The Evidence-Informed MFT

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The Evidence-Informed MFT Agenda

- Myth Busting: Theory vs. Evidence vs. Theory/Evidence
- New Paradigm: Evidence-Informed Clinician & Theory's New Role
- Defining Evidence
- Brief Tour of the Evidence Base for MFT Theories and Practice

The Big Picture

- Significant paradigm shift in mental health
- "Evidence-based" profession
- This requires greater mastery of theory AND research

Myth Busting

- Myth #1: In the age of evidence, we don’t need theories any more

Closer to the truth...

- Often more “pure” expressions of theory
- Many integrative (translation: you must master more theories)
- Careful training and emphasis on applied theory
- Thus, greater competence in more theories required

Significant paradigm shift in mental health!
"Evidence-based" profession!
This requires greater mastery of theory AND research!

Myth #1: In the age of evidence, we don’t need theories any more!
Myth #2: MFT Theory and Research are Distinct and Separable

Myth #3: Evidence-based treatment is rigid

Myth #4: I must give up “my theory” to practice evidence-based treatment

Closer to the Truth...

- MFT theories built on observational research
- Research grounded in theory
- Research/Theory: Two sides of the same coin
  - Theory develops from research (observation, clinical trials, etc.).
  - All sound research must be grounded in and tied to coherent theory
  - Research is used to refine and develop theory

- “Manualized” approaches provide specific direction
- But require
  - Flexibility
  - Adaptability
  - Clinical judgment
  - (and much of what you are already doing)

- Often use many elements of personal style and approach
- Many have flexible elements
  - Ex. Tracing interaction cycle in EFT
- Most are integrative approaches
- Most clinicians subjectively experience it as “adding” to what they already are doing
**Myth #5: Researchers agree on what constitutes evidence**

**Closer to the truth...**

- At least two camps:
  - Clinical trial advocates support manualized treatment
  - Common factors advocates focus on qualities of therapist and lack of applicability of existing manualized treatment for a large number of clients.

**Myth #6: CBT is the Only EBT**

**Closer to the truth...**

- Strong evidence for many theories, especially for general concerns such as depression and anxiety
- MFT systemic therapies developing respectable evidence base
  - E.g. Teen Conduct/Substance Abuse
- So, no, you are not confined to doing CBT to be “evidence-informed.”

**Myth #7: “Standard Practice”= Up to Date**

**Closer to the truth...**

- Treatment-as-usual is estimated to be 17-20 years behind the current evidence base
- “Evidence based movement” is in part motivated to to reduce this gap.
21st Century Mental Health Paradigm:

The Research-Informed Therapist

From 2 to 3 Dimensions

- Two Dimensions
  - Therapist-Client Relationship
  - Theory
- New Dimension
  - Research/evidence base
- Manage multiple dimensions

Theory/Research

- Theory: Provides roadmap
- Research: Provides driving tips and short cuts

Research-Informed Therapist of the 21st Century

- Competent in several theories
- Conversant with the evidence base and research
- Comfortable with measuring progress
  (Karam & Sprenkle, 2010)

Attitude

- Open: To ideas
- Flexible: Willing to try new things
- Humble: Willing to be wrong
- Collaborative: Partners with clients and other professionals
- Appreciative: Focuses on strengths of others

Defining Evidence: Terms to Know
Evidence-Based Practice
- More general term
- Use research to support practice
- Standard practice in medicine over past several decades
- Sufficient evidence base to be standard practice in mental health
- Literature review to develop treatment plans
- Presenting concerns and diagnosis
- Client demographics/diversity issues

Not to be confused with...
- Evidence-based practice
- Term used by SAMSHA to refer to evidence-based (or evidence-supported) treatments

Evidence-Based Treatments:
The Holy Grail of Research

Evidence-Based Treatments (EBTs)
- Evidence-Based Treatments
- Empirically supported treatments
- Empirically validated treatments
- Clinical trials
- Manualized and rigorously tested for specific population
- Research supported by the NIMH and SAMSHA
- Criteria set by APA

EST Criteria
- Empirically Supported Treatment
- Random assignment to treatment groups
- Treatment
- No-treatment control OR Alternative OR placebo treatment
- Treatment better than control/alternative
- Written manual
- Specific population targeted
- Reliable and valid measures to measure outcome

Efficacious Treatment
- Efficacious Treatment: Meet EST criteria PLUS
- Two independent investigations
- Efficacious and Specific: Meet above PLUS
- Better than alternative treatment in at least two studies
Who’s Paying?
National Institute of Mental Health (www.nimh.nih.gov)
Clinical trials
National Institute of Drug Abuse (www.nida.nih.gov)
Clinical trials
National Institute of Alcohol Abuse and Alcoholism (www.niaaa.nih.gov)
Clinical trials
Substance Abuse and Mental Health Administration (www.samhsa.gov)
Applied research
Information for consumers and practicing clinicians

NIMH Trends
Not funding psychopharmaceutical research in upcoming decade
Focus on manualized therapeutic interventions
Recovery-oriented therapy for severe mental illness

Lay of the Land
Evidence-based practice
A general attitude/approach.
General practice principles
Common factors research
Focuses on what makes therapy work across theories
Client-informed therapy
Focuses on what works for a particular client
Evidence-based treatments/practices
Focuses on what works for a specific population
Evidence Base for MFT Theories

A Brief Tour of the Evidence Base

Evidence-Based Practice
Using research to guide practice
Can take the form of:
- Using PsychInfo to research specific client disorder
- Attending workshops on latest practices
- Using SAMSHA toolkits
- Reading journals and books
- Generally keeping up with literature as it relates to your clients and their needs

Beutler’s Principles for Psychotherapists
- Larry Beutler
  Identified guiding principles for therapists
  Regardless of:
  - Theoretical orientation
  - Client population
  Surveyed research for evidence (Lebow, 2006)
Client Prognosis
- Less change with low levels of distress about having a problem.
- Clients with multiple or chronic problems do better when social support increased.
- Level and intensity of care
- Multiperson therapies (group or family) best for those with multiple problems.
- More frequent sessions for those more functionally impaired.

Change most likely when procedures do not evoke resistance.
- When therapist provides a trust, accepting, collaborative, and respectful relationship while allowing risk and providing safety.
- When clients deal directly with feelings and behaviors they try to avoid.
- If the initial focus of change is to build new skills and alter disruptive patterns.

Matching the intervention to the client:
- Externalizing symptoms: skill building and symptom removal
- Internalizing symptoms: insight and relationship-focused treatment
- Directive treatment: when resistance is low
- Non-directive treatment: when resistance is high
- Change most likely when client's emotional distress is moderate (not too high or too low)

Examined common elements across models that account for change (outcome variance)
- Two sets
  - Lambert's
  - Wampold's
- Both find that positive outcome attributed more to similarities than differences across models
- Theory-specific intervention has smaller impact

Lambert's Common Factors Model
- Client factors 40%
- Therapeutic relationship 30%
- Therapeutic model 15%
- Hope/placebo effect 15%
Wampold’s Common Factors

Therapeutic models

General factors

Unknown factors

Moderate Common Factors Approach

- Avoid the Dodo-bird verdict
- All have not won; not all should get prizes!
- Moderate approach (Sprenkle et al.)
- Theory is the vehicle for common factors
- Coherent and believable (placebo) treatment
- Research may not be sophisticated enough yet to separate out differences

MFT Common Factors

1. Conceptualizing difficulties in relational terms
2. Disrupting dysfunctional relational patterns
3. Expanding the direct treatment system
4. Expanding the therapeutic alliance
   (Sprenkle, Davis & Lebow, 2009)

Outcome-Informed Practice

Outcome (or Patient)-Informed Practice

Based on common factors model
- Using client feedback to inform daily practice
  - Outcome rating scale (ORS)
  - Session rating scale (SRS)
- Available free:
  - www.scottmiller.com
  - www.heartandsoulofchange.com
- Randomized clinical trials with couples (using ORS)
  - 4 x the rate of change
  - Better long-term outcomes

Outcome Rating Scale (ORS)

Rating 1: Least change, no effect
Rating 2: Some change, but not taking into account for the next step
Rating 3: Moderate change
Rating 4: Large change
Rating 5: Very large change
Sprenkle's Ranking of Methodological Strength

- Conduct disorder (12)
- Drug abuse (11)
- Psychoeducation for major mental illness (11)
- Couple distress (10)
- Alcoholism (9)
- Relationship education (6)
- Childhood and adolescent disorders (5)
- Chronic illness (4)
- Depression (3)
- Interpersonal violence (3)

Adolescent Conduct Disorders and Substance Use

- Best funded and studied
- Functional family therapy
- Multidimensional family therapy
- Multimodal family therapy
- Brief strategic family therapy

Better (modest) outcomes than treatment as usual or alternative treatment
Designed primarily for agency settings
FFT has book for individual practitioners

Principles of Conduct Disorder EBTs

- Principles
  - Systemic approach with family involvement
  - Address multiple systems: family, school, social
  - Reframe to reduce labeling and blame
  - Psychoeducation

Family Therapy for Teen and Adult Drug Abuse

Family-based treatment for teen and adult drug use are among the most powerful available interventions
For adolescents, it is the most effective.
For teens, family-based treatment
- Highest engagement
- Highest impact on drug and comorbid problems
Adult Substance Abuse

For adults, family-based treatment
- Helps engagement
- Reduces drug use and violence
- Improves family and parenting relationships
- Positively impacts children's development
- Often lower costs than individual treatment

E-B Treatments for Substance Abuse
- Multidimensional family therapy
- Cognitive behavioral therapy
- Multiple systems oriented therapy (MDST/MST)
- Brief motivational interviewing
- Functional family therapy

Alcoholism
- Most research on behavioral approaches
  - More with women in past decade
  - Few with GLBTQ and ethnic minorities
  - Not widely adopted
- Behavioral Couples Therapy
  - For male and female alcoholics
  - For alcoholics unwilling to seek treatment
  - Community Reinforcement and Family Training is more effective than traditional confrontational "intervention"

Family Psychoeducation for Severe Mental Illness
- Well-established evidence base for multi-family groups for schizophrenia (Macfarlane and colleagues)
- Multi-family group better outcomes than individual sessions
- SAMSHA Toolkit (http://www.samhsa.gov)
- More international studies in past decade

Psychoeducation for Families
- Highlights
  - Robust findings, such as reducing relapse, sense of stigma, functioning, etc., esp for schizophrenia
  - "Family Burden" and information on suicide potentiality
  - Effectiveness of early intervention
  - "Staggering" cost effectiveness implications
  - Paradox: Non-dissemination and non-accessibility

Marital Therapy
- Little federal support for research
- Because not in DSM, not recognized by NIMH
- Thus, although widely accepted by the population, not a government priority, although "cost" of divorce to society is substantial
**General Statistics for Marital Therapy**
- 70% of psychotherapists provide couples therapy.
- 70% of couples get better in E-B couples approaches.
- If not treated, couples generally do NOT get better, thus hardly a need for control group.
- Couples therapy significantly reduces divorce rate for distressed couples.
- Only couples models helpful for depression + marital distress.
- Extensive research in past 20 years on marriage: what works and what does not.

**E-B Marital Therapy Models**
- Evidence-based models.
- Emotionally focused couples therapy.
- Large effect sizes (1.3).
- Based on quickly expanding attachment evidence.
- Integrative behavioral couples therapy (revised version of behavioral marital therapy).
- Integrates acceptance and emotion.
- Insight-oriented couple therapy (promising approach).
- Note: Gottman is not evidence-based treatment: not outcome studies.

**Principles of E-B Marital Therapy**
- Dyadic conceptualization: Challenging individual pathology.
- Modifying emotionally driven maladaptive patterns: Replace with constructive ones.
- Eliciting avoided emotion-based private behaviors: Making behavior and internal world of other public.
- Fostering productive communication: Attending to problems in listening and speaking.
- Emphasizing strengths and positive behaviors.

**Relationship Education**
- 50 Studies evaluating 51 programs.
- Must have significant results (60% improve).
- Communication.
- Marital satisfaction.
- Divorce prevention.
- Given that these are non-distressed couples, seeing improvement is especially noteworthy.
- More research on diverse populations in past decade.

**Depression**
- 20% of adults report depressive symptoms in past 6 months.
- Major advancement:
  - Reciprocal and bidirectional connections between depression and marital distress: vicious cycle.
  - Similar patterns in parenting relationships.

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**Relationship Education**
- Prevention and Relationship Enhancement Program (PREP).
- Overarching goal: create safety at home.
- Communication and conflict management.
- Protect and present positive connections.
- Understand and modify transformative processes (e.g., commitment, forgiveness, and sacrifice).
Treating the Relationship-Depression Cycle
- 30% of new depression cases preceded by marital discord
- Poor outcomes without couples therapy
- Marital problems do not get better even if individual depression symptoms alleviated with medication and/or psychotherapy

More Depression Research
- SSRIs
  - Help 63%
- Psychotherapies (all theories)
  - Helps 80% with few side effects
- 10-30% are Chronic
- Don't respond to meds or therapy
- 85% relapse rate over 10-15 years

Interpersonal Violence
- New Understanding of Violence
  - Both sexes perpetrate
  - Most bilateral/reciprocal violence
  - 66% have alcohol involved; substance abuse 40-62%
- Difference types of interpersonal violence
  - Situational violence: most common; typically over particular issues
  - Intimate terrorism: individual treatment best
  - Violent resistance
  - Mutual violent control
  - Need different treatment for different types of violence

Current Treatment of Interpersonal Violence
- Historically/presently, pro-Feminist models dominant
- Separate couples
- Poor outcomes
  - 40% of "treated" batterers stop
  - 35% of untreated batterers stop
  - In some studies no difference

Conjoint Treatment of Interpersonal Violence
- Growing evidence base for conjoint treatment
  - "Situational violence" (not outside relationship)
  - Mild violence; no current violence
- Conjoint for situational violence
  - Better outcomes than individual
  - Men's anger less in multi-couple groups
  - More federal funding for this line of research

Childhood Disorders
- Internalizing disorders
  - Far less research than externalizing disorders
- Anxiety Disorders
  - Most developed family therapy research base: Family Cognitive-Behavioral Therapy
- ADHD and ODD: 3 evidence-based parenting programs
  - Parent-Child Interaction Therapy
  - Triple P: Positive Parenting Program
  - The Incredible Years
- Depression and Bipolar
  - Least research for family approaches
- Eating Disorders: Initial research on Maudsley family model
**Chronic Illness**
- Mostly psychoeducational programs.
- Preliminary results for traumatic brain injury, spinal cord injury, cancer.
- Inconclusive for stroke and cardiovascular disease.
- Family Therapy for diabetic children.
- Multisystemic therapy.
- Behavioral family therapy.

**Client Voices**
- Researchers attending more to client perspectives.
- Some key findings from qualitative research base.
- Non-judgmental.
- Fair and balanced.
- Creating intra-family alliance.
- Change both "viewing" and "doing" of problems.
- Ask for feedback throughout process.

**Anxiety Disorders**
- Strong CBT evidence base.
- Panic: exposure, self-talk.
- OCD: exposure, substitute behaviors, prevention.
- Specific phobias: exposure therapy.
- Generalized anxiety: relaxation training, self-monitoring, visualizations, cognitive examination of beliefs.

**What Does Not Work in Therapy?**
- **Group** treatment for adolescent conduct disorder and substance abuse.
- Increases antisocial behavior.
- **Rorschach**
  - Only seems to identify psychosis.
- **Critical incident stress debriefing**
  - Increases symptoms for many.

**Evidence-Base for Family Therapy Theories**

**Systemic and Structural Theories**
- **Solid Evidence Base**:
  - Conduct Disorder/Teen Substance Abuse.
  - ADHD Parent Training.
  - Adult Substance Abuse.
  - Major Mental Illness, esp. schizophrenia.
- **Structural Enactments**:
  - Eco-structural family therapy and related conduct disorder approaches.
  - Emotionally focused therapy.
- **Systemic Assessment & Reframing**:
  - EFT & IBCT.
  - Conduct Disorder treatments.
Experiential Family Therapies

- Emotionally Focused Therapy
- Focus on primary emotions
- Enactments
- Common Factors
- Therapeutic relationship
- Attachment Theory
- Need for safe emotional bonds
- Neurological research
- Emotional expression
- Journaling

Intergenerational and Psychodynamic

- Intergenerational/Bowen Theory of Differentiation
- Correlated to
  - Chronic anxiety
  - Marital satisfaction
  - Psychological distress
- Self of Therapist research
  - Quality of therapist's relationship with parents predicts quality of therapeutic alliance
- Psychodynamic
  - Brief psychodynamic theories: using insight to treat depression

Cognitive-Behavioral Therapies

- Integrative Behavioral Couples Therapy
- Parenting Programs
- Trauma-Focused CBT and PTSD
- Anxiety: general, panic, agoraphobia, phobias, OCD
- Depression and depression relapse
- Substance abuse
- See SAMSHA for more

Solution-Focused Therapy

- Growing evidence base of controlled outcome studies
- The same or slightly better than other approaches
- Specific areas of research
  - Children/adolescents with externalizing behaviors
  - Domestic violence
  - Schizophrenia
  - Child safety and protection
  - Troubled youth and runaways
  - School-based counseling
  - Alcohol
- Common factors research

Postmodern Therapies

- Open Dialogue (collaborative therapy) in Finland
- Psychosis
- Neurological and trauma research
  - Identity is “storied”
  - Trauma is lack of coherent narrative
- Multicultural/Diversity Research
  - Effects of dominant discourses and marginalization
- Qualitative research on client experiences/voices

Mindfulness

- Mindfulness-based therapies: 8 week groups
  - Mindfulness-based Stress Reduction
  - Mindfulness-Based Cognitive Therapy
  - Gold standard for depression relapse
  - Mindfulness-Based Relationship Enhancement
  - Mindfulness-Based Parenting
  - Mindfulness-Based Eating Awareness
  - Mindfulness-Based Relapse Prevention
Mindfulness-Informed Therapies
- Dialectic behavioral therapy
- Borderline personality
- Acceptance and Commitment Therapy: Contemporary behavioral analysis
- Depression
- Anxiety
- Couples

Mindfulness to Treat Physical Disorders
- Chronic pain
- Cancer: Psychological, biological, and sleep outcomes
- Cardiovascular disorders
- Epilepsy
- HIV/AIDS
- Psoriasis
- Rheumatoid arthritis
- Fibromyalgia
- Organ transplant
- Type II diabetes
- Multiple sclerosis
- Sleep disturbance
- Mixed medical diagnoses

Mindfulness to Treat Psychological Disorders
- Depressive disorders and relapse
- Bipolar disorder
- Anxiety disorders and panic
- Substance and alcohol abuse
- Eating disorders
- Borderline personality
- Attention deficit disorder
- Trauma and PTSD
- Sexual abuse
- Psychosis
- ADHD
- Couple enrichment
- Parenting
- Grief and loss

What excites you? What scares you?

Look Toward the Future
- New expectations
- Competence in theory and research base
- Greater resources to support us
- More precise
- More efficient
- Greater utilization of mental health
- General public perception as more valid
Evidence-Informed Clinician

Suggested Readings


Articles published in the *Journal of Marital and Family Therapy* January 2012 edition.


Piery, F. (2012). It is not enough to be busy. *Journal of Marital and Family Therapy, 38*, 1-2.


Online Resources

National Institute of Alcohol Abuse and Alcoholism
www.niaaa.nih.gov

National Institute of Drug Abuse
www.nida.nih.gov

National Institute of Mental Health
www.nimh.nih.gov

Outcome/Patient-Informed Therapy
www.scotdmiller.com
www.heartandsoulofchange.com

Substance Abuse and Mental Health Administration
www.samhsa.gov

SAMHSA Registry of Evidence-Based Programs and Practices
http://www.nrepp.samhsa.gov/

Trauma-Focused Cognitive Behavioral Therapy: Free Training Certificate Program
http://tfcbt.musc.edu/