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Systemic family therapy can be manualized: research process and findings

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Determining the efficacy of therapeutic interventions is becoming an increasing political and ethical necessity. Comparative therapeutic outcome trials are most powerful when there is a precise specification, or manualization, of the forms that therapies took. Manuals have begun to be developed for structural/behavioural family therapy and couple therapy. The development of these manuals is often reliant on experts' self-report, rather than a systematic analysis of the therapeutic process as it happens. This can limit their validity and applicability to standard clinical practice. In addition, no manuals exist which reflect less structured forms of family therapy aimed at incorporating systemic, postmodern and narrative frameworks. The feasibility of producing a workable manual that reflects the fluidity of such practices has been questioned.

A research project to systematically create and test such a manual is reported. Multiple data sources and research methods, primarily qualitative, were applied to generate a rich specification of the therapy. In reporting these results the contents of various aspects of the final manual are indicated. Procedures to ensure that the prescribed practice is consistent with a widely used approach to systemic family therapy are also described.

The manual will be an important tool for outcome research and therapeutic practice. The account of the research process should be helpful to researchers engaged in constructing a manual for other models of family therapy based on a rigorous analysis of actual practice. The manual itself is available for use by outcome researchers who wish to evaluate this widely used form of systemic family therapy.

Introduction

In the enterprise to improve the evidence base for family therapy the development of systemic manuals has become evident. Manuals specify different modes of clinical practice and enable comparisons of

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model efficacy through controlled outcome trials. In order for the findings from outcome research to be clinically relevant and meaningful, the manuals used must offer a fair representation of practices within the contexts in which the therapy is usually delivered. Therefore, the process involved in the development of systemic therapy manuals will be crucial.

Within the systemic manuals that currently exist, as in other areas of science, there has been a tendency for the more easily specified and measurable to be privileged. It has also been a common strategy for manuals to be defined and specified anecdotally by senior practitioners in the field, with less reliance on therapy process research from clinical contexts. These current practices in manual development and outcome research may risk the development of a 'biased' evidence base (Etchison and Kleist, 2000). Across psychotherapy, easily prescribable cognitive-behaviour techniques applied to specific diagnostic categories have been manualized before more complex psychotherapeutic techniques with more general application. Within family therapy the strategy has resulted in more behaviourally oriented forms being manualized and shown to be effective for specific conditions.

A common criticism of outcome research is of a lack of generalizability to everyday practice. Participants are unrepresentative, as they have usually been screened to exclude any with multiple difficulties; the therapy is delivered to a higher standard and in a more tightly defined form than is possible in normal practice; and most evidence will have accumulated about older forms of therapy (Shapiro and Barkham, 2002). All of these difficulties weigh most heavily on a rapidly developing therapy with broad application such as systemic family therapy. More applicable research would be facilitated by the availability of a manual derived from representative current practice, in a format that allows for current developments and the emphases of clinics in which it would be implemented. It should also be designed to consider second order change with the usual range and complexity of family difficulties. In this paper we describe the research processes undertaken for the creation of such a manual, the broad outlines of the resulting manual, and the rationales for its use.

The current status of systemic outcome research

The efficacy of family therapy is supported by outcome studies, carried out in the United States (e.g. Birmaher *et al.*, 2000; Brent

et al., 1997; Epstein *et al.*, 1990; Gingerich and Eisengart, 2000; Simpson, 1991), and to a lesser extent by European studies (e.g. Carr, 1991; Lask and Matthews, 1979; Leff *et al.*, 1985, 2000; Russell *et al.*, 1987; Sundelin and Hansson, 1999).

Recent reviews of the outcome literature, for a variety of presenting difficulties, draw a number of consistent conclusions (Carr, 2000; Cottrell and Boston, 2002; Markus *et al.*, 1990; Miller *et al.*, 2000; Ozechowski and Liddle, 2000; Pinsof and Wynne, 1995; Pinsof *et al.*, 1996; Shapiro and Barkham, 2002). Family therapy is effective when compared with no treatment controls (mean effect sizes of approximately 0.5), and, for some presenting difficulties, is more efficacious than individual interventions (e.g. marital distress, anorexia in young adolescents). Family therapy may also have advantages over individual treatments in relation to engagement and client ratings of satisfaction. Family therapy may also be more cost-effective than residential and inpatient treatments, but may not be sufficient in itself to address a variety of severe disorders and problems (e.g. schizophrenia, adolescents' conduct difficulties). The reviews emphasize the lack of data to support the differential efficacy of different family therapy models, and the paucity of controlled outcome trials for narrative and social-constructionist systemic interventions.

Despite the strength of the evidence base for systemic psychotherapy, when we look more closely at this body of research literature we are confronted with a series of methodological flaws. Design issues, such as small and sometimes unrepresentative participant samples and the lack of credible no-treatment and alternative treatment controls, continue to undermine the conclusions of the research. Such concerns have been clearly raised in reviews and meta-analyses of the systemic outcome literature (Cottrell and Boston, 2002; Etchison and Kleist, 2000; Hazelrigg *et al.*, 1987; Miller *et al.*, 2000; Pinsof and Wynne, 1995; Pinsof *et al.*,1996; Prince and Jacobson, 1995; Sandberg *et al.*, 1997; Shadish *et al.*, 1993).

One primary concern for these reviewers is the poor specification of the systemic interventions considered. It is easy to become lost in the multitude of definitions of what constitutes the family therapy interventions assessed, if, that is, the researchers have defined the interventions at all (Asen, 2002). For example, Shadish *et al.* (1993) classified the seventy-one family therapy studies in their meta-analysis into twenty-two different theoretical models and still had seven studies left over that they were unable to classify. The result is that

therapists and researchers alike remain unclear about what constitutes effective family therapy. There remains an urgent need to specify more clearly and consistently what therapy is offered in systemic outcome research.

Specifying therapy through manualization

Comparing the efficacy of family therapy with other interventions is problematic due to the inconsistency in defining what family therapy components are being used in efficacy trials. Progression to more specific efficacy research, investigating which components of complex family therapy are effective for which circumstances, is hindered by the lack of specificity in defining interventions. This decreases the utility of research in informing service planning and clinical work.

Attempts have been made to overcome these methodological difficulties by specifying the forms of therapy in some detail (e.g. Dare *et al.*, 1995) but a more rigorous approach is to manualize the therapeutic intervention employed by the therapists in the research.

Manuals for research are not the same as training manuals. For example, Stratton *et al.* (1990) provide material to provoke processes in the trainee that will result in changed meanings and new possibilities. The objective of such training texts is to activate a process of reflective learning which opens up new possibilities. A research manual has a training function but must be more prescriptive because it will specify clearly the components of therapist activity and prescribe model-specific activities, while proscribing activities from other therapeutic modalities. Adherence and competence protocols may then be used to assess the extent to which therapists using the manual can comply with the prescriptions outlined, and perform therapy to a satisfactory standard. This ensures that therapists in outcome trials are delivering consistent, model-specific interventions (Hogue *et al.*, 1996).

Comparative outcome trials that have included manualized family therapy interventions are beginning to emerge (Alexander *et al.*, 2000; Birmaher *et al.*, 2000; Brent *et al.*, 1997; Jones and Asen, 2000; Liddle *et al.*, 2001). However, these manuals have had a primarily behavioural or structural focus. For example, Brent and colleagues, in the USA, reported a manualized control trial for adolescent affective disorders (Birmaher *et al.*, 2000; Brent *et al.*, 1997). They found that cognitive behaviour therapy was more efficacious in relation to symptom resolution than systemic behaviour therapy and

non-directive supportive therapy for adolescents in clinical settings. Assessments of wider clinical improvements showed no differences between the three groups. Because a manual was reported it is possible to identify that this version of family therapy had many elements of structural family therapy (Minuchin, 1974). This makes comparisons to other outcome studies more useful and specific.

It could be assumed that behavioural and structural approaches to family therapy would lend themselves to manualization (Messer, 2001), but it is just as important to research other dominant family therapy paradigms, or at least to discover whether manualization is a practical possibility within these paradigms. By employing multiple methods, Wilkinson and Stratton (1991) have shown that it is possible to specify a multisystemic assessment interview which is flexible but of acceptable reliability and validity. Piper and Ogrodniczuk (1999) discuss the dilemma which dynamically orientated therapists and researchers face in developing more flexible manuals for less structured therapeutic interventions, and suggest an emphasis on general guidelines over technical detail.

Examples of manuals detailing less structured, systemic family therapy are limited, since until recently the ethos of these forms of family therapy has worked against anything that might look like a prescription of what the therapist should do. Jones and Asen (2000) have gone some way to assessing the feasibility of a flexible systemic manual by producing a manual for systemic couple therapy where one of the partners is showing symptoms of depression. Their manual is a compilation from their extensive clinical experience but was developed by reflection rather than a research process.

Pivotal to the development of effective manuals is the accompanying development of a comprehensive adherence protocol. This measures whether therapists are able to comply with the prescriptions of the manual and with the rigour required for outcome studies, while ensuring the standardization of treatment that is essential in forming specific conclusions about the effectiveness of therapy. Previous attempts at adherence measures in family therapy have been basic, and often reliant on self-report measures by therapists (Hogue *et al.*, 1996). This leads to measures that are less clinically meaningful, and undermines the reliability and validity of interventions assessed.

This paper reports a research project aimed at addressing the outcome research issues discussed above by developing a manual and adherence protocol for systemic family therapy. The research

involved observing and tabulating the interventions delivered by a well-established family therapy clinic and training institute in the UK, and assessing whether a usable manual could be developed from these data. Participants were practitioners at the Leeds Family Therapy and Research Centre (LFTRC) who use a form of systemic family therapy which has grown out of the Milan school (Boscolo *et al.*, 1987; Jones, 1993; Stratton *et al.*, 1990) and integrates methods from narrative, reflexive and solution-focused orientations within this broad framework. Consultation with a variety of training centres throughout the UK showed the practice tabulated to be representative of systemic practice within the UK context.

Preliminary discussions with colleagues, who were both familiar and unfamiliar with manual use, revealed considerable doubt that manualization could be achieved without oversimplifying systemic therapist practice, restricting creativity and provoking resistance from therapists (Silverman, 1996). Indeed, the research process by which a manual was created successfully was interesting and important in its own right, being informative about many issues that arise in manualized outcome studies. The manual itself provides a solid description of systemic family therapy which can be used as a research tool in manualized outcome trials. In this paper we therefore report on the research process in some detail through an exploration of the three central questions. How can we specify current family therapy process? How can this information be co-ordinated into a manual? Can family therapists use and adhere to the manual?

Research process

The research process was multifaceted and recursive, with several stages of data collection and analysis being followed by consultations with therapist participants and other family therapists in the UK. An iterative design was chosen to enhance the clinical sensitivity of the information used in the manual, and to provide participant validation of the data analysis (Elliot *et al.*, 1999). This process also ensured that the information from participants in the clinic selected was representative of other therapists' views and practice in the UK. The research was designed to be consistent with the constructionist orientation of the therapy, being primarily qualitative but using quantitative techniques such as ranking and scaling where these were judged to be informative (Sells *et al.*, 1995).

The key stages in the research process are listed here, and then discussed in detail below:

1 Semi-structured interviews with five expert family therapists, with qualitative and quantitative analysis;
2 Observational ratings of fifteen videotapes of expert family therapy sessions, using a specifically developed observational rating schedule and employing quantitative analysis;
3 Development of a draft manual;
4 Trial of the manual in practice by three experienced family therapists to obtain qualitative feedback and ascertain quantitative self-report of adherence.

At the end of this progression we were able to specify the final manual and a preliminary adherence protocol.

How can we specify current therapy practice?

The first step to creating a manual was to obtain a detailed account of representative good practice. A manual should not attempt to provide a 'gold standard' for therapy and is likely to exclude unusual, contentious or purely local procedures. But if it is to be used ethically in outcome trials with random allocation of clients, it must capture a broad enough cluster of agreed techniques in order that the therapy will be of similar efficacy to ordinary practice.

To assess what could be considered as current systemic therapy practice, the therapeutic practice of the LFTRC was tabulated and observed. The Centre had been chosen as being representative of current practice in the UK, and this assumption was tested through consultations with five major family therapy centres around the UK as the draft manual was formulated.

Stage 1 Interviews with therapists

Semi-structured interviews were conducted by the first author with five expert family therapists from LFTRC. Participants were all experienced family therapists with accreditation from the United Kingdom Council for Psychotherapy, who volunteered to participate in the research. An adapted version of the Brief Structured Recall (BSR) method was used to structure the interviews (Elliott and Shapiro, 1988). The BSR method requires therapists to review and comment on videotapes of their own practice. It was therefore

chosen, since it easily facilitated a description of systemic family therapy which illuminated the levels of approach, method and technique as discussed by Burnham (1992). That is, the theoretical, methodological and technical aspects which define a particular therapy and allow comparison with and distinction from other therapeutic models. It was also chosen as it is a reliable measure of therapeutic practice which has been used in the development of non-systemic manuals. Videotapes for review were selected purposively by the researcher from beginning, middle and end sessions of therapy in order to form descriptions of practice across the course of therapy.

The raw data from the semi-structured interviews were analysed qualitatively using a grounded theory analysis (Strauss and Corbin, 1990) which used the research team to increase reflexivity (as recommended by Barry *et al.*, 1999). The grounded theory method was judged as suitable for the current project, since it ensures that any analysis is closely related to the original participant data, and builds from an iterative process of analysis between researcher and participant, data collection and analysis.

The grounded theory analysis used open coding which is defined as 'the process of breaking down, examining, comparing and conceptualizing, and categorizing data' (Strauss and Corbin, 1990, p. 61). In addition, the subsequent stage of a grounded theory analysis was used, that of axial coding. Axial coding is defined as 'a set of procedures whereby data are put back together in new ways after open coding, by making connections between categories' (Strauss and Corbin, 1990, p. 96). A quantitative component was provided by ratings made by therapists of possible intentions, and of the emerging themes and principles.

The interview data were grouped into five key areas. These areas were defined by the BSR format and qualitative analysis of the emerging themes from the interviews. The areas were: (1) Therapist intentions; (2) systemic guiding principles; (3) systemic methods and techniques; (4) indirect work; (5) proscribed practice.

1 Therapist intentions

Following the standard BSR format as described above, therapists were required to retrospectively rate their intentions in relation to the systemic practices they observed in videotape reviews of their own therapy practice. The process here should be seen not as a realist account of intentions at the time of therapy, but as using the context to elicit accounts of the kinds of therapeutic practice the therapists

would report when confronted with samples of their own practice. Ratings of twenty-six possible intentions were given on a five-point Likert scale relating to the extent to which therapists felt they were being guided by this intention during their practice. The twenty-six intentions were made up of nineteen standard BSR intentions and seven systemic intentions added by the authors in their adaptation of the BSR format. Additional intentions included those not anticipated in individual non-systemic work, such as 'involve everyone in the discussion' and 'reframing'.

Overall, there was considerable variation in the ratings of intentions for most of the first sessions, but there was more consensus on what therapists were intending to do within the middle sessions. Common intentions across therapy included 'involve everyone', 'open up new stories' and 'reinforce change'.

2 Systemic guiding principles

Using the BSR method, therapists were also asked to comment on the theoretical ideas that were informing their practice. The written information which participants produced was analysed qualitatively, using a grounded theory approach (Strauss and Corbin, 1990) as described above. An initial open coding of the raw data identified specific themes. This was followed by axial coding, grouping the themes, returning to the raw data and seeking participant validation. This produced the following eleven broader theoretical concepts which therapists felt were the guiding principles informing their work. The guiding principles were further validated as being representative of current systemic practice through a series of semi-structured meetings with family therapists from other family therapy centres. The nineteen therapists who participated in these meetings were asked to rate the guiding principles according to their importance in their work with families, with a rank of one indicating the most important principle. The results of this analysis are outlined in Figure 1. They were also invited to add in other theoretical ideas that guided their work, and they suggested a more explicit emphasis on issues such as self-reflexivity, gender and ethics. Their input was used to enrich the definitions of the eleven concepts.

Through this recursive process the following guiding principles were produced:

1 *Systems focus*. In working systemically the central focus should be upon the system rather than the individual, particularly in relation

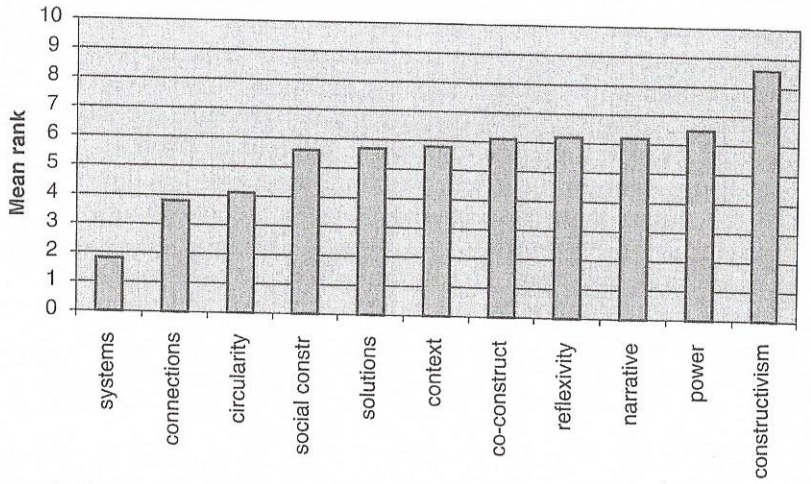

Figure 1. UK therapists' rating of the influence of theoretical guiding principles in their systemic family practice.
Note: The lower mean ranking indicates that the principle is more influential.

to the difficulties and issues that the family system brings to therapy.

2 *Connections and patterns*. In understanding relationships and difficulties within systems it will be important for the therapist to consider the connections between circular patterns of behaviour, and the connections between the beliefs and behaviours within systems. The process of therapy should enable family members to consider these connections from new and/or different perspectives.
3 *Circularity*. Patterns of behaviour develop within systems, which are repetitive and circular in nature and also constantly evolving.
4 *Social constructionism*. Meaning is created in the social interactions that take place between people and is thus context dependent and constantly changing. The concept of negotiation of a shared meaning, constructed afresh in each conversation, takes precedence over the concept of a single external reality.
5 *Strengths and solutions*. The therapist should take a non-pathologizing, positive view of the family system, and the current difficulties they are struggling with. The therapist should attend to the strengths and solutions in the stories that the family system brings to therapy.

6 *Cultural context.* The therapist should consider the importance of context, in relation to the cultural meanings and narratives within which people live their lives, including issues of race, gender, disability, religion and class. The relationship between these narratives, the therapeutic relationship and its context, as well as the wider context for the therapeutic team and the family, should be an important consideration at the point of referral and throughout the therapy.
7 *Co-constructed practice.* In therapeutic interactions reality is co-constructed between the therapist (and team) and the people with whom they meet.
8 *Reflexivity.* Therapists should aim to apply systemic thinking to themselves and thus reject any thinking about families and their processes that does not also apply to therapists and therapy. In order to use self-reflexivity it will be necessary for therapists to be alert to their own constructions, functioning and prejudices.
9 *Narratives and language.* Behaviours and beliefs form the basis of stories or narratives, which are constructed by, around and between individuals and the system itself. The language that is used to describe these narratives and the interactions between individuals construct the reality of their everyday lives.
10 *Power.* The therapist should take a reflexive stance in relation to the power differentials that exist within the therapeutic relationship, and within the family relationships.
11 *Constructivism.* The idea that each person constitutes an autonomous meaning system and will interpret and make sense of information from this frame of reference.

These categories are by no means mutually exclusive, and some degree of connection exists across these concepts, and between these principles and methods and techniques discussed below, as one might expect. The concepts were taken back to the five therapists for participant validation, and they were interviewed as a group and asked to discuss the conceptual connections that existed between the categories in their own thinking and practice. Full transcripts of these interviews were analysed qualitatively, again using grounded theory techniques, to produce a conceptual map of the connections between the guiding principles. This is presented in a non-prescriptive manner in the manual, as one way to understand the connections between the principles, but the possibility of different conceptual maps for individual therapists is discussed (Pote *et al.*, 2000).

3 Systemic methods and techniques

During the BSR interviews therapists also reported on the methods and techniques they used during their clinical practice. These are defined by Burnham (1992) as the more specific and concrete aspects of therapeutic activity. Open and axial coding of this information generated the classifications of systemic methods and techniques. The classifications developed from the qualitative analysis of the therapist interviews were taken to participants from the five collaborating systemic family therapy institutes. During group interviews, therapists were required to consider the rate of use of the methods and techniques in their own practice and to contribute any additional aspects of therapeutic activity not contained in the lists. These group interviews were audio-recorded and the data used in the grounded theory analysis to validate the existing classification and develop the final list of systemic methods and techniques.

The systemic family therapy methods outlined through this process were: *Teamwork*, including the use of a designated 'secretary' from the therapy team to communicate with the family pre-therapy; *Communications* between the therapist, team and family through earbugs and telephones; *Structuring sessions and feedback* from the team through breaks and reflecting team discussions; *Videotaping* therapy sessions; *Consultations* to the wider system before and during therapy; *Use of reading seminars* to develop team thinking.

Systemic family therapy techniques were more varied, with nineteen classifications including circular questioning, externalizing the problem, tracking life events and paying attention to language used.

4 Indirect work

Information on indirect work supporting the direct therapy with the family, such as communication with referrers, and child protection work, was derived from the qualitative analysis of the therapist interviews and group meetings with the five family therapy institutes. These were areas of systemic work, which are informed by systemic ideas but do not directly involve the presence of the family. They are regarded as essential in supporting the ongoing work with the family and therefore need to be included in the manual.

5 Proscribed practices

Information on proscribed practices, which therapists believed would indicate practice that was not characteristic of a systemic model, was

also sought and analysed from the interview schedules and group meetings with other family therapy institutes. Examples were: making psychodynamic interpretations; consistently siding with one person; and ignoring difference, for example, gender differences. For the manual to clearly differentiate systemic family therapy from other therapies it is important that it should specify these proscribed practices. This is not to claim that systemic therapists do not, or should not, find it appropriate to use some of the practices on occasion. But for the purposes of a clear research outcome, with clearly differentiated therapeutic interventions, they should be avoided as far as the interests of the clients allow. Because the list is explicit about what is proscribed it is easy to record whenever one of the practices was used.

Stage 2 Videotape observations

The purpose of rating videotapes of sessions was to describe therapeutic activity from an observer perspective and to enrich the description of the therapeutic process. It also enabled validation of the qualitative analysis of therapist interview, through triangulation of the data (Elliot *et al.*, 1999).

Observational sample

Videotapes of therapy sessions were rated to provide a further direct source of information about therapist activities in practice. This stage of the research generated much interesting detail about therapist practices but the report here is restricted to those aspects that directly affected the production of the manual. In order to maximize the occurrence of therapeutic activity without processing an unrealistic amount of tape, and to exclude administrative and other processes at the start and end of session, all samples were of fifteen minutes, begun fifteen minutes from the start of the session.

Fifteen videotapes of therapy sessions, which had not been used in the initial therapist interviews, were purposively sampled from the library of therapy sessions held at LFTRC using the following inclusion criteria: recent family therapy practice (1992 to 1998); child in the family between the ages of 10 and 20; family attended at least three family therapy sessions; the sessions were not used in Stage 1 of the research process. Sampling also ensured an equal number of five videotapes each from beginning, middle and end sessions of therapy.

Development of an observational rating schedule

Information obtained from the analysis of the BSR interview data in Stage 1 was used to develop an observational rating system which could be applied to videotapes of family therapy sessions. Rater categories were taken from the results of the analysis of the BSR for therapists' intentions, methods and techniques. In addition, the BSR interview data were again open coded to identify the content of discussion in therapy and family triggers. Family triggers were defined as actions or comments made by the family (sometimes called marker events) that preceded therapist activities.

The categories were simplified for the purposes of a coding system, and the final categories were grouped into four sections: (1) therapist's intention – the intervention that the therapist was observed to be attempting to implement, for example, reframing; (2) family trigger event – the immediate actions of a family member before the therapist event, for example, talking about the problem; (3) therapist techniques – the type of therapist event, for example, the use of a statement or circular question; and (4) content of the discussion – the overall theme of the therapist and family interaction for each therapist speech act, for example, talking about solutions.

Raters were asked to choose one of the subcategories from each of the four categories for each therapist speech act (therapist event); that is, every meaningful utterance by the therapist during the session. The beginning time of the speech act was also recorded. All categories had to be completed, and if raters could not code any element of the interaction this was noted.

Raters also had the opportunity to add any additional qualitative information about the therapist event which they felt was not captured by that rating. In addition, they could add comments across ratings; for example, a series of linear questions which when viewed together form a circular pattern, or indicating the type of circular questions used. This allowed for a rich picture of therapist activity to develop, and was used in providing clinical examples for the manual.

Inter-rater reliability

Four raters, who were all experienced family therapists and members of LFTRC, independently coded samples of the videotapes. Inter-rater reliabilities were calculated using these data. The raters were provided with summary definitions of rating for the four categories,

and rated a random sample of beginning, middle and end sessions of family therapy. The inter-rater reliabilities were acceptable overall. From the detailed breakdown shown in Table 1, it is clear that the category of family event was difficult to code reliably, so this category was used more tentatively in constructing the manual. Two other categories proved difficult to code reliably for the middle sessions. This is explained by the randomly chosen sections of videotape which contained complex combinations of interventions by the therapist. For example, explanations and questions were combined in single speech acts, and this made ratings ambiguous. This information was used helpfully in the manual to proscribe against long or complex therapist interventions.

Videotape observation findings

The findings from the videotape observations were useful in confirming predicted areas of practice and providing additional insights into the form systemic family therapy takes. Three particularly interesting areas are discussed below.

1 How do therapists achieve different intentions? Findings showed that therapists used different types of technique according to the kind of intervention they were intending to achieve. The extent to which different techniques were used and their relationship with what the therapists were intending to achieve are illustrated in Table 2.

The technique which therapists used most frequently was asking linear questions, though they often used these in a circular fashion, moving around the family to build up a picture of events from everyone's perspective. More complex intentions were associated with circular questioning, and statements were used to clearly distinguish team and therapists' ideas.

TABLE 1 *Inter-rater reliability alpha scores for video ratings*

	Rating categories			
Session	Therapist intention	Therapist technique	Family event	Overall content
First	0.75	0.89	0.50	0.85
Middle	0.40	0.90	−0.19	0.33
End	0.72	0.85	0.59	0.61

TABLE 2 *Therapeutic techniques associated with therapists' intentions*

	Techniques		
	Linear questions 47%	Circular questions 31%	Statements 21%
Intentions	• Elicit family information • Elicit solutions • Hear views of the difficulties • Identify behaviour patterns	• Reframe • Explore beliefs • Hear views of the difficulties • Identify behaviour patterns	• Introduce team ideas • Introduce therapist ideas

2 How do therapists' interventions change across therapy? Particular attention was paid to the differences in therapist and family activity at different stages of the therapy (see Table 3). Differences were sufficiently clear to give a basis for structuring the prescriptions in the manual in terms of opening, mid-therapy and ending sessions.

3 What family actions trigger therapist activity? To try to determine what activated the therapist to follow different directions and goals in therapy, the activities of families were linked to the therapist intervention which followed. The most consistent findings about common connections were used in the manual to indicate the contexts of family discussion in which each therapist activity was most likely to be used.

Stage 3 Co-ordinating the information into a draft manual

The research processes and findings described above enabled us to produce a detailed specification of the essential components of a widely acceptable form of systemic family therapy. The decision-making process about what information should be included in the manual was a complex developmental process moving fluidly between the qualitative and quantitative information we had collected and the beliefs of the research team as therapists and researchers. Essential to this process were consultations with the other five collaborating family therapy institutes. Their judgements and ratings were used to ensure that the decisions about what to include in the manual remained grounded not only in the data collected from therapists originally but therapists' overall experiences of systemic family therapy. For example, using the information on guiding

TABLE 3 *Summary of changing focus across therapy*

	Beginning	Middle	End
Intentions	• Eliciting family information • Hearing the family's view of the difficulties • Exploration of beliefs	• Eliciting family information • Hearing the family's views about the difficulties • Continuing to explore beliefs • Eliciting information about the wider system • Eliciting information about family patterns of decision-making and interaction Reframing difficulties	• Exploring beliefs • Successes and solutions
Central Intervention	• Linear questions	• Circular questions	• Circular questions • Linear questions
Family's focus	• Difficulties • Sharing information about their family	• Linear questions • Statements • Difficulties • Views about therapy • Successes and solutions	• Statements • Difficulties • Relationships

principles from the initial therapist interviews, we were able to survey theoretical influences that were guiding therapists' practice at other centres in the UK, and to replicate exactly the modified list of guiding principles as a section of the manual.

Particular issues were considered in co-ordinating the information to produce the manual. First, the information had to be tailored to the appropriate level for the readership. As the manual was intended initially as an outcome research tool it was decided that trained therapists would be the most likely users. This allowed us to make assumptions about general standards of therapeutic practice related to existing therapeutic training. It also enabled us to decide upon an appropriate level of specificity in the prescriptions and descriptions used in the manual.

As previously stated, the manual does not seek to define optimal practice. Some valuable techniques were omitted because they cannot be prescribed to be used consistently in therapeutic practice. However, in order to create some room for flexibility and creativity the manual indicates occasions when it may be appropriate not to

follow its guidelines, and makes provision for therapists to record these individual variations.

Structure of the manual

Using all of the information discussed above a manual was constructed. This paper is a report of the research process, and it would not be possible to incorporate the manual and adherence protocol within a journal article. The manual is therefore made available on the LFTRC website (Pote *et al.*, 2000) but the structure is indicated by the list of sections described in Table 4.

To give more of a flavour of the final product, a specific example may be helpful. The section chosen is from the middle session of

TABLE 4 *Outline of the manual*

Section	Description
1 Introduction	An introduction to the scope of the manual as a tool for outcome research, and guidelines on how to follow and use the manual.
2 Guiding principles	An outline of the theoretical principles which should be informing therapists.
3 Outline of therapeutic change	A hypothesized model of change, which was drawn from LFTRC practice.
4 Outline of therapist interventions	A summary of the central interventions therapists should use across the course of therapy, for example, linear and circular questioning.
5 Therapeutic setting	Information for therapists and therapy teams about the methods they should use to organize the work with families, for example, the use of screens and videotapes.
6 Initial session guidelines	Specific outline of therapy goals for initial sessions and the interventions appropriate in achieving these; for example, gathering family information through the use of linear questions.
7 Middle session guidelines	Specific outline of therapy goals for middle sessions and the interventions appropriate in achieving these; for example, working towards change at the level of behaviours and beliefs through reframing.
8 End session guidelines	Specific outline of therapy goals for end sessions and the interventions appropriate in achieving these; for example, collaborative ending decision using linear and circular questions.
9 Indirect work	Outline of the areas of indirect systemic work

TABLE 4 *(continued)*

Section	Description
	that will be helpful in supporting the direct work with the family.
10 Proscribed practices	Information regarding elements of practice that should not be common in systemic family therapy.
11 Samples of correspondence	Examples of letters to families and professionals that should be used by therapists in following the manual.

therapy, looking at the goal of working towards change at the level of behaviours and beliefs. A number of methods for achieving this goal are presented for the therapist. In this example the method of reframing is discussed. The format of the discussion is consistent throughout the manual; after a brief description of the method, a clinical example is provided to give the therapist a flavour of how this might look in practice.

Middle session

- *Aim 4. Work towards change at the level of beliefs and behaviours*

Working towards change at the level of beliefs and behaviours can be achieved in a variety of ways during middle sessions. Listed below are descriptions of options available to the therapist.

- *Method 1. Reframe*

Reframe some of the constraining ideas presented by the family. Relabel in a positive way ideas and descriptions given by family members in a manner which is consistent with their realities.

Clinical example

A father (Cl) is defining himself and his parenting behaviour as the 'problem' in relation to his children's teenage struggles. The therapist (Th) works towards redefining the descriptions of behaviour as less problematic, and offering some positives for the family.

Cl: I think I'm basically just too inconsistent, it depends what mood I am in, or how busy I am, as to what answer the kids will get from me.
Th: I am just wondering, this inconsistency, who is it a problem for?
Cl: Well them, I think.
Th: Does it leave people not knowing where they stand or does it leave people just having to make up their own minds?
Cl: Well both, I've never really thought about it like that, but I feel like I don't always think before I react.
Th: Tell me Jane what are some of the helpful things about your dad just reacting sometimes?

Stage 4 Can therapists adhere to the manual?

To assess whether therapists could follow the prescriptions outlined within the manual, to a sufficient level of adherence for standardized treatment implementation, three experienced family therapists who had worked extensively in LFTRC and who had not participated previously in the research were trained in use of the manual, and adherence measures were developed. The therapists were trained to use the draft manual in a group training workshop conducted by the first author.

Therapists completed a questionnaire, giving their own ratings of whether they felt they could adhere to the prescriptions of the manual. Ratings ranged on a seven-point Likert scale from *not adhere at all* to *adhere all the time*. Therapists' self-reports of adherence were good. For example, in middle sessions, therapists reported high adherence to the fifteen tasks outlined; adherence ratings ranged from 2.2 to 5.2 with a mean of 3.5.

The research team decided that self-report measures of adherence, which are used commonly in outcome studies, were not sufficiently rigorous in assessing adherence. An independently rated measure of adherence is therefore being developed from the items contained within the manual. The current version is available on our website (Pote *et al.*, 2000). This measure is designed to be used with videotaped material of manualized therapy. Where necessary, items for the adherence protocol are being operationalized further by three experienced systemic therapists in the research team, in order that adherence measures could be assessed by non-clinical raters.

Discussion: Is it possible to create a workable manual that will meet the requirements of outcome research?

Many questions have been raised by systemic therapists and researchers about the feasibility of a manual for systemic family therapy which can meet the prescriptive requirements of a manual without being reductionist and restrictive to the variety and creativity characteristic of systemic models. To evaluate the present manual we consider its content and operation in the light of these potential objections.

Systemic practice is too unique

Informed by social constructionist frameworks we acknowledged that each therapeutic conversation is unique. It is created by the current

thoughts, feelings and contexts of therapist and family. As these ideas and contexts are constantly evolving and being informed by the conversations that have gone before, the pattern of interactions continually changes, and can never be repeated in exactly the same format. However, from the interviews and observations we conducted of therapy, both cross-sectional, across different therapists/families, and longitudinal, with the same therapists/families over time, we did find some common patterns. It was these common patterns discussed above that we felt could contribute helpfully to a manual, and form a prescriptive base, from which therapists could develop their own creative components.

Systemic practice is too broad and changes too fast to be fixed in a manual

Another issue concerned the definition of what constituted systemic family therapy. This related to two aspects. Should a manual attempt to encompass the wide gamut of theoretical models and techniques found under the umbrella of systemic family therapy? In addressing this issue we realized that the task of describing the wide range of systemic practice was impractical. We therefore pragmatically confined the descriptions of practice to those that were most represented within the clinics at the Leeds Family Therapy and Research Centre. Thus the systemic practice described is more reliant on Post-Milan while drawing on Narrative and other models to enrich the practice. It is focused on therapeutic work with families across the lifespan, rather than organizational, couple or individual consultations.

In common with many recent commentators we reject the idea that approaches developed during the past fifteen years (collaborative, reflexive, solution focus and narrative) do not depend on previous achievements in the systemic field. The practice embodied in the manual makes full use of established systemic good practice in ways that enable recent advances to be incorporated.

A manual will be too prescriptive; systemic work is not like CBT

In responding to the BSR, therapists identified a number of goals or intentions about the kind of therapeutic intervention they were trying to achieve through the course of therapy. These varied across the course of therapy and were used to form a task analysis model similar to those prescribed in other models of therapy, such as cognitive

behavioural work. There were however two important elements of the manual that guarded against it becoming prescriptive and overly goal orientated.

1 *Guiding principles*. We recognized the important role which systemic guiding principles play in organizing therapeutic practice, with these often being given greater priority by therapists than specific goals during the process of therapy. Considerable attention and weight is given to systemic guiding principles at the beginning of the manual to orientate the therapist before any consideration of specific goals.
2 *Broad and flexible goals*. The goals outlined in the manual were specifically left as broad directions for the therapist to increase the flexibility by which they might be achieved. For example, the goal of 'Open up new stories' enables therapists to use a range of systemic ideas and techniques.

Families need to set their own agendas

In prescribing a therapist's agenda before therapy begins one is in danger of contravening a central tenet of systemic family therapy: that of the co-constructed nature of therapy between therapist and family. In order to address this concern we brought into the manual the prescription of co-constructed therapy, and specifically guided therapists to enquire about and negotiate the family's agenda throughout the process of therapy. It seems that by making a therapist's agenda explicit we may be making it more available for negotiation and adaptation, in contrast to the usual unexamined assumptions which therapists may possess (Cecchin *et al.*, 1994).

A manual will not reflect clinical practice

We were aware that manuals are often criticized for lack of grounding in real clinical practice, and represent unrealistic ideals of therapeutic practice. Throughout the process of developing the manual we therefore drew on actual therapy encounters. The data collected which formed the basis of the manual, and examples used in the manual, were all taken from the clinical material of practising family therapists. By developing the manual directly from the successful work of therapists in practice it is more likely to reflect actual therapy than an unrecognizable or idealized form of treatment. This makes

the manual grounded and meaningful, while still achieving the rigour required for adherence protocols.

A manual is a modernist document

One of the tensions we have found in tabulating what therapists do is that we may be at risk of creating a modern document in a therapeutic world that is becoming increasingly influenced by postmodern ideas. Our position has been that postmodernism offers a useful stance from which to question assumptions about therapy, families and culture, but it is not (and, according to its own tenets, it should not be) exclusive of other routes to understanding. The manual allows for a cycling between different positions (constructivist, constructionist and postmodern) and between different domains (Lang *et al.*, 1990), and so specifies a broadly acceptable form of therapy which can develop over time, a characteristic it shares with any form of training. The choice of research paradigm in which to use it is for the researcher to make. It is true that the manual could be used within a hypothesis testing paradigm but that does not preclude other kinds of usage.

A manual will be too technique focused and ignore therapist variables

Silverman (1996), in his article 'Cookbooks, manuals and paint-by-numbers: psychotherapy in the 90's', describes his pessimism about the utility of manuals in aiding effective treatment and improving standards of outcome research. He feels that by focusing on techniques at the expense of therapist variables, manuals deliver a form of treatment that does not reflect the actual process of therapy. However, in this manual we have striven for clinical richness. In order to move away from a collection of techniques we have enriched the manual by discussion of theoretical principles and models of change, and developed any techniques described through the use of multiple clinical examples.

Therapists will not be able to stick to a manual

One dilemma is how to make manuals designed for research acceptable to practitioners. The uniformity for which manuals strive may be much more palatable to researchers. We hope that by taking a bottom-up approach, by researching the current practice of systemic therapists in clinics, we are not imposing some theoretical and

unrealistic ideal of therapy, and that what we have developed makes sense and is recognizable to therapists. That is certainly the central experience we have had so far. We also hope that by developing the manual in this way we are not school-bound and exclude people due to theoretical allegiances. It is also important to remember that a manual should be a clinically rich guide, not a total prescription, and adherence is not required to be one hundred per cent, allowing room for therapists' creativity.

Conclusion

It is possible to manualize systemic family therapy on the basis of real world practice, but this is not a process without serious methodological and ethical issues. In describing the research process that was used to develop such a manual, we hope to have demonstrated some successful methods for addressing these dilemmas. We believe this process has enabled us to produce a workable manual which is grounded in therapy practice, making it acceptable for therapists and researchers alike. While our chief intention has been to make the manual available for outcome research on this model of systemic family therapy, we hope also that the report of our research process will be useful to other researchers who wish to use an empirical study of therapeutic practice as a route to manualizing other models of family therapy.

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What the family brings: gathering evidence for strengths-based work

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Families attending child and adolescent mental health (CAMH) services are often assumed to have problems in key areas such as communication, belonging/acceptance and problem-solving. Family therapy is often directed towards addressing these difficulties. With increasing emphasis in family therapy and human services fields over the last decade on identifying and building from strengths, a different starting point has been advocated. This paper describes a large survey of the self-reported pre-therapy functioning of children and families using a public CAMH service (n = 416). Before commencing family therapy parents identified family strengths across a range of key areas, despite the burden of caring for children with moderate to severe mental health problems. This evidence supports theoretical and clinical work that advocates a strengths perspective, and highlights how resilience framed in family (and social) rather than individual terms enables a greater appreciation of how strengths may be harnessed in therapeutic work.

Introduction

Despite the radical departure from individualistic approaches to psychotherapy that family therapy represented, a problem-centred focus pervaded most theoretical schools into the 1980s (Nichols and Schwartz, 1998). With the advent at this time of earlier versions of solution-focused brief therapies and narrative therapies, the transition into second order cybernetics and, a little later, the postmodern

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