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Action research in the light of integrative practice of marital and family therapists and some other research problems

Abstract

Marital and family therapists are likely to use multiple models or treatment approaches, combine several techniques, theories, or factors in their therapy to address the complexity of the therapeutic situation and abandon or modify "pure" theories and models. That makes research in marital and family therapy (MFT) even more complicated, especially when we talk about the applicability for practitioners. The practice of the majority of MFT practitioners is very individualized or idiographic, as are the clinical problems and circumstances. Action research method, which has been mainly overlooked in MFT research, is suggested to be able to help with some of the problems in MFT, although it has its own limitations and weaknesses. One of the possible ways of using repeating cycles of the four basic steps in action research (gathering information, reflecting, planning and acting) is described and briefly discussed.

Introduction

Increasing evidences support the efficacy of family-based psychotherapies for a variety of psychological disorders (for a review cf. Diamond et al, 1996; Pinsof and Wynne, 1995; Sprenkle, 2002). In certain areas (e.g., drug abuse, conduct disorder and delinquency, alcoholism, and family management of schizophrenia) the most high-quality, accretive, programmatic research has taken place, and family therapy research has clearly established the effectiveness of family therapy (for a review cf. Sprenkle, 2002). In the past few years, effectiveness research – which deals with the extent to which clients change over the course of therapy and generally uses randomized clinical (i.e., controlled) trials in which treatment subjects are randomly assigned to experimental and control groups under carefully monitored conditions – has also become an economic, professional, and ethical necessity in MFT.

There are also other important kinds of research on MFT in addition to effectiveness and efficacy research. One other important group of research in MFT could be described as process research. It investigates what occurs within a therapy session and strives to explain, how and why change occurs in the process of therapy (e.g. Pinsof and Wynne, 2000). Although effectiveness and efficacy research has been and still is necessary, successful and fruitful, this kind of research methodology may have obscured other important research methods that have not received much attention (Goldfried and Wolfe, 1996; Sprenkle, 2003). According to some researchers (e.g. Elliott et al, 2001; Johnson, 2003) certain major problems encountered today in research in MFT (and in therapy in general) are mainly the consequence of the predominance of this type of research over other types.

Problems in MFT research in the light of integrative and eclectic practice

The most frequently practiced and most rapidly growing types of treatment in general and in the field of MFT, integrative (techniques or theoretical tenets from diverse treatment approaches try to be linked by an overarching organizational or conceptual framework) and eclectic (the use of various therapeutic intervention models) therapy, are still poorly defined and inadequately researched. The strict therapeutic protocols and uses of therapy manuals that are necessary for comparing global therapeutic models and which are most frequently used in randomized clinical trials are not representative for the integrative or eclectic practice of therapy, which is according to some studies the most common for the majority of marital and family therapists (Lebow, 2003; Pinsof and Wynne, 2000). Maybe the lack of research in this area is also because of the nature of these types of treatments, where interventions are often very individualized according to specifics of the therapeutic situation. The diversity of possibilities for integrative and eclectic practice between marital and family therapists, makes the usefulness of different studies in MFT even more problematic.

Nonetheless, this movement (integration) in clinical practice may be the phenomenon that best defines psychotherapy's maturation process (Kopta et al, 1999) and MFT's maturation process (Johnson and Lebow, 2000). Today, only a

modest number of therapists (who are likely to be the followers of theorists who founded well-conceived approaches) believe one method or approach to therapy is sufficient to meet the needs of a wide range of individual, couple and family issues (Smith and Southern, 2005). In an attempt to offer effective psychotherapeutic services to couples and families, marital and family therapists are likely to use multiple models or treatment approaches, combine several techniques, theories, or factors in their therapy to address the complexity of family systems and abandon or modify “pure” theories and models (Pinsof and Wynne, 2000; Smith and Southern, 2005). Interventions are becoming more and more adopted to specific presenting problems and populations (Russell, 1998). There is a growing recognition in the family therapy field of the need to integrate different theoretical perspectives and practice models for effective practice (Greene and Bogo, 2002). Also each therapist put his or her mark on a personal practice approach, typically involving some form of integration (Smith and Southern, 2005). Often the umbrella term “integrative” or “eclectic” has been assigned to such an approach. The term “integrative” seems to be replacing the term “eclectic” when describing new approaches combining techniques, theories or factors of therapy (Smith and Southern, 2005). Eclecticism usually refers more to the use of diverse techniques without necessary approval of their theoretical orientation and integration refers more also to the theoretical combining, but the difference between these terms is not completely clear (Smith and Southern, 2005). Integration is often also considered to cover three major categories: theoretical integration, technical eclecticism and common factors (Prochaska and Norcross, 1999). The integration of MFT interventions across models has been called a “quiet revolution”, which have the potential to offer greater flexibility, an increased repertoire of interventions, higher treatment efficacy and greater acceptability among clients (Johnson and Lebow, 2000; Lebow, 1997). And the trend toward integration will probably continue (Smith and Southern, 2005).

Although poorly researched, integrative or eclectic marital therapies have clear empirical support in meta-analytic research (Shadish and Baldwin, 2003). When tailoring couple therapy to individual differences, a moderate level of integration or eclecticism affords the best outcome. It is also hypothesized (Snyder et al, 2003) that at some intermediate range of integration and eclecticism, treatment outcome is optimized by the therapist’s ability to draw on diverse interventions targeting unique attributes of clients’ individual or relationship functioning that lie outside the domain of any one system or school of therapy. A higher level of integration provides some protection against the weakening effects of high levels of eclecticism.

Maybe described discrepancy between types of treatments in the majority of MFT research (where »pure« therapies are usually studied) and types of treatments in practice is also one of the reason for so many times cited problem with the gap between research and practice, and appeals to bridge this gap in psychotherapy in general (e.g. Heppner et al, 1999; Kopta et al, 1999; Strupp, 2001) and in MFT (e.g. Johnson, 2003; Johnson and Lebow, 2000; Lebow, 1988; Liddle, 1991;
Pinsof and Wynne, 2000; Sprenkle, 2003). Studies have shown that research has almost no influence on the practice of the majority of marital and family therapists (e.g. Pinsof and Wynne, 2000). Many authors (e.g. Johnson, 2003; Pinsof and Wynne, 2000; Sprenkle, 2003) emphasize that studies however have shown that practicing therapists do seek and want research that focuses on the therapist's and/or client's behavior, leading to important moments of change during therapy. Another type of research, process research, tries to cover these questions (e.g. Johnson, 2003).

One of the major problems in MFT research is that every therapist and his practice is something very idiographic, especially in some sorts of therapy that are less structured and provide more space for aspects of the therapist (e.g. Gostečnik, 2002, 2004; Kompan-Erzar, 2003; Kompan-Erzar and Erzar, 2006). In some studies, the practice and outcome variance attributable to therapist differences has been greater than the variance attributed to treatment differences (e.g. Crits-Christoph et al, 1991; Crits-Christoph and Mintz, 1991). Thus, instead of studying certain general conceptual frameworks that should work for everybody, it is also desirable for MFT therapists to study their own practice and try to determine what is most effective for them. Every family, every marriage, every client, every relation, and every therapy is specific. The problem is also similar in other types of psychotherapies. Thus there is a problem with generalizing the results of certain type of studies, especially randomized clinical trials. This is why some emphasize transferability instead of generalizability (Barnes et al, 2005; Kendall and Southam-Gerow, 1995; Lincoln and Guba, 1985). Transferability refers to how much some results (e.g., what was successful in one therapy) can be transferred to another practical situation. The emphasis is not on common properties of participants (e.g., that all participants have depression), but on describing and specifying the circumstances and situations of a therapeutic case or moment. The reader can then transfer the results of research into his own therapeutic practice and consider differences between situations.

Process Research

Researchers have tried to solve some of the problems described above (especially the process of change during therapy and gap between research and practice) through process research. Important process research methodologies include for example significant event text strategies like task analysis (e.g. Bradley and Johnson, 2005), conversational analysis and perhaps grounded theory methodology (cf. Strauss and Corbin, 1990). The most frequently used process research methodology has studied the therapeutic process through coding systems, in which frequency counts of variables across sessions were correlated with other processes or outcomes (Diamond and Diamond, 2001). Although these kinds of process research are a step further in the desired direction, they generally had unsatisfying results, especially coding systems methodology (Elliott et al, 2001; Stiles, 1996) - researchers have failed to demonstrate any important kind of consistent relationship between in-therapy therapist behavior and patient behavior, or between both of these and patient outcome, except for finding a certain degree of a positive relationship between the therapeutic alliance (an interactive variable measured through patient self-reports) and outcome (Pinsof, 1997; Pinsof and Wynne, 2000).

Action research in MFT

Because of increasingly integrative or eclectic practice of majority of marital and family therapists, constantly adapting therapeutic interventions and stances to the individual characteristics of the course of treatment and other problems of research in MFT, described above, at our institute we have started to use action research (AR) methodology for studying MFT (e.g. Cvetek, 2004). In my opinion this research method has been mainly overlooked in the field of psychotherapy research and in the field of MFT, although there have often been appeals for reflexive praxis of therapists. AR has been used a lot in the education, social work, in the field of nursing, health-care etc.

In the time of writing this article we have found one description (Mendenhall and Doherty, 2005) of the use of AR specifically in the field of MFT, that has some differences from our approach, that will be described in the continuation.

The objective of AR as a research strategy is to reach an interaction between practice and theoretical research. It aims to solve current practical problems (taking actions) while expanding scientific knowledge (theory about that actions) (Styhre and Sundgren, 2005). Unlike other research methods, in which the researcher seeks to study phenomena but not to change them, the action researcher is concerned with creating change in the phenomena studied and simultaneously studying the process (Baburoglu and Ravn, 1992). This kind of research methodology is very suitable for integrative and eclectic practice of MFT; it is very individualized and contextually oriented; it is close to therapeutic practice; and it is characterized as being problem focused, involving change and aiming at improvement. It could be performed by therapist-practitioners themselves. In fact, AR cycles mirror practice already established in the therapeutic work, in which in general there are two phases of work – therapy and analysis of therapy and supervision (and so can be easily incorporated) – with the difference that AR can provide more rigorous, systematic, structured and valid research (and therapeutic) work.

"Action research is simply a form of self-reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their own practices, their understanding of these practices, and the situations in which the practices are carried out" (Carr and Kemmis, 1986, p. 162).

In AR researcher studies the family system through action. Kurt Lewin, the founder of AR, said that it is only possible to understand a social system by trying to change it (Carr and Kemmis, 1986). This is what therapists try to do.

Use off our steps of AR in MFT

According to Hyrkas (1997, p. 802) "the most characteristic feature of action research is considered to be the spiral-like progress with alternating phases and cycles that evolve over a period of time." Most action researchers agree that AR consists of repeating cycles of (1) observing and gathering information (also called analysis, fact-finding, evaluation, problem identification), (2) reflecting (conceptualization, diagnosis), (3) planning, and (4) acting or intervening (Cassell and Johnson, 2006; Dickens and Watkins, 1999; Hyrkas, 1997; Melrose, 2001).

Studying different possibilities of the four steps in AR for use in MFT research is still in progress and will probably remain so because organizing this kind of research allows a great deal of useful variations and innovations. For example, this four steps can be applied so that there is one cycle for one therapy session (in the therapy sessions, planned actions are carried out, information is gathered in the session or after it, and then reflection and planning is possible and new plans can be carried out in the next session), they can be used less frequently (e.g., when therapy gets

stuck), or perhaps even all four steps can be used in the session.

Currently the most promising form of AR that has proved the most useful in our research practice is the use of one cycle for one therapy session (described above). The cycle consists of:

1. Observing and gathering information

Therapist (or research team) describes and defines (usually after the therapy session) what has happened, what the current situation is (what the problem is), and what the context is. Therapist (or research team) can describe what is known about client system so far, what actions have already been carried out and what outcomes were achieved, and how and why these differed (if so) from what were expected. Data sources might include transcripts of therapy session, information from clients or those who know them, results of questionnaires, scales, observations, and any other information that the therapists (or research team) considers informative to provide evidence for the conclusions.

2. Reflecting

The situation and problem(s) are interpreted, analyzed, and explained. It is determined what theory would say about the problem and the therapists may form their own theories about the specifics of the case. The worth, effectiveness, appropriateness, and outcomes of activities already carried out are evaluated and the therapists define what has been learned about the therapy, relations, themselves, and so on from previous actions.

This step can also involve supervision, intervision, consultation with colleagues, focus groups, self-reflective notes and study of professional literature. It is strongly suggested to check interpretations, theories and tentative conclusions with others.

3. Planning

At this stage, on the basis of the information gathered and reflection, the therapist (or research team) identifies the need for change, the direction that that change might take and generate possible solutions to the identified problem (this involves some reflection too). The therapist (or researcher) defines the outcomes she/he hopes to achieve in the next therapy session and why she/he believes they are worth pursuing (the contributions she/he expects those outcomes to make to the long-term goals, or solutions, and why she/he expects them). The therapist describes the actions she/he is planning to take to achieve these outcomes, how these actions can be carried out, and why she/he thinks these actions will achieve desirable outcomes in the particular situation. One can define theoretical constructs or ideas that provide a foundation for the planned actions and solutions.

Planning could be sometimes considered not to be a completely separate step but rather embedded in action and reflection (Melrose, 2001).

4. Acting

In this stage, planned activities (usually in the therapy session) are carried out.

The therapist (or research team) continue with this cycle until they have solved the problem that they identified. Usually one cycle is not enough and several iterations are needed before the problem is correctly identified and fully addressed. The value of AR especially lies in repeating cycles of these four steps. In the subsequent cycles it is possible to also check accomplishments of this cycle and properly adopt subsequent actions.

Question of participation

AR covers a variety of approaches (May and Lathlean, 2001), a wide range of methodologies, grounded in different traditions (Reason and Bradbury, 2001) and emphasizing different elements of the AR process (Dickens and Watkins, 1999). As mentioned, the only found published description of the use of AR specifically in MFT (in the narrow meaning) is in Mendenhall and Doherty (2005), and even there the emphasis is on studying (local) communities (in a broader sense than families). There have been some calls for increased visibility and implementation of AR from organization like Collaborative Family Healthcare Association, Society for Teachers in Family Medicine, the Families and Democracy Project/Center for Citizen Health Care. But these (including Mendenhall and Doherty, 2005) who emphasize some features like “collaborative stance between researchers and participants” (in terms of therapeutic process understood as collaborative stance between therapist/researcher and clients) and “a local community focus”, as essential features of AR. Mendenhall in Doherty (2005) stress the collaborative partnership between researchers and research participants (“clients”) at very stage of AR in MFT. All involved members are seen as equal contributors to the AR process and are expected to participate as such. They also stress solving local (community) problems. Sometimes these kinds of research are also called Community-based Participatory Research.

Different ways of using principles of AR enrich the field of research and are welcomed. In the presented model of AR in this article the essential feature is the use of the spiral of four steps (figure 1), not the necessary inclusion of local community in AR or importance of democratic inclusion of research participants (clients) in all phases of AR. Probably in some studies the role of therapist as researcher (as opposed to therapist and clients (participants) as researchers) in AR is preferable, especially in some difficult cases. In some cases we should accepts and values different contributions and roles between therapist-researcher and clients, and a special relationship between them, that help them to gain from it.

Often another form of participation is applicable in AR in MFT. In the process of AR it is often useful to include an expert, professional researcher or theorist in the area of AR. Some authors even agree that AR must be implemented through the involvement of external researcher(s) (Cassell and Johnson, 2006). Researchers can initiate research, assist with an initial research plan, promote practitioner involvement, provide technical and material assistance, introduce theoretical perspectives, encourage reflection, pose critical questions etc. If we look at AR in MFT as a team work of practitioners as therapists and »researchers« or »theorists« to improve their practice and contribute to the knowledge about changes in psychotherapy, the collaboration in all stages of AR can be essential.

Characteristics of presented form of AR

This kind of AR may represent some solutions to problems faced by MFT research today and described in this article. In their conclusions to their study on barriers to researcher-clinician cooperation, Sandberg et al. (2002, p. 67) stated that: “in-depth case studies of mutually beneficial, collaborative relationships where clinically relevant and applicable research is the major outcome would be of great value." This kind of AR has probably even more advantages than case studies because of the use of the clear four steps. Based on transferability, it is useful for other practitioners because it is focused on the “next move” during treatment and on actions that bring important changes during therapy. This is what practicing marital and family therapists want and expect. It is also very individualized and personal, very adapted to individual problems, the client system, circumstances, the therapist, and so on.

Some problems and quality of AR

For many researchers AR is rigorous, yet sensitive research design, that shares a place alongside the experiment, the survey, ethnography etc. (May and Lathlean, 2001). On the other side AR is often seen as inappropriate for producing findings with high external validity – that is, findings that are valid outside the context of the AR (Berkowitz and Donnerstein, 1982).

Regarding the quality of AR the higher reliability and validity of the instruments and methods for data collection and analysis used in AR can be helpful. The use of multiple methods for data collection and confirmation of conclusion (data triangulation) can be used to ensure reliability and validity of the findings. Because of successive iterations in the AR cycle, disconfirmatory evidence in further iterations may help correct distortions in the findings of previous iterations. As stated previously, a problem with the generalization of findings in MFT research still remains, and one suggestion is the focus on transferability instead of generalizability. Although the findings may be individual, unique, and specific, they can be valid for the particular case and also useful in other practical situations.

Supervision, intervision, consultation with colleagues, self-reflective notes and study of professional literature can facilitate engagement in inquiry, reflection and theorizing about the case under study and play an important role in ensuring that AR is done rigorously and results are useful. The quality of those activities (for example reputation, credibility of supervisors or experiences of researchers) can also increase perceived rigour of AR.

One issue in this kind of research in MFT that has turned out to be problematic at the realization level is that sometimes it is hard to carry out planned activities. They may no longer be appropriate for a current situation. Families and marriages are systems that change, and between two therapeutic sessions many things can happen. Therapist-researchers must evaluate the current state and assess whether the planned actions are still appropriate. If not, they should not insist on the planned actions and should adopt or even abandon them. The latter case is likely very instructive for understanding the therapeutic situation and valuable for forming more effective reflection, planning of actions and their realization. Also the reflections step can not be accurate enough and it can be checked with clients in the therapy session. This leads to the one critical argument: how sensible is planning future therapeutic actions - therapists should consider current therapeutic situation and plan according to it. In part I agree, but the therapist should also know, at least in general, in which direction solutions for clients exist. This issue also opens the question of how possible and useful more concrete or global, or more short-term or long- term, planning is in different therapeutic

approaches. This should be answered in future studies of AR in MFT.

Conclusion

Johnson (2003) in describing new directions in couple therapy, stated that the field of marital therapy appears to be in the process of integrating description, prediction, and explanation. Theory, practice, and systematic investigation are beginning to create a coherent whole. Although AR has its own limitations and variations appears to be one step further in this direction.

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