5 Research and evaluation

Introduction

The relationships between systemic family therapy and research has been an interesting one. Early work in the 1950s was regarded as primarily a research endeavour. Haley (1978: 73) observed that during this era, 'it was taken for granted that a therapist and a researcher were of the same species (although the therapist had a more second-class status)'.

Some of the ideas which became fundamental to systemic theory and practice arose from research interests. For example, Bateson in the 1950s (1972) was involved in research into communication processes and learning in mammals, including some fascinating studies of communicational processes in dolphins. This led to extensive research on communication in humans and relationships, such as families and to the seminal book of the Palo Alto group, *Pragmatics of Human Communication* (Watzlawick *et al.* 1967). This not only inspired a plethora of research on 'deviant' communication processes, for example explorations of families with a schizophrenic member, but also a wide range of research into communication in non-pathological contexts. Interestingly much of this initial research centred on audiotaping of family therapy sessions or interviews with families. The process of family therapy was seen as a potential goldmine of research. Watzlawick *et al.* (1967), Weakland (1962) and others published a fascinating range of studies based on the analysis of transcripts of therapy sessions. With the advent of video recording these studies expanded to include observations of the interrelationships between modes of communication, for example inconsistencies between the verbal and non-verbal messages. Such observational studies led to some important models, for example the double-bind theory, and the discovery of the importance of non-verbal

communication, such as when there is inconsistency between the verbal and non-verbal messages the latter, especially for children, may be given more credit.

Another influential body of research was directed towards exploration of family variables in attempts to identify family 'types', for example family dynamics associated with anorexia nervosa or schizophrenia. It was hoped that such research would reveal important factors related to aetiology and subsequently could be employed diagnostically and to guide treatment. A central interest was also on what types of treatment were appropriate for different disorders. For example, Minuchin *et al.* (1978) produced accounts of work with psychosomatic families, Haley (1966) and Weakland (1962, 1976) on work with schizophrenia and the Milan team reported on their work with anorexia and subsequently schizophrenia (Palazzoli *et al.* 1978). The studies range in their methods from detailed attempts to control variables and employ standardized instruments to measure family factors, to studies that relied on descriptive case study material. This variety of methods led to criticisms of lack of vigorous research and evaluation of systemic therapies. Though having some validity, these criticisms may also have missed the point that valid research may need to be multi-faceted and explore the intricacies of families' experiences, as well as employing more 'scientific' and 'objective' instruments such as psychological tests and inventories.

Why conduct research?

Despite the legacy of research in systemic therapy there has also been a considerable backlash against research. Interestingly one of the strongest articulations of this protest came from Jay Haley (1971, 1976a, 1976b) who, ironically, was also one of the most influential and productive of the early researchers. He argued that the purposes of research were distinct from that of therapy. Specifically he argued, from a pragmatic approach that embodied the strategic and solution-focused approaches which were gaining ascendancy, that the production of change could occur without ultimate understanding of the nature or causes of change. More profoundly he suggested that therapy was an infinitely complex shifting web of interactions, feelings, beliefs and emotions. These in turn were shaped by the past experiences of each family member, the therapist and the supervision team. To attempt to fully understand and to be able to predict this complexity was, he argued, futile. This view is in fact central to systems theory. Though systems can be seen to display predictable patterns it is argued that it is not possible to predict precisely the effect that interventions or perturbations

of the system will have (Weiner 1961; von Foerster and Zopf 1962; Bateson 1972, 1980). Moreover, as we have seen, the second-phase suggested that there was in fact no system, 'out there' to predict but that the observer was inevitably part of the equation. The act of observation inevitably produced an element of perturbation and altered the family dynamics being observed.

We want to suggest that, though important, these doubts about the value of research may inevitably be misguided. Perhaps one of the most obvious reasons for this is the very fact that systemic therapies arose from research and that to abandon this might stifle future creativity. Second, it may be that there has until recently been a restricted view of what counts as research. Arguably the daily work of family therapists involves important aspects of what can legitimately be counted as research. For example, the fundamental systemic notion of revising interventions on the basis of feedback is a microcosm of the research process. Third, we agree at least to some extent with the move in psychotherapy and more broadly in all areas of clinical and medical work to proceed on the basis of evidence. This emphasis has been described as the need to develop 'evidence based practice' in which practitioners continually attempt to evaluate the nature and effectiveness of their work. Such data is of course valuable to managers and purchasers in making decisions about what services to support and develop. However, we suggest that what counts as evidence should be considered broadly. Simply counting cases and supposedly objective measures of outcomes may offer scant information and may also at times be misleading if we do not understand the nature of the work undertaken or, for example some of the subtleties of changes that may be occurring.

We suggest that an interest in research encapsulates the notion of family therapy as motivated by 'curiosity'. Sometimes this may have a direct and instrumental focus, for example the research may be driven by questions about the cost-effectiveness of alternative forms of family treatment and at other times by more conceptual questions about the process of change, or qualitative questions such as how family members experience family therapy. The kinds of questions we may wish to ask can be grouped into the following categories:

Evaluation research may be concerned with questions about the effectiveness of family therapy:

- comparison of systemic family therapy to other forms of therapy, such as cognitive therapies;
- comparisons between different types of systemic therapies;
- effectiveness of systemic therapies for different types of disorder.

Process research is concerned with more specific questions about how therapy works and what the active ingredients may be:

- the therapeutic alliance – the relationship between the family and the therapist and how this relates to the effectiveness of different types of interventions;
- how change occurs – different stages in therapy, changes in family dynamics, family beliefs and emotional dynamics;
- therapist variables – gender, race, experience of the therapist;
- family members' experience and expectation of therapy and how this relates to change, experiences of different types of interventions;
- supervision, for example comparisons of reflecting team vs consultation approaches.

Family theory research is research that is aimed at exploring family life more broadly that just the therapeutic context:

- family dynamics in relation to different types of disorders and problems;
- family roles, such as gender roles and cultural expectations;
- decision making in families, power and influence strategies;
- family communicational processes;
- emotions and family dynamics;
- family life cycle processes, transitions and change.

These three broad categories of research are to some extent distinct but also show considerable overlap. Evidence from therapy, for example informs family theory and in turn theoretical research about family dynamics also offers ideas for the development of practice. Research is associated predominantly with evaluation and this may not always be the most inspiring. Reiss (1988: 34) argues that in order to 'do family therapy research without dying of boredom' we might wish to concentrate on process and conceptual research:

> Our true passion . . . is reserved for demonstrating to others by what mechanisms we have achieved effectiveness . . . what we cherish and what we believe permits us to be effective is our insight into family life and its relationship to psychiatric symptomology.

In our experience many trainee family therapists share Reiss's view. Evaluation of the effectiveness of therapy is seen as a laudable and worthy aim but also one that under- rather than overwhelms them with enthusiasm. Arguably evaluation on its own provides a bland picture that may be of interest to purchasers of services but ultimately is of little value to clinicians in terms of helping them to improve what they do. Critical to any development of therapy is to develop increasingly sophisticated ideas about the active ingredients of therapy. However, it is also suggested that in order to achieve increases in such

understanding it is necessary to develop theories of therapeutic change and family functioning. Pinsof (1988) refers to this as a 'discovery' oriented approach as opposed to a 'confirmatory' one. He also argues that systemic therapy tends to have general rather than specific theoretical principles and there is a need to develop more specific microtheories. An important example is to consider the nature of the therapeutic alliance. A range of studies, both systemic and individual, have indicated that the relationship between the client/s and therapist is critical to the outcome of therapy. For systemic therapy this poses a range of related questions, for example whether the therapist needs to be allied to every family member, the identified patient, various subsystems, the most powerful or influential members of the family and so on.

Research on natural family dynamics and processes can be of considerable interest but also relevance to therapy. Watzlawick *et al.* (1974) examined change processes in a variety of natural settings and these ideas have been extensively applied to work with families and individuals. However there has subsequently been a dearth of research on natural processes of change in families:

> There has been relatively little interest among family therapists in systematic observations of families in non-therapeutic settings. In particular there has been surprisingly little interest in the circumstances and processes that lead to major or substantial change in family patterns in natural settings – changes that, in some instances, might truly be called self-healing.
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> (Reiss 1988: 37)

This lack of attention to natural healing processes is generally evident in psychotherapy research yet is perhaps least explainable for systemic theory since its roots were so firmly in observations of family dynamics. It's as if we have become fixed in looking only at deadlocks in families rather than how the majority, a vast untreated population of families who experience problems, also manage to resolve these problems themselves. However, there is increasing interest in the question of family resilience (Walsh 1996; Dallos *et al.* 1997).

Science, research and systemic therapy

Arguably the practice of systemic therapy is one of the therapies that is most compatible with research. This may seem an odd assertion given that there has been considerable criticism that systemic family therapy has lacked rigorous research. Compatibility with a

scientific method can readily be seen both in terms of the process and the practice of family therapy. Modern science does not claim to provide definitive explanations; instead it attempts to produce the best explanatory model that is possible. Furthermore, science is not seen as the dogged accumulation of facts but as developing on the basis of paradigm shifts (Popper 1962; Kuhn 1970). For example, the move from Newtonian physics to relativity theory involved a creative leap to a new theory which took account of the relative position of the observer to what is being observed. Though this offered a better explanation of the observed facts, it is not seen as a definitive, once and for all theory. Science in its essence involves a continual process of formulating theory, testing and reformulation based on the evidence or feedback. This is consistent with the systemic notion of therapy as guided by a process of 'progressive hypothesizing'. Therapists are not trying to capture fundamental truths about a family but instead are attempting to develop more or less useful explanations.

The practice of family therapy also lends itself to scientific research. For example the common usage of supervision teams means that it is possible to introduce inter-rater reliability measures into observations about family and family–therapist interactions. In contrast to most other therapies, where the therapist works alone with one client, family therapy is public and less subject to potential personal biases. Likewise, the videorecording of sessions is extremely common and this material also offers scope for structured analysis and, for example inter-rater observational analysis. It is also possible to transcribe videotaped sessions and engage in detailed analysis of the content of the sessions. The hitherto frequent use of tasks or assignments between sessions can also be seen as offering an opportunity for research investigation.

Systemic therapy is not only compatible with the principles of the natural sciences but more so with the profound developments in the theoretical and research bases of the social sciences. It has been acknowledged that the positivist principles of the natural sciences – the reliance of objective, observable data – is not sufficient for an understanding of social phenomena. If it is recognized that a fundamental feature of human beings is that we create meanings rather than just behave, then it is not sufficient to simply attempt exploration through experimental or observational approaches. For example, we need to have some ideas about how families experience therapy and what changes occur in their beliefs and explanations in order to understand more about how therapy functions. Furthermore, in order to develop such understandings we may also need to consider how our own experiences may be colouring what we are able to hear families say about these experiences. In the social sciences such issues have been taken up in a range of research approaches.

Varieties of research

There is a common assumption among trainees and many experienced family therapists that research basically involves a choice between giving families a variety of questionnaires or tests or alternatively interviewing them in some way. Despite the fact that family therapy relies fundamentally on observation this is often not even considered as a research possibility. In fact there are a wide range of research methods that have relevance to research into systemic family therapy. The realization of this potential choice and recognition that much of the practice of family therapy can be turned into research can be quite a liberating experience. However, there can be seen to be a fundamental division between *quantitative* and *qualitative* research methods.

Quantitative methods rest on positivist assumptions about an objective reality, quantification and reliable measurement. The theoretical basis is drawn from the natural sciences and the aim is to be able to create generalizable models from which specific predictions can be made. These are set out in the form of testable hypotheses and statistical techniques are employed to assess the probabilities that the observed results could have occurred by chance. Evaluative studies of family therapy tend to be in this mould, with the focus on observable changes in symptomatic behaviours. By and large these approaches are also reductionist in that attempts are made to reduce the phenomena to small, focused and manageable components. In evaluation therefore it might be argued that change can be reduced to a measure of some key behaviours rather than looking at the complexity of family functioning over time and the multiplicity of potential influences.

Qualitative methods are largely based on theoretical positions that are concerned with exploring meanings rather than simply observable behaviours. Constructivist and social constructionist approaches to family therapy fall into this category. Families are seen as creating meanings that guide action and it is change in the meanings of their actions, including the 'symptoms' which is of fundamental significance. Simply focusing on the 'problems' is seen as inadequate since this would, for example fail to take into account the processes whereby they have evolved from the conversations in families and between families and professionals. It is suggested that there is no objective reality 'out there' but that the researcher or therapist is inevitably bringing a set of their own assumptions that colours what they see. In order to conduct research there is a need to engage in a collaborative process of exploration with the family. In effect the family tells or helps the researcher to form an understanding of the family's world.

Ethnography emphasizes that the understanding of social phenomena involves the researcher becoming immersed in the subject matter. An example would be a study of street gangs in which the researchers

join and live with the gangs for a period to gain an idea of what this experience is like, to become immersed in their activities and to learn their language, idioms and vocabulary. Similarly Vetere and Gale (1987) conducted a study which involved the researchers living in with families for several weeks to gain an insight into their lives (see pp. 168–9). On the basis of this immersion the researcher formulates and successively reformulates his or her hypotheses or guiding propositions. Rather than simply attempting to eliminate the researcher's 'biases', ethnography recognizes that this is both a futile and sterile endeavour. Instead, the researcher continually attempts to reflect on how the events being studied impact on him or her and also how these alter and change. Part of this reflection involves a consideration of the researcher's social and cultural contexts, for example how a researcher's white and middle-class background may influence their perceptions and reactions to the actions and beliefs of black youths and their behaviour in gangs.

Such conscious use of self is also reminiscent of the therapist's involvement with a family. We will explore a variety of such qualitative methods in some more detail later but the significant point is that research methods in social sciences parallel the shifts from first- to second- and third-order cybernetics. There is an emphasis on the inevitability of the observing position and also that the observer is in turn influenced by their social and cultural contexts. As in the example of youth gangs, a family therapist or researcher is involved in attempting to understand a family set of beliefs – in a sense attempting to learn their language.

At the extremes, these two positions are worlds apart. However, it is possible to see considerable overlaps, for example measurement and quantification may be included in both approaches. The number of times a family employs a particular concept in their descriptions may be meaningful and add to the picture given by an analysis of the meanings of their explanations and stories, for example, how important and central the theme currently is for the family. It is also possible to distinguish the approaches in terms of their technical aspects as opposed to the conceptual differences. For example, interviews are usually regarded as a qualitative approach but the analysis of the content can include quantification into themes or categories. It is our suggestion that it is useful to think of ways of integrating the approaches, especially if we are interested not just in evaluating therapy but exploring the processes of change.

Returning to our three broad categories of research – evaluation research, process research and family theory research – we can see that there are a range of different research methods that are located within these (see Sprenkle and Moon 1996 and Wynne 1988 for very helpful overviews of the variety of family therapy research possible). These are summarized in Figure 5.1.

Case studies

These consist of in-depth explorations of effects of therapeutic treatments, or a family's experiences of different kinds of event, such as changes in their relationships over time. The researcher may employ a variety of methods within a case study, such as observation, interview, asking the family to keep diaries, observations of people outside of the family etc. to build a rich and detailed picture.

Case studies may be individual or multiple case studies, for example a study might consider in-depth the experience of a family who has had a positive *vs* a negative experience of therapy.

Interview studies

These consist of the use of interviews with family members, either individually or together (or both). The interviews are usually transcribed and explored to gain a picture of the nature of people's understandings, beliefs and experiences of various family events (loss, break-up, transitions), or their experience of therapy. Due to the extensive time involved in analysis, interviews usually involve a relatively small number of people, for example, 20 families would be a sizeable sample.

Focus groups are used in an approach where a group of people are interviewed, for example, members of a family support group, or a group of therapists. Such interviews allow further information to emerge through the mutual prompting of ideas that surface through discussion.

Questionnaire/survey studies

These involve the use of questionnaires designed to explore family members' beliefs and feelings about various issues, for example, aspects of their lives, experiences of therapy, attitudes to services. Questionnaires may involve a large sample to gain a broad picture, or general attitudes to various issues.

They also allow the use of statistical methods to allow predictions to be made, for example about various trends such as gender differences, family attitudes to divorce or support services.

These studies can also involve selecting a particular sample, e.g. family therapists working with different approaches, to explore their views and employ a process of feedback to the participants to arrive at a consensual view, for example the key differences between narrative and strategic approaches (Delphi studies).

Experimental or comparative studies

These usually involve some attempts at control or manipulation of certain variables by the researcher. For example, different types of therapy may be compared or attempts made to compare the responses to different types of interventions.

Frequently standardized measures may be employed, such as inventories of family functioning (e.g. The FACES measure of family cohesion and adaptability, Olson *et al.* 1989). Statistical techniques may also be employed, for example to assess significance of differences between types of treatment and to allow generalizable predictions to be made.

Observational studies

These involve various forms of observations of families. The kind of observations may vary from external observations where the researcher attempts to gain a relatively 'objective' picture, for example of family communication patterns, to more subjective or participant observation where the researcher tries to become immersed and fully understand the nature of family experiences. In turn, the observations may vary from structured – using quantifiable ratings of pre-determined aspects of family dynamics – to unstructured, where an informal approach is used and particular events are focused on as and when they emerge as important.

Figure 5.1 Varieties of research methods

Evaluation research

A much repeated critique of family therapy has been that there has been inadequate research designed to evaluate its effectiveness in comparison to other treatments and in terms of types of problems and family variables.

Group comparison evaluative studies

These are perhaps the best known of all research designs. The most widely employed method in clinical research had been to compare two groups of clients, for example those undergoing a particular treatment with those who are not receiving any treatment (a control group). The inclusion of a control group is to identify whether change in a group of people may be happening naturally as a result of time spent engaged in any activity. These studies also employ pretest and posttest measures, usually a range of standardized tests and questionnaires and may in addition include ratings of change based on structured observation. Participants are randomly allocated to either the treatment or control groups so that biases, such as severity of problems, age, abilities and resources, do not obscure or bias the results. Predominantly the focus is on assessing overall average change for the various treatments. Statistical tests are typically employed to determine the probability of whether the changes pre- and posttherapy could have occurred by chance. A standard benchmark of probability is that if the chances of this are less than 5 per cent (less than five times out of 100) it is usually concluded that the effects due to the treatments are significant. However, there have been occasions where consternation is caused when it is found that non-treatment and the effects of spontaneous recovery can be as good as therapy (Rachman and Wilson 1980).

A drawback of such group-based experimental studies can be that individual differences in response to treatments may be obscured. Also, such studies may tell us little about the active ingredients of a treatment. Reiss (1988) argues that in a climate of competing resources for services the main aim of such studies is often to reassure or convince fund-holders to maintain or increase resources rather than to develop our knowledge of therapeutic effectiveness. This kind of design is also subject to ethical criticisms in that the control group is not allowed the benefit of assistance when they may be in considerable distress. In this section we will examine a number of approaches to evaluative research.

'The comparative efficacy of Milan family therapy for disturbed children and their families' (Simpson 1990)

This study attempted to compare the effectiveness of a Milan family therapy approach with other 'routinely employed' treatments in an out-patient child psychiatry department. Eighty-seven families took part in a study in which families were randomly assigned either to a course of Milan family therapy treatment (MFT) or to an eclectic package of treatments including individual psychotherapy, behavioural and cognitive approaches and non-Milan family therapy. The families contained children displaying a wide range of problems but families with a child displaying psychotic symptoms were excluded since this was an experimental study. All the families were assessed prior to treatment, at the end of treatment and at a six-month follow-up on a range of measures: semi-structured interviews, the Rutter A and B scales (a measure of disturbance in school-aged children, three rating scales on which parents indicated the severity of the presenting problems, satisfaction with current family life and satisfaction with therapy and the Life Event Inventory).

In addition the therapists also completed an assessment schedule at the end of each therapy session including details of the session and, at the end of treatment, the therapist's impression of the amount of change that had occurred.

The results indicated that MFT was as effective as the other therapeutic techniques employed even though these had the advantage of being more specifically selected according to the children's presenting characteristics. MFT was shorter in duration than the other treatments and families reported greater positive change on general family functioning.

'The clinical and theoretical impact of a controlled trial of family therapy in anorexia nervosa' (Dare et al. *1990)*

This study attempted to evaluate the effectiveness of family therapy in comparison to individual supportive therapy for women suffering from anorexia. A sample of 80 women participated in this study and each person was randomly assigned to the two treatment groups. Individual supportive therapy (average of 16 sessions) was a symptom focused treatment which made use of a broad range of therapeutic interventions including behavioural, analytic and strategic techniques. Family therapy (average of nine sessions) included a range of approaches including structural, strategic and systemic approaches.

The therapy was also adjusted according to the age of the women. With the younger group the first phase was focused predominantly on the eating problem and with encouraging the parents to take charge. Once progress with weight gain was established other family

issues relating to the eating were discussed. Later the sessions moved towards the encouragement of autonomy and enabling the young women to take control of their eating and discussions of their eventual leaving-home transitions and the impact this had on the parents' marriage and so on. Four therapists took part and they provided both the family and individual treatments in order to control individual variables. Both groups were intended to have approximately the same number of sessions though the individual group on average had 16 as opposed to nine sessions for the family therapy group. With the older age group there was no initial attempt to get the parents to take charge. Instead the focus was more on issues of separation and on reducing the use of the eating disorder as a medium of communication.

In addition the women were selected to fall into four subgroups in order to be able to explore a range of related specific questions:

1 age of onset of the anorexia was at 18 years or under and had been for a duration of less than three years (n = 21);
2 age of onset of the anorexia was at 18 years or under and had been for a duration of more than three years (n = 19);
3 age of onset of the anorexia was at over 18 years (n = 14);
4 women suffering with bulimia (n = 19).

Seven women in total dropped out of treatment.

Outcome measures were taken immediately after the cessation of treatment and at a one-year follow-up. In addition the initial assessment included a measure of expressed-emotion between the patients and their parents. Progress was classified in terms of one of three categories:

- good outcome – a weight of more than 85 per cent of normal weight and resumption of menstruation and an absence of bulimic symptoms;
- intermediate outcome – a weight of more than 85 per cent of normal weight but no resumption of menstruation, bulimic symptoms occurring no more than once per week;
- poor outcome – body weight less than 85 per cent of normal weight or bulimic symptoms occurring more than once per week.

For the first group pre-18 at time of onset and duration of less than three years – family therapy was found to be significantly superior to individual treatment. There were no significant (statistically) differences for the other groups though family therapy appeared to be somewhat less effective for the post-18 age of onset subgroup.

A related finding was that dropout from treatment was significantly related to the level of expressed emotions. For example in family

therapy a high level of critical comments expressed by the mother towards the patient was likely to predict an early dropout from treatment.

Overall the study suggested that family therapy is an effective approach with a younger age group, especially where the symptoms are of relatively short duration. The authors also discuss the nature of the processes of change and conclude that the apparently contrasting techniques of putting the parents in charge for the younger group and of encouraging the parents to disengage in the older group share the function of exploring and clarifying the boundaries between the generations and of accepting the need to consider new ways of coping in the face of the life cycle changes that need to be negotiated.

Evaluative studies may incorporate important conceptual perspectives into the study. For example, the next study is based upon the conceptual framework of *expressed emotion* (EE) which is a measure of the emotional tone and processes in families. This factor is seen to consist of three related aspects: overinvolvement, critical comments and warmth. As we saw in Chapter 4, these factors can be seen as encapsulating some of the key findings regarding family dynamics and pathology, such as schizophrenia, that have been identified repeatedly, for example, Bateson *et al.* (1956), Wynne *et al.* (1958), Weakland (1976) and Minuchin *et al.* (1978).

'A trial of family therapy versus a relatives' group for schizophrenia' (Leff et al. *1989)*

The work of Leff and his colleagues supported the idea that the level of expressed emotion in the family environment of a person who has suffered from serious mental disturbance is significantly related to the likelihood that they will subsequently relapse. The three factors comprising EE – high levels of criticism, emotional overinvolvement and lack of emotional warmth – have all been seen as likely to promote relapse following hospitalization and recovery (Vaughn and Leff 1985; Berkowitz 1987). An important question that this study attempted to address was whether family therapy could be employed to alter the family atmosphere by reducing EE and therefore cutting the risk of relapse. The family therapy provided was eclectic and described as a combination of 'educational, behavioural, structural and systemic techniques'.

The participants were aged between 16 and 65 and had been diagnosed as suffering with schizophrenia and were either living with, or spending more than 35 hours per week in face-to-face contact with one or more relatives. All of the families were selected on the basis of having high EE. The participants were randomly assigned to be offered either education plus family therapy (n = 12) or education

plus a relatives' group (n = 11). All participants were also still taking neuroleptic medication. Eleven of the 12 families accepted family therapy (conducted in their homes) but only six out of the 11 accepted participation in the relatives' group. The family therapy sessions lasted for about half an hour and the relatives' groups for about an hour and a half. Non-acceptance was generally associated with poorer outcome. Assessment of the participants' mental state, social activities and the parents' levels of EE (Camberwell Family Interview) was assessed independently before the treatment, at nine months after the start of treatment and at a follow-up after two years.

The relapse over nine months in the family therapy group was 8 per cent as compared to 17 per cent in the relatives group. Generally the participants' social functioning also showed 'small, non-significant gains'. Relapse was defined as the reoccurrence of psychotic symptoms that had previously subsided or the increase in symptoms still present. For both groups there was a decrease in expressed emotion. For the family therapy group there was a significant reduction in contact and for the relatives' group a significant reduction in EE. Reduction in contact occurred in various ways, for example as a result of moving to independent living by two people, more social activity or attending a day centre. Families who did not take part in the relatives' group showed very little change in EE and no reduction in relapse rates.

The findings overall were taken to suggest that both family therapy and a relatives' group can be effective in reducing relapse in people suffering from schizophrenia and that this reduction is associated with a reduction of EE and a reduction in face-to-face contact. This reduction in contact in turn may be associated with a reduction in overinvolvement. However, education plus family therapy was seen as the most efficient form of intervention since there was a much lower tendency for families to drop out of treatment.

Evaluative case studies

These have a long tradition in clinical research spanning the famous case studies of Freud's pioneering work and the early case studies in the systemic literature which, for example, explored the nature of communication and family dynamics in relation to various types of problems, such as schizophrenia and anorexia (Weakland 1976; Haley 1976b; Minuchin *et al.* 1978). These typically involved the presentation of extended pieces of transcripts from therapeutic sessions with families with a commentary and theoretical analysis. The reports could include details of individual cases or multiple case studies offering comparisons and contrasts across a number of families. The development of systemic family therapy can be seen to owe much to the accumulated knowledge gained by combining such case studies

conducted by different therapists in a variety of contexts with families. This produced a form of meta-analysis where the combination of many case studies built a generalizable picture. It also permitted a sequential testing of theories and models through the selective exploration of different cases and examining the significance of cases which suggested exceptions or inadequacies of the models (Yin 1994). For example, generalizations about anorectic family types as conflict-avoiding and enmeshed might be questioned by description of cases showing family dynamics that do not fit with this generalization. A progressive use of case studies to test theories through 'falsification' is consistent with the pure version of the scientific method (Popper 1962).

'Using the partner in the psychosocial treatment of schizophrenia: a multiple single case design' (Bennum and Lucas 1990)

The study examined the effects of an educational programme for six couples where one partner had a long-standing psychiatric history of schizophrenia. The programme offered information about schizophrenia and systemic family management including problem solving and communication raining. This was followed by eight sessions of treatment in which the ideas were explored and applied by each couple to their particular concerns. The effects of the programme were assessed by means of a standardized test, the Psychiatric Assessment scale and a five-minute sample of speech from the non-clinical spouse about their partner was used to assess the level of expressed emotion. A personal approach to assessing change was also employed by means of a personal questionnaire. Each couple generated four target problems that they hoped would be addressed during the treatment programme. These were then turned into statements such that each partner could rate improvements on a four-point scale. The measures were employed eight weeks prior to the course, before and after the two-day course, following the eight-week programme of treatment where the skills were applied to specific problems, and at follow-up – three, six and 12 months after treatment had ended.

The results were analysed for each of the six cases to provide an individual profile of change. In addition commonalities in the changes across the six couples were also drawn out. Positive changes, especially in terms of the personal questionnaire, and problems identified specifically by each couple were found and were maintained over the follow-up period. Partners generally felt more confident about their ability to cope and there were indications of deterioration in symptoms. Individual factors were also examined – for example the two spouses who had been rated as high EE at the start of the treatment showed a change to low EE – had become less critical and emotionally hostile to their partners.

Observational studies

Case studies can combine elements of observational studies. Of particular interest for therapeutic work are studies that have explored in detail the processes of change in family therapy. This can involve a variety of methods, but there is a growing interest in qualitative case studies that focus on the processes of conversations in family therapy. Specifically these are concerned with exploring how changes in meanings surrounding the problems alter as therapy progresses. Such studies complement clinical practice and do not necessarily require any additional burden to be placed on the clinician.

Observational studies have been highly important in systemic family therapy. They laid the basis for ideas regarding family dynamics as displaying pattern and predictability. Initially observational studies predominantly took an 'outside' perspective in that families were observed in order to identify 'objective' patterns and structures. Minuchin (1974) and Minuchin *et al.* (1978), for example conducted studies (see Chapter 2) to investigate the relationships between family dynamics and emotional arousal in family members. A wide range of studies have been conducted to explore causal links between family dynamics and types of disorder. An example of the use of observational measures has been the work on expressed emotion (Vaughn and Leff 1985) and the related concept of parental affective style (Doane *et al.* 1981, 1984, 1985). Expressed emotion (criticisms, warmth or hostility, and overinvolvement) was measured from interviews with each parent on their own. Affective style on the other hand is measured directly from family interactions. Doane *et al.* (1981, 1985) have shown that a high level of expressed emotions, which are found to be associated with relapse in families with a schizophrenic member, are also shown directly in their interactions.

Most observational studies have involved such structured observation and have adopted a quantitative approach. However, participant observation is an interesting alternative. In participant observation the observer includes himself or herself as part of the study. For example, this could involve accounts not only of the therapist's observations of a family but also their reactions, feelings, memories triggered regarding their own family and so on. Though few specifically participant observational studies have been conducted, arguably most case studies of family therapy involve participant observation since the therapist comments on therapeutic processes in which he or she is integrally involved. An interesting and little repeated study was conducted by Vetere and Gale (1987) in which researchers lived with families for a period and were able to observe family dynamics in their natural setting, for example interactions at meal times, leisure activities, disputes and so on. A structural framework based on Minuchin's structural family therapy model was employed to categorize the observations but

in addition the researchers also commented on their own reactions, possible influences they may have had on the family and so on.

'Changes of expressed emotion in systemic family therapy'
(Vostanis et al. *1992)*

An exploratory study exploring observations of changes in expressed emotion during family therapy was conducted by Vostanis *et al.* (1992). The study explored changes in expressed emotion displayed in the interaction in 12 families as they progressed through therapy. The families had been referred for child related problems and varied in composition from nine nuclear, two step and one single-parent families. The therapeutic orientation was based on the Milan model. Video recordings of the first, second and last session were analysed by an independent observer using the EE dimensions and an overall global rating was made of the sessions for emotional overinvolvement and warmth, and the number of instances of critical and positive comments were counted. These measures were based on a combination of the speech of family members. Ratings were made for each family member and then combined to give an overall measure for the family.

The results indicated that all three measures – overinvolvement, critical comments and warmth – changed 'significantly between the beginning and termination of therapy'. The authors also employed the measures to look at the specific patterns of transactions between the family members over the course of therapy. Suggesting that specific patterns, such as critical comments between parents about each other or a pattern of comments directed towards the identified patient, may change to patterns of expressions of mutual warmth as therapy proceeds successfully.

Questionnaire and self-report studies

These formats are perhaps the most common type of research in family therapy. Particularly in relation to evaluation, many studies have been conducted which employ a variety of measures such as satisfaction questionnaires and various tests, such as the Beck Depression Inventory (BDI) (Beck 1967) or family tests, such as the Family Adaptibility and Cohesiveness (FACES) (Olson 1989) to assess change in family therapy. Specifically many studies have been conducted to compare the effectiveness of various forms of family therapy or to compare family therapy to other forms of therapy or treatment. Mostly these studies have been in a quantitative tradition with the intention of producing 'objective' and reliable information about the comparative effectiveness of family therapy. Such studies, though making strong claims for scientific objectivity, essentially rely on subjective measures in that

family members in completing tests and questionnaires are offering self-reports – their view of how they feel and of the family dynamics.

Questionnaires vary in their design but most contain a balance of closed vs open-ended questions. The following is an example of a closed question:

> Please rate each statement according to how well it describes your family, and tick the appropriate box.
>
> We resolve most emotional upsets that come up.
>
> *strongly agree* ☐ *agree* ☐ *disagree* ☐ *strongly disagree* ☐

In addition questionnaires may include a range of open-ended questions which invite participants to offer their own views in their own words. It is possible to phrase these in the format of circular questions:

- Who would you say in your family most wanted to go for therapy and who least wanted to?
- Why do you think this was the case?
- What has been the most significant way that therapy has effected your family?

The analysis of responses to such open-ended questions is more complex and less easily quantifiable. However, it is possible to start with a content analysis, for example by attempting to find categories into which the responses fall. The number of times certain categories are referred to, for example if the therapist's personality is mentioned frequently as a key factor by most families, this suggests that this is an important factor.

Therapy process research

The aim of process studies is not simply to produce evaluations of therapy in terms of outcome but to reveal more about the nature of the therapeutic process – the active ingredients of therapy. Many therapists write eloquently about what they do and their reasons for conducting the work in various ways. However, it may be the case that our ideas about what works and why, may not closely match what, for example, families perceive to be helpful. Process research can be helpful in distinguishing between therapeutic approaches but also in drawing out commonalities. For example, a good, positive therapeutic relationship seems to be central to all forms of family

therapy, and even to all psychotherapy. We might also suggest different forms of family therapy, such as narrative vs strategic approaches, share some important features, such as utilizing spontaneous events or changes that families themselves initiate, reframing problems and working with families in a pragmatic and experimental manner. In this section we will review a number of studies that have attempted to explore aspects of the process of family therapy, starting with a study that has attempted to explore the nature of the therapeutic alliance in family therapy.

A therapeutic process study

'Dimensions of therapeutic alliance and their associations with outcome in family therapy' (Quinn et al. *1997)*

From a variety of studies in psychotherapy the nature of the therapeutic alliance has emerged as a central feature. This study attempted to explore the extent to which this is also true for family therapy. However, in contrast to individual therapies the situation is more complex since there are a range of alliances – each individual member and the therapist, subsystems (e.g. the parents) and the therapist, and the family overall and the therapist.

In this study an instrument called the Interpersonal Psychotherapy Alliance Scale (IPAS) was employed. This scale, developed by Pinsof and Catherall (1986) assesses the relationships between the client and therapist, therapist and other important family members and the family group and therapist. The IPAS questionnaire consists of a series of statements, such as 'The therapist cares about me as a person', 'The therapist has the skills and abilities to help me' and 'The therapist and I are in agreement about the goals of therapy' to which a seven-point response is made ranging from completely agree to completely disagree. This measure was taken at the end of the third therapy session since by then the nature of the relationships between the family members and the therapist would reasonably be expected to have become established.

Seventeen couples undergoing marital or family therapy took part. At the termination of therapy the families and couples were asked to rate how effective the therapy had been in terms of two questions: the degree to which they felt that the goals of therapy had been met and the degree to which they believed the changes would last more than six months.

The results showed strong statistically significant positive correlations between the ratings of the therapeutic alliance and the family's estimates of success of therapy. The more highly the family members rated the relationship with the therapist, the better the eventual

outcome. Some specific findings were that most positive outcomes in therapy were associated with the women, more than the men, feeling aligned with the therapist with respect to the therapeutic task, but also who believed that other family members were also working well with the therapist.

In-depth single case process study

'Engaging with change: a process study of family therapy'
(Frosh et al. *1996)*

This was a study that aimed to identify some of the factors that are involved in the process of change during the course of family therapy. Rather than imposing any manipulations, this study explored a piece of family therapy that had already taken place. Hence there was no possible bias effect since the therapist had no idea beforehand that the sessions would be analysed. Permission was asked after the sessions had already taken place.

Videotapes of six out of eight sessions of a programme of family therapy were transcribed and analysed in detail. The parents had recently separated – a decision made by the father and initially resisted by the mother. The analysis was based on a 'grounded theory' (Glaser and Strauss 1967) approach in which themes are allowed to emerge from the analysis rather than imposed a priori. The transcripts were initially analysed to elicit themes in the conversations between the therapist and family regarding change. Successive readings were made of the text to refine the categories. From this analysis two predominant themes emerged: managed vs evolving change (though other complex issues were also evident). The concept of managed change contained the idea that change occurred through people actively attempting to do things differently, as opposed to evolving change which occurs spontaneously and naturally. These beliefs or discourse about change were seen to be employed strategically in different ways at different times by the family members in order to meet their own needs. The father who had initiated the separation argued that change was spontaneous and talking about things – trying to manage it – was pointless. This seemed to fit with his wish not to reverse his decision to leave as a result of therapy, whereas his wife initially did wish to reverse the separation.

The analysis involved presenting extensive examples of these two concepts of change and mapping how their usage altered as therapy progressed. Over the course of therapy, family members were seen to move from relatively polarized and rigid positions in their views of change, to a recognition that therapy could be helpful in helping them come to terms with their separation. The family conversations gradually showed a greater tolerance of alternative ideas of change.

Exploring the experience of family therapy

'The voices of children: preadolescent children's experiences in family therapy' (Stith et al. *1996)*

Despite the fact that one of the most common applications of family therapy has been in relation to children's problems there has been little research on how children experience therapy and what this might tell us about ways of making the process interesting and effective for them. This study explored the experience of 16 children undergoing therapy with their families (12 families in total). The children ranged in ages: one 5-year-old, nine between 8 and 9, five were preadolescents (aged 10–12) and one early adolescent (age 13). Fourteen of the children were white and two were Afro-American. Ten of the children were in single-parent families (headed by single mothers), four were in nuclear families, one was in a remarried family and one child was being raised by grandparents. Eleven of the 12 families presented with child-focused problems and the remaining family identified marital problems as the main concern.

Therapists were asked to invite families to participate and the families were then contacted by a researcher. Children were usually interviewed while the parents were seeing the therapist. Each child was interviewed twice and the parents were interviewed once.

A semi-structured interview lasting about half an hour was employed. Children were invited to tell their experience of therapy in their own words but a number of general questions were included, such as: When you and your family talk about coming here, what do you call this place? What happens when you and your family come here? What do you like/don't like about coming here? Do you ever wonder about the people behind the mirror? What do you think about them? An attempt was made to compare the children's accounts with their parents' or a teenage sibling's perceptions of the child's experience. These interviews employed a number of questions, such as: What do you think Mary (for example) thinks about coming to family therapy? How does he or she respond when it's time to come to therapy?

The interviews were transcribed and then members of the team each independently analysed two of the initial transcripts employing a 'grounded theory' framework (Glaser and Strauss 1967). This involved systematically reading through the transcripts and coding each sentence, combining these into preliminary categories, progressively sifting and recoding these categories. These codes were employed to generate more refined questions for the subsequent interviews. This was an iterative process with the interviews being successively analysed and refining the interviews. The categories were then discussed by the team and refined until no new categories emerged.

The children's experiences were found to fall into four areas or themes:

1 *The reactions of the children to the process of videotaping and live supervision.* All of the children were aware of the mirror and that there were people behind it, but not all were aware of the purpose of this arrangement:

> *Interviewer:* Have you ever wondered who those people are back there? What do you think their job is?
> *Child:* To see what we're doing and to tell the counsellor if they're doing good or if they want to improve things, or like to just see what's going on in families . . . and seeing what their problems are and seeing what their advantages are.
>
> (boy, age 9)

2 *How they understood why they and their families came to therapy.* Most children saw the existence of problems that needed solving as the main reason the family had come:

> Mom and Dad get into fights and stuff and they didn't get along.
>
> (girl, age 9)

> We're coming here to make our family a better place . . . a better family, to make us have happier lives.
>
> (boy, age 8)

3 *How they described what happened in therapy.* A dominant theme was that children described that they wanted to be included in the therapy. They generally did not like being left in the waiting room and wanted to be involved actively in talking not just about themselves but about issues in the family more generally. They also preferred to be able to engage in activities, such as drawing or 'games', such as sculpting:

> I feel comfortable when we are talking about someone else, then I can contribute.
>
> (boy, age 8)

> I don't mind the questions. It's just all the time and everything. Like they ask me a question and they make a question out of my answer.
>
> (girl, age 12)

4 *What they said had changed during the time they had been coming to therapy.* The children talked about what had changed in how they

felt during the therapy itself and how things had changed at home. Generally they described becoming more comfortable with therapy as time went on. The therapy was generally seen as having helped to solve particular problems:

> Before I had tons of problems, like at school, but now I'm doing OK.
>
> (boy, age 11)

> It's brought everybody closer. Everybody's been able to talk about their problems. They can talk it out and come together. Usually, everybody's apart and they keep their feelings to themselves and just let it happen.
>
> (brother, age 15)

In general all the children interviewed indicated a desire to be included actively in the therapy. All but the youngest understood the purpose of therapy and reported that talking about problems was helpful to them and their families. The younger children (aged 5–9) enjoyed play activities and found the personality of the therapist to be important. The key conclusion reached was that children wished to be included but did not wish to be the sole focus. They wanted to learn more about the workings of their family, help in the solutions of problems, and not have their own troubles be the focus. However, an hour of 'adult talk' may be too much for many children and therapists need to find ways of connecting with children through activity and play. The parents' and siblings' responses also suggested that children were more comfortable the more they knew about the reasons the family had come for therapy. Discussing this and the reasons for the technology may be very useful in the initial sessions. Though initially resistant the children saw some value in the sessions over time. Finally, the researchers suggested that therapists who are interested in children, able to express warmth and connection to them, and willing to operate in the child's world will have more success involving them in therapy.

Family theory research

The origins of family therapy arose from research studies into the nature of communication and its relationship to the development of pathology. This quickly developed into a plethora of enthusiastic studies which attempted, for example, to discover causal links between patterns of family dynamics and types of pathology. This led to research on the nature of 'psychosomatic and anorexic' families, or

'schizophrenic' families, 'addictive' families and 'delinquents'' families. Though of some value, much of this line of research has not proven fruitful, partly since it is extremely complex to classify families and also because such work missed the systemic understanding that family systems inevitably have a uniqueness and unpredictability and evolve and change over time. Nevertheless, studies attempting to explore families to explore theoretical models can also be valuable, for example in pointing to common tasks and processes that families undergo, how family beliefs are shaped, the impact of the wider culture and the dynamics of families in various contexts. Our first study in this section is an attempt to explore the last question – namely how families function in settings other than the therapy suite.

A participant observational study

Ecological Studies of Family Life (Vetere and Gale 1987)

This study aimed to explore the nature of interaction of families who had presented with child focused problems. Though we know much about how families interact in the context of family therapy suites, we know less about how they actually act in their home situations. Furthermore, less is known about the detailed nature of interactions and what it feels like from the 'inside'. A participant observational approach was employed whereby a researcher lived with a family for three weeks. During this time she engaged in the full range of family activities, such as meal times, outings, domestic duties and leisure pastimes, such as watching television and playing games. The researcher kept detailed notes of the family interaction primarily using a structural systemic format noting the family structure: family boundaries, subsystems, hierarchy, alliances and triangulations. In addition, detailed notes were kept of the experience of family – the emotional atmosphere, impact on the researcher and inferences about the possible experiences of the various family members.

The study suggested that family dynamics as observed in the homes were analogous to those typically observed in therapeutic situations. However, the timing and pacing were on a different time scale. For example, arguments, disagreements, sulking and so on could last for days rather than the accelerated pace of events in therapy. The analysis of family beliefs from the repertory grid analysis suggested that the family dynamics were significantly shaped by the nature of the families' beliefs. These had a stability and, for example were at the basis of patterns of scapegoating that could occur. A wide range of gender stereotyped behaviour and ideas also became evident as part of the observations, such as implicit expectations about domestic roles, duties and obligations.

Interview studies

Next to questionnaire-based studies, interviews are perhaps the most common form of research and especially qualitative research. Simply the purpose of an interview is to enable participants to express their views, opinions, explanations, accounts and narratives about an area. One of the advantages of an interview is that it enables us to hear what is important to members of a family rather than imposing a set of questions on them. However, interviews may vary in the extent to which they are prestructured, for example in some cases the researcher has a large number of specific questions they wish to ask. At one extreme such an interview may resemble a verbally administered questionnaire. At the other end interviews may be largely unstructured and represent a conversation between the interviewer and family member/s. Perhaps most commonly a semi-structured compromise is employed where the interviewer does have a range of questions but also aims to explore issues as they arise. Some elaborations on interviewing have been suggested; one important addition is to consider the interview a collaborative venture. For example, the interview can be in two parts so that following a break (either during the interview or at a later stage) the interviewer asks the respondent to comment on the process, suggest their own questions and the interviewer may comment upon some of the key issues that have struck them and invite the reflections. Also, the interviewer can offer a written summary of their impressions of the interviewer to a family and hold a subsequent interview to discuss the family's reactions to these. Another variation based in ethnography is that following each interview the interviewer analyse their data. Based on this analysis they may alter their focus, adding or deleting some questions according to the themes that are emerging. In this way there is a greater sensitivity to focusing on questions that are of relevance to the respondents than to questions assumed to be important by the interviewer.

Interestingly, though family therapists have developed considerable skills in interviewing families there has been a relative dearth of studies that employ interviews of couples or families. These can of course be complemented by interviews with each individual member. However, conjoint interviews offer the bonus of a wide range of interactional material, including the nature of family conversations regarding different areas, how families jointly remember events, differences in opinions and how these are dealt with. Outside family therapy, interviews with groups of people can be found in focus group studies, the aim of these being that the group processes facilitate opinions and ideas surfacing since members may prompt each other to consider issues and voice a wider range of opinions than they might otherwise.

A conjoint interview study

'Pathways to problems – the evolution of pathology'
(Dallos et al. *1997)*

The aim of the study was to explore processes of resilience in families and in particular the accounts that family members offered of how problems had developed. In order to offer some contrasts two groups were interviewed: a group of young adults who had experienced extended mental health problems and their families and a group of young people who were not known to have a clinical history. The study employed retrospective interviews which were intended to draw out accounts from both groups of how initial difficulties had been dealt with. One of the key hypotheses was that the nature of the initial perceptions of problems may lead to attempted solutions that can serve to aggravate, as opposed to alleviate, distress. A semi-structured interview format was developed which included drawing a life-line on which key positive and negative events from the child's birth were plotted. Families were interviewed together. This produced accounts of the key events, early indications of difficulties and details of attempted solutions. In addition the conjoint interviews also gave a picture of the processes of how families construct memories, including who is dominant in telling the story, differences in their memories and more broadly how memories of key events are constructed for the identified patient.

The interviews were videotaped and transcribed and independent analyses performed to generate common themes in the accounts and the influence of dominant discourses, such as medical models of emotional distress. These themes were successively checked against the transcripts and revised. A count of the frequency of different themes mentioned by the families was also produced. In addition the videotapes were examined to produce a map of the family dynamics. The summaries of the analyses were discussed by the researchers and also shown to some of the participants to collaborate the analysis. The results indicated that there was surprisingly little difference between the two groups in their accounts of the severity of early difficulties experienced. However, the clinical group's accounts indicated fewer resources, such as emotional 'spare capacity' in the family and practical support available. Also, the clinical group showed less ability to contemplate alternative narratives (negative as well as positive) about how events may have proceeded along different paths.

Case study series

Family Games: General Models of Psychotic Processes in the family (Palazzoli et al. *1989)*

Palazzoli and her team have employed a research/therapeutic approach in which the developmental nature of psychosis in young adults and the efficacy of a therapeutic approach have been explored simultaneously. Combining detailed notes of the developmental history of the problems in families the team employed a standard package of treatment to investigate commonalities and differences in 149 families' responses. A feature of their approach was the use of the 'invariant prescription' in which the parents are instructed to go out together on a secret outing. The children are not to be informed of any details of where the couple are going or what they will do together.

The intervention was regarded as both a therapeutic and research technique. Its aim was to explore the developmental hypothesis that children experiencing psychotic disturbance have become entangled and embroiled in a no-win stalemated struggle between their parents. Over the years it is suggested that one or other child in the family, perhaps as a consequence of some special sensitivity or the timing of their entry into the family, becomes progressively conscripted into siding with one or other parent against the other and also ultimately betrayed when the parents eventually redirect their attentions unto each other, thereby also emotionally abandoning the child.

The invariant prescription is intended to both reveal and help break up this pattern. The responses of the children and their families across a series of families were seen as providing a test of the developmental hypothesis and of testing the efficacy of this therapeutic approach. The responses of the families were categorized into various types. For example, a common feature to the invariant prescription was a display of extreme anger by a non-symptomatic sibling, which was seen to reveal and challenge their secret collusion in gaining a favoured and powerful role in the family.

The findings of the team based on more than 50 families presenting with psychotic symptoms in a young adult was seen as supporting the developmental hypothesis and as indicating that the invariant prescription provoked significant positive changes in the families. The changes were measured in terms of standard psychiatric measures based on the American Psychiatric Association (1980) family perceptions and independent observations and ratings by the therapy team members.

Discussion and reflections

We hope that this brief journey across the landscape of research in family therapy has not led you, in David Reiss's (1988: 34) terms into

'dying of boredom'. As we have discussed there is considerable pressure from managers and purchasers of therapeutic services to provide evidence of effectiveness. More broadly this has been described as the need to develop evidence based practice. This is perhaps especially significant for family therapy since it is seen as a high cost resource, especially when it is conducted in teams, and also requires more in the way of resources such as video equipment. At times it might appear that all that is required is an audit of the effectiveness, which will be sufficient.

In some cases this may be true but we hope that you have also seen that evaluative studies can and need to do more. Good research helps to reveal the nature of the therapeutic process and also helps to develop general theory about family functioning. Without knowledge of what aspects of therapy were significant and the nature of the experience for families, evaluation may just become a sterile activity. Given the limited time that most clinicians have available for research, they may therefore be more reluctant to undertake such an activity. One of the challenges for research into family therapy, and into other forms of psychotherapy, is for the research to be compatible with the process of clinical work. Qualitative research, for example the kind of study conducted by Frosh *et al.* (1996) points towards such a compatible approach.

As we indicated at the start of the chapter, family therapy with its techniques of videorecording and live supervision lends itself readily to the collection of material that can subsequently be analysed and presented as good qualitative research. In turn, it may be that such qualitative studies can be pursued as larger studies including some quantitative measures. However, we do feel that the traditional view that research must involve quantitative measures is no longer tenable. Further we suggest that research that does not include qualitative aspects, such as attempts to consider family members' views and experiences is seriously limited.

There follows a list of some key reference texts relating to family therapy research. In addition we have included some papers relating more broadly to psychotherapy research which you may find interesting to follow up, such as work on readiness to change, the therapeutic alliance and explorations of client's perceptions of significant events in therapy.

Key texts

Aveline, M. and Shapiro, D.A. (eds) (1995) *Research Foundations for Psychotherapy Practice*. New York: Free Press.

Barkham, M., Shapiro, D.A. and Firth-Cozens, J. (1989) Personal questionnaires in prescriptive vs exploratory psychotherapy. *British Journal of Clinical Psychology*, 28: 97–107.

Bennum, I. and Lucas, R. (1990) Using the partner in the psychosocial treatment of schizophrenia: a multiple single case design. *British Journal of Clinical Psychology*, 29: 185–92.

Berkowitz, R. (1987) Rating expressed emotion from initial family therapy sessions (a pilot study). *Journal of Family Therapy*, 9: 27–37.

Elliott, R. (1986) Interpersonal Process Recall (IPR) as a process research method, in L. Greenberg and W. Pinsof (eds) *The Psychotherapeutic Process: A Research Handbook*. New York: Guilford Press.

Elliot, R. and Shapiro, D.A. (1988) Brief structured recall: A more efficient method for studying significant therapy events. *British Journal of Medical Psychology*, 61: 141–53.

Fonagy, A. and Roth, A. (1997) *What Works for Whom?: A Critical Review of Psychotherapy Research*. London: Guilford Press.

Friedman, M.S. and Goldstein, M.J. (1994) Relatives' perception of the interactional behaviour with a schizophrenic family member. *Family Process*, 33: 377–87.

Frosh, S., Burck, C., Strickland-Clark, L. and Morgan, K. (1996) Engaging with change: a process study of family therapy. *Journal of Family Therapy*, 18: 141–61.

Llewelyn, S.P., Elliott, R., Shapiro, D.A., Hardy, G. and Firth-Cozens, J. (1988) Client perceptions of significant events in and prescriptive and exploratory periods of individual therapy. *British Journal of Clinical Psychology*, 27: 105–14.

Miklowitz, D.J., Goldstein, M.J., Falloon, I.R.H. and Doane, J.A. (1984) Interactional correlates of expressed emotion in families of schizophrenics. *British Journal of Psychiatry*, 144: 482–7.

Olson, D.H. (1989) Circumplex model of family systems viii: Family asssessment and intervention, in D.H. Olson, C.S. Russel and D.H. Sprenkle (eds) *Circumplex Model: Systematic Assessment and Treatment of Families*. New York: Haworth Press.

Pinsof, W.M. and Catherall, D.R. (1986) The integrative psychotherapy alliance: family, couple and individual therapy scales. *Journal of Family and Marital Therapy*, 12: 132–51.

Prochaska, J., Diclemente, C.C. and Norcross, J.C. (1992) In search of how people change: applications to addictive behaviours. *American Psychologist*, 47(9): 1102–14.

Quinn, W.H., Dotson, D. and Jordan, K. (1997) Dimensions of therapeutic alliance and their associations with outcome in family therapy. *Psychotherapy Research*, 7: 429–38.

Martin, G. and Allison, S. (1993) Therapeutic alliance: a view constructed by a family therapy team. *Australia and New Zealand Journal of Family Therapy*, 14: 205–14.

Simpson, L. (1990) The comparative efficacy of Milan family therapy for disturbed children and their families. *Journal of Family Therapy*, 13: 267–84.

Sprenkle, D.H. and Moon, S.M. (1996) *Research Methods in Family Therapy*. London: Guildford Press.

Stith, S.M., Rosen, K.H., McCollum, E.E., Coleman, J.U. and Herman, S.A. (1996) The voices of children: preadolescent children's experiences in family therapy. *Journal of Marital and Family Therapy*, 22: 69–86.

Vostanis, P., Burnham, J. and Harris, W. (1992) Changes of expressed emotion in systemic family therapy. *Journal of Family Therapy*, 14: 15–27.

Wynne, L.C. (ed.) (1988) *The State of the Art in Family Therapy Research*. New York: Family Process Press.