks increasing cohesion to counter historical fragmentation. These four themes are the key drivers of change in the profession of psychotherapy (p. 6).

We may argue, of course, that the theme of efficiency might not be one we want to emulate and that the definition of evidence above is limited, but the parallels are still there. The four developments that I have identified, however, make sense for us in concert, because they imply that the field is going through a period of transition. The journey from structural to narrative allowed us to establish our identity, differentiating us clearly from psychoanalysis and the medical model. Now that this has been achieved we are secure enough to enter into relationships as a field. Our focus on integration demonstrates that we are relating better with each other. Our active boundary crossing into other fields shows that we are reaching outside of what was a somewhat closed system in the past. I am also proposing that this sense of security in our identity means that we are much more ready to put our ideas to empirical test.

Three Myths about Research
If Accountability through Research is going to continue as a major theme in family therapy I think it is important for us to explore some of the misconceptions we hold about the research endeavour. I want to do this by exploring three common myths that I believe still serve as restraints to research in family therapy.
Myth 1. Manuals Will Curtail the Therapeutic Alliance

Personally I spent five years using a manual conducting the Maudsley model of family-based treatment for anorexia (Lock et al., 2001). This manual and many others do not prescribe every move of the therapist but provide a structure to therapy based on specific models of practice and phases of treatment. The manual represents a sophisticated integration of structural, systemic and narrative therapy, with the rationale for the phasing of treatment well documented in the literature (Whitney & Eisler, 2005). It represents a set of non-negotiables or principles that the therapist must follow rather than prescribing every word.

Our own work has supported the need to follow these non-negotiables, demonstrating that the six core ingredients of this model each serve as predictors of treatment outcome, a study conducted as part of a five-year randomised control trial (Ellisson, Rhodes, Madden, Miscovec, Wallis, Kohn & Touyz, 2011). Pereira and Lock (2006) have also found that the working alliance is still a critical component of treatment, despite the structure required by manualisation. Langer, McLeod & Weisz (2011) found that children in individual psychotherapy actually reported a stronger therapeutic alliance for manualised treatment than non-manualised. We can hypothesise about why but my hypothesis is the therapist actually knew what the hell they were doing. I am concerned that our supposed fear of structure masks a fear of the boundaries that might be imposed by manualisation, a paradox indeed given our clinical emphasis on the value of containment.

Myth 2. Evidenced-Based Practice is a Form of Big Brother

I think we often assume that adherence to evidence-based practice will render us robots, mindlessly copying other people’s ideas without considering the unique needs of our patients. If you actually read Sackett, Straus, Richardson, Rosenberg & Haynes (2000), however, where they articulate the tripartite model of evidence-based medicine, you will see that it allows for an integration of science and practice, by recognising the role of clinical wisdom in the implementation of treatment techniques. It does not suggest that we are blinded by science, riding roughshod over creativity or simply bypassing the person of the therapist:

> evidence based practice entails making decisions about how to promote health or provide care by integrating the best available evidence with practitioner expertise and other resources, and with the characteristics, state, needs, values and preferences of those who will be affected. This is done in a manner that is compatible with the environmental and organizational context (www.ebbp.org)

These notions are far from novel, of course, with Kuhn (1962) proposing that scientific theory is insufficient and that ‘puzzle solving’ was required for a scientist to be considered as competent. The American Psychological Society (APA) also recognises this approach, stating that practitioners need to consider research findings, clinical expertise and patient characteristics in decision making. Clinical expertise is seen to include self-reflection and interpersonal skills and patient characteristics, including their unique strengths, cultural context and preferences.
Myth 3. The Results of RCTs Are Not Relevant to Real-World Practice

Many family therapists seem to have the view that the results of randomised control trials are not necessarily relevant because they focus on outcome over process and do not allow for the unique characteristics of individual families to be considered. This may have been true in the past but in the last 10 years there has been an increasing recognition that more sophistication needs to be built into RCTs. In particular, Kazdin (2007) insists that all RCTs need to include an analysis of treatment mediators and moderators if they are to be relevant. Mediators are those variables that are responsible for outcomes; the core ingredients responsible for change. Moderators are those variables that influence the likelihood that mediators will contribute to outcome. This type of analysis allows the therapist to look under the bonnet of a particular treatment and at its most sophisticated would allow for the recognition of different mechanisms of change for different variations in population. Given these developments we can no longer argue that the RCT renders clinical decision making obsolete.

As family therapists, it is my assertion that we can no longer afford to be afraid of the research endeavour. If we fail to put our ideas to the test, to conduct our own work in the light of what people have found to work before us, to take seriously the need to be informed by evidence, there is a real risk of quackery. My own experience as a supervisor and a past Editor of *ANZJFT* tells me that there are still many therapists working in glorious isolation, relatively oblivious to well established evidence. Creativity and the development of unique approaches to complex families, is, of course, critical in our work. It is what inspired many of us to take up family therapy and continue with it.

However from my perspective when you are dealing with life threatening situations, like anorexia nervosa, suicidality and self-harm, violence and abuse, not being informed about what might work should no longer be tolerated in our field. This does not imply a slavish application of research findings, but rather their integration into our creative and collaborative engagements with families. Science, done well, should inform rather than impede the meeting between human beings in therapy.

Unique Outcomes: Signs of Change

Having said all that, I do think there are many signs that we are beginning to take the research endeavour more seriously in Australia. As discussed I think we are in transition and as such it is not hard to see many examples of change. Certainly, this is better established overseas; take a look at any issue of *Family Process* for example. In Australia, we are currently producing what I believe to be a record number of PhDs. This level of academic achievement is becoming much more common place and is an enormous investment in the development of a research culture in our future. Our Journal, *ANZJFT*, has also endeavoured to embrace research, through the publication of Research Editions, from the publication of many other research pieces and by knocking back papers that are in the category of glorious isolation as described earlier.

As yet, however, especially if we compare our development with our colleagues in nursing or psychotherapy, there is a real risk of us getting left behind if this problem...
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is not further addressed. Nursing, for example, are national leaders when it comes to rigorous qualitative research. Also, just take a look at the journal *Psychotherapy Research* or the program of their recent Sydney conference to see how far this field has come, in terms of research, compared to our own endeavours.

**What Can Family Therapy Offer Research?**

If research was to become a more significant aspect of our culture what would it look like? What do we, as family therapists, have to offer the research endeavour? Despite the value of the randomised control trial I am fairly confident that most family therapists do not want us to go down the track of an exclusive commitment to branded treatments or RCTs. While this has a very important role I believe that part of the answer lies in the integration of the values we learned from the first phase of our development with those of a structured and rigorous approach to investigation. In particular, I am proposing that we might be more at home with the following types of research:

1. Process research: the investigation of the intrapersonal and interpersonal in the therapy room (Rhodes, 2011).
2. Participatory action research: collaborative research that joins with participants to make and document change.
3. Research based on methods closely aligned with specific models of therapy.

Below I provide some specific examples of research from each category that I am currently conducting with students enrolled in the Doctorate of Clinical Psychology at the University of Sydney. Hopefully these will demonstrate research that is of direct relevance to the values and interests of family therapists.

**Process Research**

Greenberg and Watson (2009) argue eloquently for process research, stating that the interplay of therapist and patient variables need to be studied in all their complexity if we are to understand the means by which outcomes are established. In my own paper (Rhodes, 2011) I provide a detailed exploration of different methodologies that can be described as process research, including mechanisms of change research, patient-focused research, interpersonal process recall and conversational analysis. I will describe two studies that I am currently conducting with my students, one exploring the dynamics of change in the family meal as part of the family-based treatment of anorexia nervosa, the other exploring how interns make decisions in the therapy room during training.

**The family meal in the family-based treatment of anorexia nervosa.** The family meal is an iconic feature of Minuchin’s structural approach (Minuchin, Rosman & Baker, 1978) and serves as the second session in the manualised family-based treatment model (Lock et al., 2001). Both position the meal session as an important driver of change in therapy, but little research has been conducted to explore or test this assertion. In our study videos of 35 meals are being transcribed and coded to answer the following questions:
a. What do therapists and family members each do to contribute towards success in
the meal, as defined by the child eating?
b. Does structural family therapy theory account for these changes?
c. What patterns of interaction differentiate meals that work from those that do not?
d. What specific therapeutic strategies does the therapist use to contribute towards
success?
e. What specific behavioural strategies do family members use?

A variety of qualitative methods will be used to answer these questions. In the first case
principles of grounded theory (Strauss & Corbin, 1998) will be used for a preliminary
analysis of transcripts. Structural and systemic theory will then be used as potential
lenses for analysis, following the principle of theoretical triangulation (Denzin, 1970).
Four meals will then be selected for conversational analysis (Sidnell, 2010), two that
are successful and two that are not, for an in depth exploration of the turn-taking
process, including verbal and non-verbal interactions.

We will also test, through quantitative means, whether success in the meal predicts
final treatment outcome. By doing this we will be able to isolate specific interactions
between therapist and family members that contribute towards recovery.

The dialogical self and clinical psychology interns: An exploration of intense emotion
and supervision needs. Traditional teaching of clinical psychology focuses on the
development of competencies and skills at the expense of reflective practice. While
this focus is important it can be limited when new interns in clinical practice may be
anxious, stressed or stuck in their work with clients. This study explores the emotional
experiences of novice therapists early in their training and aims to understand:

1. Their intense emotions during therapy.
2. The personal and professional dilemmas related to these emotions.
3. The quality of their attempts to resolve these dilemmas in the therapy room.

In particular we hope to be informed by Rober’s (2005) work with more experienced
therapists, revealing the kind of dialogues that occur for novices, between their personal
and professional selves. This project uses Interpersonal Process Recall (IPR) (Larsen,
Flesaker & Steig, 2008), a method that involves in-depth interviewing of participants
while they watch a videotape of themselves conducting therapy. In this study videotape
is played directly after the session and the student is instructed to stop the tape when
they recall experiencing an intense emotion. The IPR interview is then conducted,
exploring the internal dialogue associated with that emotion. Final transcripts have
three columns of data; the therapy session, the IPR interview and quality rating
of therapy conducted by expert clinicians. The coding of each column, followed
by the coding of patterns between columns, allows the development of theories
regarding the internal world of the intern and how it relates to performance in
therapy.

Participatory Action Research

Participatory action research (PAR) (Israel, Eng, Schultz and Parker, 2005) is informed
by a philosophy similar to second-order cybernetics (Hoffman, 1990). This holds that
most quantitative research looks at subjects from the outside, conducting research on
them, not with them and results in global not local solutions. PAR involves a more collaborative engagement with others, where researcher and participants join together to become more actively involved in change. An example follows.

Family of origin coaching for child and adolescent mental health clinicians: A participatory action study. Family of origin coaching is a unique model of supervision (Donnelly & Gosbee, 2009), given the focus on the clinician themselves that excludes any reference to case material. This model is currently being utilised with busy clinicians working in a tertiary child and adolescent mental health service. As little research has been conducted on this approach, the researcher has joined with the supervisor and clinicians to explore the effects it may have on clinical practice and refine the procedures and processes involved.

The research follows the experience of five clinicians participating in family of origin coaching, in group format, for a 12-month period. Focus groups and individual interviews are being conducted at three-monthly intervals to explore the personal, clinical and organisational effects of coaching sessions. These interviews are transcribed and coded and summaries are then fed back to all participants at regular action meetings where changes to groups can be made if appropriate. This circular process of exploration and action allows for this model to be developed and refined and may serve as a precursor to an outcome study.

Research Methods Closely Aligned With Models of Therapy

The array of qualitative data collection and analysis methods is as varied as the methods of family therapy and finding a good fit can significantly enhance a research project. Below are brief descriptions of two studies, one informed by systemic practice using social network analysis and another informed by narrative practice using narrative inquiry.

Systemic consultation for disability case managers: Exploring effects on interactions and workflow. Case management is a much undervalued profession, one that demands the capacity for both leadership and systemic thinking. In the field of developmental disabilities cases are often very challenging, involving a highly stressed family and large burdened wider system. This study also compares groups of case managers in disability services, one receiving standard supervision and the other participating in supervision based on Andersen’s (1987) reflecting team approach with a team of systemically trained supervisors (Rhodes, Whatson, Mora, Hansson, Dikian & Brearley, 2011).

Case managers detail and rate their interactions with all stakeholders in a case, before and after supervision, resulting in the development of pre- and post-interactive maps. These maps are evaluated statistically, following social network analysis (Freeman, 2006) and this data, when coupled with coded interview transcripts allows for the isolation of interactional changes resulting from both types of supervision.

Recovery from chronic anorexia: Comparing insider and outsider knowledge. Recovery from chronic anorexia nervosa is considered rare, with no current treatments yielding significant results (Fairburn & Harrison, 2003). The aim of this study is
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to interview across Australia people who have recovered, to access and archive their ‘insider knowledge’ (Madigan, 2011), with the hope of contributing towards the development of treatment in the future. Twenty women are being interviewed, each recovered according to DSM-IV criteria for more than five years after a minimum of seven years’ anorexia nervosa.

Narrative inquiry involves the following steps (Clandinin & Connelly, 2000):

a. Conduct lengthy interviews where the person is asked to tell the story of their recovery.

b. Transcribe and then reorganise the text, so that it appears in temporal order, in the third person and with extraneous material excluded.

c. Conduct a second interview to ask the person to reflect on the rewritten narrative, making additions or changes if necessary.

d. Code themes within subjects and over time code typologies of stories as they emerge between subjects.

The typologies of stories of recovery will then be used to hypothesise about possible treatment applications. Stories will also be published in a format that can be accessed by current sufferers of anorexia nervosa.

I have now described a small group of studies with the aim of demonstrating that research can be of direct relevance to the needs of family therapists. Each of the three categories described, process research, participatory action research and methods aligned to specific models of therapy are inherently consistent with our own interests. The exploration of therapy room dynamics, a commitment to collaborative innovation and change and the investigation of interactive patterns and narratives are all part of our historical tradition.

Quality Control in Research

Before I conclude I would like to address one more issue: how we might ensure that our research is of high quality as we proceed? While it may be challenging to set clear criteria in this respect, I would like to propose three basic standards as a way of starting the conversation:

1. **Researchers conduct systematic reviews before developing research questions.** Just because we have a fantastic idea in the therapy room does not mean many others have not had the same revelation themselves. Established protocols for conducting systematic reviews (Petticrew & Roberts, 2006) provide a rigorous scientific way for us to demonstrate that we have done our homework and can be used for reviews of both quantitative and qualitative studies (Thomas et al., 2004). These reviews, once published, serve to guide research but are critical if family therapists are to become more scientifically literate.

2. **Researchers choose methods to suit their question rather than vice-versa.** Researchers, like therapists, must eventually learn more than one approach if they are to be effective. Many qualitative researchers hold a default position of grounded theory, or worse still thematic analysis, when there is a host of more sophisticated methods that allow for a richer description of lived experience. Multiple sources of data and modes of analysis enhance the credibility of findings.
3. Researchers include processes that mediate against bias in their research design. Chiovitti and Piran (2003), Seale and Silverman (1997) and others describe a variety of measures for qualitative research that can be taken in this respect. These include:

a. Cross coding
Making sure that someone else codes some of your interviews and that you then meet and compare notes and modify codes if necessary.

b. Member checking
Taking your coded data, themes or theories back to your participants to ask for feedback and making changes if necessary.

c. Audit trail
This ensures your results can be clearly tracked back to your themes, which in turn can be tracked back to your transcripts, via a process of thorough memoing.

**Conclusion**

I have argued that family therapy has entered a new era since the 1990s, namely that of a mature field prepared to contribute to the research endeavour. I have argued that we have nothing to fear from research. Firstly, because manuals, evidence-based practice and the RCT are not as detrimental as we might have thought and might even be a force for good. Secondly, because there is a place for us to contribute in ways that are fundamentally congruent with the interests and values that we have always had.

Personally I am concerned about the sustainability of our field if we do not embrace research in more substantial ways. Nursing, psychotherapy clinical psychology and psychiatry are thriving in this regard and there is a real possibility of us getting left behind. I am also of the firm view that we need to question the value of continuing to present or publish our ideas without putting them through some form of rigorous investigation. I am not suggesting, of course, that research takes the place of practice, epistemology and ethics. Hopefully I have been able to demonstrate that research can be used to further these interests.

**References**


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