

## Family therapy and the politics of evidence

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This article situates family therapy in the politics of evidence-based practice. While there is a wealth of outcome research showing that family therapy works, it remains on the margin of mainstream therapy and mental health practice. Until recently it has been difficult to satisfy 'gold standards' of randomized control research which require manualization and controlled replication by independent investigators. This is because systemic family therapy is language-based, client-directed and focused on relational process rather than step-by-step operational techniques.

As a consequence family therapy is an empirically supported treatment unable to join the evidence-based club. The politics here concerns what is 'evidence', who defines it and the limitations of a scientist-practitioner model. Therapy is art *and* science and its research needs to be grounded in real-life clinical practice. Common factors such as personal hope and resourcefulness and the therapeutic relationship contribute more to change than technique or model.

While arguing for a wider definition of science and evidence it is politic to seek evidence-based status for family therapy. Family therapy is a best practice approach for all therapists where systemic wisdom helps to decide *what to do with whom when*. A systemic-practitioner model is informed by quantitative and qualitative research and holds modern and postmodern perspectives in tension, a stance I call *paramodern*. Family therapy is both scientific and systemic; it is a science of context, narrative and relationship.

### Introduction: family therapy at the crossroads

Family therapists today are under increasing challenge from public and private mental health funding bodies to demonstrate an evidence base. Here they face strong competition from biological and cognitive therapies backed by powerful voices of representation in the disciplines of psychiatry and clinical psychology. Recently practitioners have been encouraged by an emerging research literature showing family therapy *is* effective across a range of clinical populations and problems (for summaries of this research see Campbell, 1997;

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Carr, 2000a, 2000b; Pinsoff and Wynne, 1995, 2000; Shadish *et al.*, 1993, 1995; Sprenkle, 2003). For example, Sprenkle (2003) has recently edited a whole volume of 'gold standard' outcome research indicating that family therapy is close to becoming an evidence-based discipline.

Yet while family therapy continues to invite interest and application, particularly in child and adolescent therapy (Cottrell and Boston, 2002), it is not high on the preferred treatment list for mental health services or included as a substantial component of training in psychiatry and clinical psychology. Nathan and Gorman's (1998) influential guide to psychosocial treatments that work largely reports the dominance of cognitive-behavioural therapies, as does Kazdin's (2003) recent review of evidence-based therapy for children and adolescents, even while it notes the importance of addressing context and family in the work. Family therapy as most of us know it is not perceived widely as a major treatment of choice, and is at risk of being supplanted by other evidence-based protocols and techniques (Larner, 2003). As Baldwin and Huggins (1998) observe, family therapists remain marginalized and 'continue to operate at the fringe of the mental health system' (p. 218).

### **Is family therapy evidence-based?**

One reason for this situation may be that the necessary research into 'what works for whom under what conditions' in family therapy still needs to be done (Kennedy, 2001). As one recent practitioner review concluded: 'Systemic family therapy is an effective intervention for children and adolescents but further well-designed outcome studies are needed using clearly specified, manualised forms of treatment and conceptually relevant outcome measures' (Cottrell and Boston, 2002, p. 573). In strict scientific terms, family therapy so far lacks the experimental rigour required of an evidence-based treatment, which has to satisfy three criteria: (1) The approach has been shown to work using double-blind treatment and control groups with replication by at least two independent studies. (2) It has been translated into a treatment manual. (3) The treatment has been applied with specific client populations and problems, for example, depressed adolescents (Nathan and Gorman, 1998).

With respect to criterion 1 there is partial compliance with a substantial body of empirical evidence demonstrating that family therapy *works*. For example, Shadish *et al.*'s (1993, 1995) meta-analysis of 163 randomized trial studies clearly shows it to be more effective

than no treatment. In relation to criterion 3 a growing number of studies demonstrate good outcomes for family therapy with a range of client groups and problems, particularly for difficult issues such as substance abuse, delinquency and psychosis (Sprenkle, 2003). However, until recently the criteria of a procedural manual for systemic family therapy (Pote *et al.*, 2003) and replication by independent investigators, which obviously go together, have been more difficult to satisfy for a number of reasons.

### **Family therapy as relational process**

Family therapy is not a single treatment method but a generic term for a number of approaches based on broad systemic principles such as strategic, structural, Milan, post-Milan, feminist, Bowenian, narrative, solution-focused, social constructionist and so on. The specifics of treatment can vary between family therapists according to preferred style and focus even within a particular model. Techniques tend to be flexibly and pragmatically applied in response to the complexity of client contexts and presentations with integrative models becoming the norm (Lebow, 1997; Pinsoff, 1999; Larnar, 2003). At the same time the emphasis of systemic family therapy is a relational process or who says what to whom, rather than the discrete application of an operational method. As a collaborative and reflective form of therapy, the person's language and agency is given priority rather than a particular model or technique. Special consideration is given to issues of culture, gender, politics and spirituality. In highlighting personal and systemic narratives and solutions family therapists may even step back from specific interventions.

In other words, family therapy is an ecological intervention in a natural environment that does not translate easily into a step-by-step procedure or intervention manual that can be repeatedly applied and tested. This is easier for structural or behavioural forms of family therapy and hybrid family-based treatment packages that incorporate psychoeducation, cognitive-behavioural techniques and management training programmes in addressing specific problems and target groups (Carr, 2000a, 2000b). Several such treatment programmes have been empirically supported by randomized treatment control trials (RCTs) including functional family therapy for conduct disorder in children (Alexander, 1988), multisystemic family therapy for juvenile delinquency (Henggeler and Borduin, 1990) and attachment-based family therapy for depressed adolescents

(Diamond *et al.*, 2003), and the list is growing. However, social constructionist, narrative and systemic approaches, which are widely practised and have defined theory and practice in the field for well over a decade, have been less amenable to manualization and replication. Here recent development of a clinician-friendly and practice-relevant manual for systemic family therapy by Pote *et al.* (2003) is an important research tool in the evidence-based stakes, with application to training and clinical practice (Allison *et al.*, 2002).

### **Family therapy: art and science**

None the less, systemic family therapy to date is an empirically supported treatment unable to join the evidence-based club. This scenario will hopefully change with the advent of systemic manuals, tighter research methodology and greater awareness by mental health authorities and practitioners of the emerging empirical base for family therapy. Yet what it highlights is the politics of evidence-based practice, in particular an inherent tension between the science and research of therapy and its art or application in clinical practice. As psychology researchers Soldz and McCullough (2000) argue, the practice of therapy ultimately cannot be reconciled with its scientific research in controlled academic settings: 'Psychotherapy practice, involving as it does a complex interpersonal relationship, cannot be reduced to the application of research findings any more than the construction of a house involves simply knowledge of the materials to be used to construct the house' (p. 7). In human relational psychology the process of therapeutic change is not easily subject to control through scientific experiment and probably never will be.

While family therapists acknowledge the need for clinical practice to be evidence-based, the difficulty is identifying any one methodology that does justice to the work. Here researchers and clinicians are beginning to ask for a wider understanding of the scientist-practitioner and biopsychosocial model that forms the basis for current definitions of evidence-based practice (Eisler, 2002; Harari, 2001; Harper *et al.*, 2003; Larner, 2001; Soldz and McCullough, 2000). There is ongoing controversy about the political economy of evidence, how it is defined and who defines it. This is not a question of evidence *or* no evidence but who controls the definition of evidence and which kind is acceptable to whom.

The politics here concerns whether clinically relevant and practice-based qualitative evidence is allowed. This is a choice not between

science and non-science, but between a narrow positivism which only validates RCTs and an evidence base with application in the real world of therapy. In everyday clinical practice persons do not fit neatly into discrete diagnostic categories and respond differently to standard interventions which need to be flexibly and creatively applied. In other words, family therapy is both science *and* art, or, as I will later suggest, may be described as a systemic science of context, narrative and relationship.

### **Critique of the scientist-practitioner model**

A major critique by family therapists, also voiced recently within medicine, clinical psychology and psychiatry, is a lack of evidence for the scientist-practitioner model itself. As the medical bioethicist Kenneth Goodman (2003) says: 'At its core, evidence-based practice rests on a supposition which, while probably true, itself has unclear evidentiary support' (p. 3). There is no evidence that singular treatments shown to be effective under randomized controlled conditions with restricted client samples actually work in everyday real-life therapy practice. On this point respected clinical psychology researcher Alan Kazdin (2003, p. 259) is particularly damning. In a comprehensive review of evidence-based psychotherapy research with children and adolescents he says:

The ways in which psychotherapy is studied depart considerably from how treatment is implemented in clinical practice. Consequently, the extent to which findings can be applied to work in clinical settings can be challenged....The extent to which results from research extend to clinical work is very much an open question with sparse evidence on the matter and different conclusions by different reviewers.

Part of the difficulty is that children and adolescents seen by clinicians have more severe, chronic and co-morbid presentations and live in more dysfunctional and disadvantaged families than those recruited for research. Kazdin (2003) notes that a range of evidence is needed to adequately test therapy outcome, particularly from qualitative studies. In addition, research into *why* and *how* therapy works is virtually non-existent.

A more flexible and realistic approach to evidence-based practice is also urged within child psychiatry by Harrington *et al.* (2002), who suggest that RCTs are a guide but they need to be interpreted in the light of other evidence. In child psychiatric practice, treatments are

typically combined in a multisystemic approach to target co-morbid problems. Most interventions are psychosocial, addressing contextual influences of family, peer group and school, and 'cannot be studied using the apparently double-blind methods of drug trials' (p. 697).

As pre-eminent commentators Sackett *et al.* (1996) note, evidence-based medicine and presumably psychiatry is not restricted to randomized trials and meta-analyses. Here the world-famous Cochrane Foundation highlights the significant role of observation and qualitative research in evaluating the effectiveness of health interventions (Popay, 2000). Likewise the UK Department of National Service Framework for Mental Health (DoH, 1999) provides five categories of evidence: Type I evidence (at least one good systematic review and RCT for a range of problems), Type II evidence (at least one good RCT), Type III evidence (at least one non-randomized intervention study), Type IV evidence (at least one well-designed observational study) and Type V evidence (expert opinion, particularly of service carers and users).

Family therapists agree that therapy should be empirically grounded; at issue is the narrow kind of evidence allowed. As Crane and Hafen (2002) report in this journal, the scientist-practitioner model is not widely applied by systemic practitioners or used in training programmes because of serious flaws: it does not fit well with clinical practice, has not been tested itself and is too reliant on the medical model. In rejoinder Eisler (2002) argues that evidence-based practice is more than prescribing a narrow band of RCTs, suggesting research be integrated as a part of clinical practice and expertise.

In this vein Australian family therapists Steifel and colleagues (2003) propose three types of evidence apart from RCTs. These include developing practice guidelines or protocols from multiple-source information, using practical clinical experience gained from working with complex family problems as well as client feedback and satisfaction. Likewise Campbell (2002) argues that in science, randomized experiment is not a sacred cow but adapts its methodology to the types of questions being researched: 'The ways of generating evidence are significantly more varied than just RCT and allow for many more voices, perspectives, and values in therapeutic practice to be explored' (p. 216). Campbell (2003) suggests that family therapists can do useful research by drawing upon 'practice-based evidence' and by developing *Practice Research Networks* where clinicians and teams collaborate on long-term projects. Fishman (2003)

proposes that clinicians develop their own database of 'pragmatic case studies' which combines quantitative evidence of outcome with qualitative narratives. All these authors urge that evidence-based practice be grounded in the real world in which family therapists work.

### **Common factors in therapy**

Another major critique of the scientist-practitioner model is the significant role of other factors apart from therapeutic model or technique (Duncan, 2001; Lebow, 2001; Pinsoff, 1999). The argument to widen the evidence base of family therapy is supported by meta-analytic studies of what is effective in therapy where the particular therapeutic approach accounts for less than 15% of the success (Miller and Duncan, 2000). Most of the variance for therapy outcome is covered by the common ground between all therapies: client resourcefulness and chance events that produce change (40%); the client-therapist relationship and experience of therapy as empathic, collaborative and affirmative (30%); the client's expectation and hope for change (15%). As Miller and Duncan (2000) say: 'The resounding conclusion of this research is that in terms of outcome it simply doesn't matter whether one exclusively practices cognitive-behavioural, psychodynamic, psychopharmacology, or – as the research cited in this issue makes clear – solution-focused therapy' (p. 23).

Aaron Beck, founder of the quintessential evidence-based approach of cognitive therapy, acknowledges this major contribution of extra-model and relational factors to therapy outcome. He urges cognitive therapists to give 'attention to the therapist qualities and therapeutic relationship factors shown to be important in conducting successful therapy' (Alford and Beck, 1997, p. 77). For this reason he suggests cognitive therapy should integrate approaches like family therapy: 'Cognitive therapists are now using a greater variety of treatment formats, such as group and family therapy' (p. 3). What works in therapy is not technique alone but its application in the context of human relationships, and here Beck would appear to be more systemically aware than some of his disciples.

The key evidence-based task for any therapist is to form a collaborative therapeutic relationship and engage a person's expectations and hopes for change as reflected in their personal narrative and lived relationships. As the particular therapeutic technique used

is not highly significant for outcome, all therapists should be more relational and client-directed than model-driven. To overplay the hand of therapeutic technique and minimize the contribution of personal and relational factors has more to do with the politics of evidence than its science. This defines evidence for therapy outcome in a way not connected with actual practice in the field, and ignores the wider family, political, social justice and cultural grounding of psychological problems. I will return to this critique below.

### **Evidence that family therapy works**

Outcome research shows that family therapy is effective with a range of clinical problems and it is politic to present this evidence across the models. According to Carr (2000a, 2000b), empirical research provides global support for family therapy as an effective treatment intervention; however, there is still a need for specific evidence statements about which approaches work for particular problems. Carr (2000a) presents some of this evidence in relation to a range of child and adolescent mental health issues, including child abuse, conduct problems, attention-deficit disorder, drug abuse, anxiety, depression, psychosomatic complaints and anorexia. For example, brief family therapy assists depressed and bereaved children and adolescents, while narrative therapy is more effective than behaviour therapy for psychosomatic problems such as soiling. In general, family therapy-based approaches work with child and adolescent problems in combination with pharmacological, cognitive-behavioural and psychoeducational programmes. For example, low-dose medication, structural family therapy, parental guidance and school behavioural programmes form an effective management approach to ADD.

Child and adolescent approaches supported by the evidence include multisystemic therapy, which combines individual, marital and family session components with wider systems consultations, and family therapy-based parent training programmes where parents are trained to monitor and reward positive behaviours using reward systems such as star charts or tokens. As Kazdin (2003) notes, parent management programmes for oppositional and aggressive behaviour are the most researched treatment in child and adolescent therapy. Carr (2000b) also presents evidence for the effectiveness of family therapy with adult psychological problems based on controlled trial studies including marital distress, sexual problems, anxiety, OCD, mood disorders, psychosis, alcohol abuse and chronic pain. For



example, cognitive-behavioural treatment of agoraphobia using self-talk, relaxation skills and exposure is more effective when applied in a family than in an individual therapy context. For schizophrenia psychoeducational programmes in league with medication and family counselling to address conflict and negative expressed emotion is also effective.

Pinsof and Wynne (1995) reviewed the research evidence for couple and family therapy (CFT) in a special issue of the *Journal of Marital and Family Therapy*. Based on 'gold standards' of efficacy research using clinical trials with specific mental health disorders, these authors found evidence that family therapy is better than no treatment with an exhaustive list of clients and problems including: families of schizophrenics, depressed women, adult alcohol and drug abuse, conduct problems in both children and adolescents, aggression and noncompliance in ADHD, young female anorexics and so on. In a follow-up article, Pinsof and Wynne (2000) explored the implications of efficacy research for family therapy practice. As they state, CFT has been shown to be effective with the range of mental health problems, it is supported by the evidence and all approaches help about two-thirds of clients. However, for more severe and chronic disorders an integrative approach that uses CFT with other modalities such as cognitive therapy, drug treatments and group programmes works best. They note that treatments need to be shown to work outside the laboratory in real-life contexts. Here therapists are collaborative and improvise in response to presenting issues and relational context: 'Therapist behaviour is organized and modified recursively in response to the client's responses to it' (p. 4). They suggest research should focus on change as a learning process both inside and outside therapy.

Campbell (1997) reviewed a range of studies showing CFT to be an effective intervention with schizophrenia, depression and behaviour problems in children, conduct disorders in adolescents, substance abuse and physical illness. Sandberg *et al.*'s (1997) summary of outcome research demonstrated the efficacy of CFT in treating thirteen disorders such as depression, delinquency, conduct disorders, substance abuse, eating disorders and marital discord. Approaches proven to be effective include behavioural family therapy, structural therapy, multisystemic therapy and symbolic-experiential therapy. As they note, CFT occurs 'within the complex of interconnected systems that encompass individual, family, and extra familial (peer, school, neighborhood)' (p. 351).

Baldwin and Huggins' (1998) review of outcome research in CFT demonstrated its efficacy with a broad range of severe psychological problems. They recommend that family therapists adopt a multi-modal intervention approach, such as combining systemic or solution-focused assessment tools with DSM. This underscores the need for family therapists to work collaboratively in multidisciplinary mental health teams. There is also growing evidence for the efficacy of multidimensional family therapy with adolescent substance abuse, depression and behaviour problems (Diamond and Liddle, 1999). Here the therapist uses a key intervention to shift the family focus from impasse and conflict to core interpersonal issues such as attachment failure.

### **Recent research**

There has been a dramatic improvement in the evidence base for family therapy even over the past few years. Asen (2002) presents a range of evidence to show that family therapy is becoming a major treatment of choice in psychiatry and psychological medicine for a range of problems including anorexia, psychosis and mood disorders. Sprenkle (2003) recently presented a volume of research chapters in marriage and family therapy that largely meet the 'gold standard' of manualized and supervised treatments, randomized clinical trials and replication by independent investigators. Attention is given to multiple outcome measures, co-morbidity and the issue of transportability to real-life clinical situations. Evidence-based family treatments are provided for conduct disorder and delinquency, substance abuse, childhood behaviour disorders, alcohol abuse, marital problems, relationship difficulties, domestic violence, severe mental illness, affective disorders, physical problems and the management of schizophrenia.

#### *Attachment-based family therapy*

Diamond *et al.* (2003) recently developed a manualized treatment model for depressed adolescents called attachment-based family therapy. So far it has empirical support from one randomized clinical trial, with further trials planned addressing co-morbid problems such as psychosis and substance abuse.

*Solution-focused therapy*

Gingerich and Eisengart (2000) reviewed fifteen outcome studies for solution-focused brief therapy (SFBT), suggesting preliminary empirical support. Five studies were well controlled demonstrating efficacy with depression, parenting skills, recidivism in a prison population, antisocial adolescent behaviour and orthopaedic recovery.

*Narrative therapy*

Etchison and Kleist's (2000) review of evidence for narrative therapy uncovered a limited number of studies, including Besa's (1994) use of a single case research design demonstrating effectiveness in reducing parent-child conflict for five out of six families. Of course narrative therapists favour a client-consultative model for evaluating effectiveness (St James O'Connor *et al.*, 1997).

*Bowenian family therapy*

Charles's (2001) summary of eight studies in Bowen's family systems theory found empirical support for key concepts of this model, including differentiation, triangulation and fusion. A recent cross-cultural study by Bell *et al.* (2001) demonstrated triangulation in families of adolescents in Japan and the USA.

**Qualitative methods in family therapy research**

A content analysis of the family therapy literature by Faulkner *et al.* (2002) shows qualitative research is becoming widely accepted as a valid mode of empirical enquiry. The number of qualitative studies reported has doubled between 1980 and 1999 with a particular focus on therapy process, family relationships and divorce. Likewise Addison *et al.* (2002) note that there is a wealth of research demonstrating that family therapy works for a variety of problems and situations, which has been ignored in review studies because it is non-experimental. In a review of fifteen years of MFT research they found that multiple methodologies were used to establish its effectiveness, including quasi-experimental comparisons of treatment and control groups, client satisfaction and outcome surveys, qualitative studies and case studies as the most common. They suggest that in real-world family therapy a multi-modal approach to research is required where 'there are many different levels and types of evidence

for effectiveness' (p. 341). Thus for Roy-Chowdhury (2003) a drug metaphor in family therapy research fails to address the real-life complexity of therapy process. He illustrates the benefits of discourse analysis in a qualitative study of discourses of power and culture in actual family therapy sessions.

### **Science or scientism**

In summary there is growing evidence that family therapy by itself is an effective treatment for a range of psychological difficulties, particularly with children and adolescents. Practitioners can be confident it is a treatment that works (Nathan and Gorman, 1998) and has a broad evidence-based credibility likely to improve with research. There is strong empirical support for an integrative approach combining various models of family therapy (e.g. structural) with other modalities such as cognitive therapy, psychoeducation, medication and behavioural approaches. At the same time meta-analytic research shows central aspects of systemic thinking and practice such as personal narrative, interpersonal process and the quality of the therapeutic relationship play a significant role in therapy outcome.

Given the formative state of outcome research it is premature to draw up politically correct lists of evidence-based treatments, as experienced therapists would concur. It is scientific to be open and not foreclose on what works in therapy. There is a difference between grounding clinical practice in empirical research and rejecting any therapeutic approach or idea that has not first been demonstrated to be RCT effective. One is evidence-based, the other evidence-obsessed. In the world of therapy nothing is set in stone or, as Soldz and McCullough (2000) say: 'At the current state of knowledge, that a treatment is not on the approved list is far from evidence that the approach is ineffective' (p. 260). For this reason any hard distinction between empirically and non-empirically validated treatments is misleading as Eisler (2002) argues: 'The fact that a treatment has not been evaluated does not in itself put it in a different class of treatments but simply means that we have less knowledge of whether and how it works' (p. 16).

In the real world of therapy change is a complex and many-sided affair where variables that are difficult to control muddy the scientific equation. Any strict application of evidence-based practice along RCT lines is flawed because scientific control in therapy is more myth than

fact (Duncan, 2001). Here we may know more about what does not work than what does, as recently brought home in a study by Ben-Tovim *et al.* (2001). This demonstrated that what had been widely accepted for many years as evidence-based treatment of anorexia was in fact not supported by the evidence, though family therapy was seen as helpful.

To say personal, relational and contextual factors such as culture, gender, narrative and family are irrelevant to what works in therapy because they are not totally amenable to prediction and control is not science but scientism. It ignores what is real in people's lives, a stance that is not curious or scientific. To be scientific is to maintain an investigative curiosity about how and why therapy works and to accept that science may never be enough to explain the process. This is because individuals can be described not only in biological, cognitive and behavioural terms but also as ethical, political and spiritual beings (Larner, in press).

### **The politics of evidence**

What made correction possible also doomed it.  
(Franzen, 2001, p. 281)

At times evidence-based rhetoric can sound less like dispassionate science and more like political posturing according to prevailing political-economic agendas of late capitalism. The prescription for psychological suffering is another consumer product (increasingly pharmaceutical) where the role of social, cultural and political systems is denigrated as unscientific. Under a rationalist economic, governments pander to the pharmaceutical industry's desire to control a lucrative therapy market. Mental health institutes, research councils and academic institutions fall in to jockey for a bigger slice of the evidence-based therapy pie using RCT research as a funding catch-cry. Yet the ecopolitical issue of providing cost-effective mental health services is no sanction to make a fetish of science.

A recent wake-up call to the politics of evidence comes from a report in the *British Medical Journal* (Moynihan, 2003) that clinical trials sponsored by pharmaceutical companies tend to produce more favourable outcomes. At the same time there is a widespread culture of influence by drug company representatives over what is accepted by doctors as evidence-based medical practice. The latter can mask corporate influence on a large scale, where patient care is

compromised for the price of a pizza or a fancy pen. Here Albee's (2000) lamentation about the future of therapy in psychology would resonate with the concerns of many family therapists: 'Psychologists are now stuck in a blind alley blocked by a for-profit health care system, a corporate world where the only concern is the bottom line. Psychotherapy is effective, but it is too expensive to be profitable to the corporate health system, so psychotherapy is not supported' (p. 248).

The politics of evidence concerns *who* controls and benefits most from its definition, which, as Meagher (2002) notes, is currently based on a corporate model of accountability with little relevance for relationship-based services and therapies. This is where the science of therapy is not true to the real world it purports to study objectively. As Michell (2003) argues cogently, the evidence-based imperative in psychology indicates a breakdown in scientific curiosity and enquiry giving 'rise to a form of science that is a closed system' (p. 25). This quantitative bias is a methodological dogma and error, part of the 'mystical underbelly' of the discipline or mere 'window dressing' driven by politico-economic motivations: 'It was the continuation of this consensus for more than fifty years, held in place by the economic structures supporting research in psychology, that caused the resistance to qualitative methods' (p. 16).

Yet the 'politic and lunatics' of evidence-based practice is obviously complex. I borrow the former phrase from the late Australian aboriginal family therapist Colleen Brown, who I am sure would have had much to say on the topic from a cultural perspective. Her grief counselling using indigenous stories and art of the stolen generation (Brown and Larner, 1992 and in press) would not get a look-in under the current regime. And there are many cultural life situations for which evidence-based treatments do not exist. On the one hand, family therapists concur with the need for more research, accountability and knowledge about *what works* in therapy; on the other, they critically challenge the imposition of an unrealistic positivist-science model on systemic practice.

### **Family therapy as best practice**

It is certainly not evidence-based to close one's eyes to the complexity of lived human experience and say treatments work when there is no evidence they do so in real-life clinical situations. Individuals do not fit textbook categories and the real evidence-based challenge for

therapists is what works for whom in local practice contexts. Here an important distinction may be drawn between evidence-based and *best practice*, where therapists choose interventions collaboratively with clients using clinical intuition and research knowledge. In unique and complex presentations evidence-based treatments may not be best practice; they may simply not work or research may be inconclusive, ambiguous or nonexistent. Ethical best practice is about managing such uncertainty as part of the scientific venture (Goodman, 2003).

Like recent developments in narrative-based medicine best practice integrates the science and art of therapy. As Greenhalgh (1999) notes: 'Clinical method is an interpretive act which draws on narrative skills to integrate the overlapping stories told by patients, clinicians and test results' (p. 323). The bottom line is that family therapists, like doctors, need to know what works in practice, how to best help a person, and research shows working with personal narrative and relational context is integral to the healing process. As Beutler's (2000) survey of good therapy outcomes demonstrated, clients overwhelmed by complex difficulties are more likely to respond to family therapy than prescribed evidence-based treatments.

In complex therapeutic systems evidence-based techniques need to be applied in clinically relevant ways and here family therapy *is* best practice. This is especially the case in child and adolescent mental health work where systemic and narrative approaches complement and enrich other evidence-based therapies such as cognitive therapy and biological psychiatry (Larner, 2003). Thus, following a review of empirically supported treatments in child and adolescent therapy, Kazdin and Weisz (1998) noted all intervention with this age group is *de facto* family therapy whatever the treatment espoused.

### **Integrative practice model: systemic wisdom**

We do not receive wisdom, we must discover it for ourselves, after a journey through the wilderness which no one else can make for us, which no one can spare us, for our wisdom is the point of view from which we come at last to regard the world.

(Proust, 1996)

In ethical best practice evidence-based techniques are applied *in response to* unique narratives of individuals in political, cultural, community, spiritual and family contexts. Here an integrative practice

model is a preferred approach. Thus Lebow (1997) documents an integrative revolution in family therapy that combines concepts and methods across previously distinct schools and between individual and family approaches. Similarly Reimers (2001) identifies three principles of user-friendly family therapy practice based on a survey of recent research in the field: (1) Be open to using mixed therapeutic approaches. (2) The therapy approach, such as directive, expert-led versus reflective, collaborative, should be tailored to the needs of particular families. (3) Therapy should be based on both outcome research and the therapeutic relationship. Pinsoff (1999) calls an integrative approach 'choosing the right door' where the therapist attempts to break the 'logjam' behind the problem: 'I can only try one thing after another and either succeed or fail' (p. 55).

In integrative practice the art and science of therapy are combined in a therapeutic stance that is pragmatic, creative, intuitive and curious. As Sprenkle (2003) suggests, systemic practitioners value clinical wisdom *and* scientific method as alternative ways of knowing, though critically questioning both. Likewise Roberts (2000) details tensions between narrative and psychiatric practice with severe mental illness but sees their convergence in narrative-based medicine. In this sense evidence-based therapy is the art of integrating research in clinical practice. Sackett *et al.* (2000) say this clearly: 'Evidence-based medicine...is the integration of best research evidence with clinical expertise and patient values' (p. 1). The science of therapy is a creative artful process where evidence about what works best for whom is applied to the person's story.

Systemic wisdom as *what to do with whom when* is a practical knowing that comes from the *doing* of therapy (Larner, 2001). It is the gateway through which the science of therapy is applied, an intuitive and creative response of therapists in deciding best practice in a relational context. This maximizes the agency and voice of the client in the process of change. Pare (2002) calls it 'discursive wisdom' because expertise and knowledge are located collaboratively in the dialogue between therapist and client. As a relational approach to evidence-based practice, it is what Stratton (2001) in a recent UK forum called *interactional evidence*: 'We can shift the emphasis of research from finding evidence for something that works toward an ongoing dialogue among those people who are involved in creating the context for treatment' (p. 13). In choosing an effective treatment the therapist consults not only a research manual but also the client.



### **A systemic-practitioner model**

As research vindicates the efficacy of family therapy across a wide range of problems and populations it is appropriate that family therapists adopt a systemic-practitioner model. In real-life clinical situations Paul's (1967) original question of 'what works for whom under what conditions' appears impossible to answer without a relational or systemic understanding of therapy. Here systemic wisdom is an integral part of evidence-based therapy practice. For example, in working with adolescents with early psychosis, relational work with the family is the substratum for introducing other evidence-based treatments such as psychoeducation, medication and cognitive therapy. The challenge is to integrate research in clinical work in a way that sustains systemic thinking. This art of balancing clinical experience, relational know-how and science or research helps to prevent evidence-based practice from becoming a strait-jacket for the field (Soldz and McCullough, 2000).

A systemic-practitioner model uses both quantitative and qualitative research, local practice experience and systemic wisdom to apply relevant therapy techniques in a relational and narrative context. This is wider than a scientist-practitioner model because RCTs are one of several factors to consider in choosing an effective treatment. As Harper *et al.* (2003) note, the former are group results that tell us little about what works for individuals. In a systemic-practitioner model the important research question is how to measure systemic process whether in quantitative or qualitative terms (3), though as Michel (2003) notes, psychological meaning is primarily a qualitative attribute. The research 'data' for family therapy are relational meaning or discourse; in systemic terms they concern what person A does, says or means by Y *in relation to* persons B and C.

### **Paramodern tensions and systemic science**

One dilemma for the family therapy field is whether it should continue to strive to meet unrealistic and clinically irrelevant 'gold standards' of RCT drug research or challenge this dominant ideology in favour of a more diverse evidence base. Interestingly in the literature there is movement on both these positions at once. There are continued efforts to establish an evidence base for family therapy, and there are recent indications that it is already well advanced along this path (Sprenkle, 2003). This responds to the political reality that

RCT research currently provides the benchmark for evidence-based practice in medicine, psychiatry and mental health service delivery (Campbell, 2003). At the same time there is lively critique of a scientist-practitioner model of evidence and its applicability to clinical practice. While clinical researchers such as Pote *et al.* (2003) and Diamond *et al.* (2003) present manualized models for clinical RCT research, they and others challenge its limitations and suggest alternative methodologies for evaluating the effectiveness of family therapy, such as practice-based research and qualitative studies (Addison *et al.*, 2002; Faulkner *et al.*, 2002).

I would like to suggest that this both/and stance in family therapy research is modern and postmodern at once, what I call *paramodern* (Larner, 1994, 2000, 2001). Here narrative and science, qualitative and quantitative research, modern and postmodern perspectives sit together as a necessary tension, sharing an investigative, ethical and pragmatic curiosity about what is helpful in the difficult work of therapy. This collaborative stance does not reject a modern science of psychology and therapy, which would merely perpetuate a relational violence towards what is different or other, but seeks to critique, deconstruct and enrich its institution from within (Larner, 2002; Pare and Larner, in press). As Derrida makes clear, to deconstruct is not to destroy an institution but to find ways to make it more just and less oppressive: 'This accounts for my sympathy for structuralism, even if, as you know, I raised questions and voiced disagreements. But basically I have a great deal of respect for that which appears to me always necessary and legitimate in the reading of a text, culture, system or configuration' (Derrida and Ferraris, 2001, p. 45).

The challenge for the systemic practitioner is how to be scientific *and* systemic at the same time, what Carmel Flaskas (2002) calls a diversity of theory and practice in family therapy. Elsewhere I have suggested that an ethic of hospitality towards scientific and biopsychosocial paradigms is part of the very meaning of 'systemic' (Larner, 2003, in press). Family therapy is concerned as much with what lies outside its own system of theory and thinking as within it. Whether in therapy or in liaison with mental health colleagues, systemic practitioners bring contradictory and opposing voices and perspectives into conversation.

## Conclusion

This article has presented a best practice model of family therapy based on a systemic politic of evidence. First, there is little point

applying a strict scientist-practitioner model in family therapy if it does not work or fit clinical reality. The evidence for evidence-based practice is unclear and in real life therapy needs to be defined more broadly than RCT research allows. Second, therapy is both a science *and* an art; what is common to all successful therapy is the therapy relationship and working with the client story and context. Third, there is strong empirical support from quantitative and qualitative research that family therapy works. Fourth, the definition of evidence-based practice is a process of political and social construction significantly influenced by governance based on corporate models of accountability. Fifth, a systemic wisdom that integrates relational context and personal narrative with technique to decide what works for whom when is best practice for any therapist.

Finally, family therapists should adopt a systemic-practitioner model that integrates modern and postmodern approaches in research and practice. In addition to biological, cognitive and behavioural factors this recognizes the powerful role of personal narrative and wider systems in therapeutic change, such as family, culture, community, spirituality and ecopolitical-social contexts. In the politics of evidence the way forward is to identify family therapy as a *systemic science* of context, narrative and relationship.

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