Can a classification of family therapy be developed from expert consensus opinion?

Gary Edward Jen-Yu Lee

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ABSTRACT

Systematic reviews have shown that family therapy is effective for a range of disorders (Carr, 2009a,b). However, there are many forms of family therapy and it is unclear which specific forms work best for which conditions. One problem is that reviewers have used inconsistent definitions of the field to guide the selection and exclusion of studies from reports. Furthermore, there seems to be little agreement about how to classify family therapies for comparison, leading to difficulties in establishing a clear evidence-base. The current thesis aimed to address these problems by using a Delphi survey (Linstone & Turoff, 1975), to see whether a panel of senior family therapists could agree on a definition and classification of family therapy by consensus opinion. Twenty-seven international experts on family therapy were initially recruited to complete three, iterative rounds of Delphi questionnaires. The process resulted in a consensus profile of essential, unique and proscribed elements of family therapy. There was agreement that family therapy should incorporate a set of essential (systemic) theories, practices and aspects of therapists' training. However, there was little consensus over the specific types of practices that should be excluded and only a few unique elements of family therapy were agreed. Two classifications of the field were agreed as useful based on 1) mechanisms of change and 2) the focus of therapy (specific disorders versus relationships). Overall, results suggest that it is possible to employ consensus-building techniques to inform a contemporary definition and classification of family therapy. The use of consensus definitions may produce more informative reviews that contribute to the evidence-base. Future work would need to address how some of the broad concepts, identified by the experts panel, could be operationalised for this purpose.

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1. INTRODUCTION

Evidence-based practice requires the rigorous evaluation of treatment efficacy and effectiveness (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). With therapies where there have been multiple studies to assess effectiveness, it is common to employ a systematic review, a powerful tool that synthesises existing research to allow specific conclusions to be reached about the effectiveness of therapies with distinct populations or problems (Green, 2005).

The quality of a systematic review is dependent on multiple factors. However, one assumption is that treatments, populations and problems are well-defined, and grouped together in meaningful ways, so that clear conclusions can be reached about what works best under what conditions (Centre for Reviews and Dissemination, 2009). Many authors have attempted to review the effectiveness of family therapy for specific problems (e.g. Eisler, 2005; Fisher, Hetrick & Rushford, 2010). However, family therapy approaches have proliferated over the years, and the definition of 'family therapy' has evolved over time. To get around this, researchers have adopted two main approaches to reviews. First, they have embraced ever-expanding definitions and categories of family therapy, which have differed between reviews (see section 1.4.5). Alternatively, they have chosen to conduct very narrow reviews on the effectiveness of a particular type of family therapy in relation to certain problem (e.g., Functional family therapy for behavioural problems in people aged 11-18; Littell, Winsvold, Bjørndal, & Hammerstrøm, 2009). This second method ignores the fact that there are many commonalities between family therapy approaches (Stratton, 2010), which may be critical to effectiveness. Consequently, specific family therapies may be promoted, when a range of potentially useful family therapies exist, which share common factors.

Overall, these issues limit the quality of reviews and makes it difficult to draw conclusions for research and practice. It also means that potentially important differences in effectiveness between types of family therapy may be obscured. Researchers have highlighted two main ways to overcome these problems. For example, definitions can be collated from historical reviews, protocols and analysed qualitatively so that core elements of family therapy can be deduced and operationalized for use in future reviews. Another method to overcome the problem of arbitrary definition is to seek consensus opinion from experts in the field (Shepperd et al., 2009). This has the

advantage of tapping into up-to-date views about how family therapy should be defined. Furthermore, it would help elucidate what experts consider as potentially useful comparisons of the field. The current thesis aims to see if a consensus of opinion amongst experts can be established to identify the core components and divisions of family therapy in the 21st century to help inform future reviews of the literature.

1.1 The changing face of family therapy: a journey through the ages

Family therapy has evolved dramatically over the 60-year period since its initial conception. Within that time, the field has constantly shifted in both theory and practice. Today family therapy is practised in many forms, which makes it difficult to draw together an exhaustive list of interventions currently employed. This diversity was illustrated by Shadish et al. (1993), who attempted to distinguish family therapies according to their theoretical orientation. Although the authors managed to classify the 71 studies included in their meta-analyses into 22 different theoretical orientations, there were still 7 studies remaining, which eluded categorisation.

It is useful to trace the historical roots of family therapy to appreciate how and why the field has diversified. There are many writings about the history of family therapy (e.g, Dallos & Draper, 2010; Goldenberg & Goldenberg, 2011), inevitably, these accounts stress different aspects of that history (Rivett & Street, 2009). However, in a helpful introduction, Dallos and Draper (2010) outline three major eras of development for family therapy, beginning in the 1950s and summarised briefly below.

1.1.1 First phase (1950 to mid 1970s)

An early driver for family therapy came from a growing dissatisfaction during the 1950s with the main psychotherapeutic approaches of the time. In particular, they seemed to be less effective for more severe conditions, such as schizophrenia. Furthermore, these approaches were criticised for over-emphasising intrapsychic processes as an explanation for symptoms. Thus, therapists began to pay closer attention to the role of the wider social environment in mental health problems. Several ideas were highly influential at this time, including systems theory and the family life cycle.

Systems theory had gained currency across several disciplines, including biology, mathematics and sociology. A central premise was that systems favour stability and that this stability is maintained by underlying feedback mechanisms. For example, biologists had discovered that the homeostatic control of body temperature and blood sugar levels were achieved by complex feedback mechanisms between vital organs in the body. These ideas were quickly adapted by psychologists in thinking about families. In particular, psychologists began to consider the interactions between family members as forms of feedback within the family system.

From the notion of feedback mechanisms also arose the concept of circularities (Watzlawick, 1967). Bateson highlighted circularity in his studies of communication patterns in schizophrenia, where he observed that symptomatic behaviours of ill family members were often met with reactions from others that ultimately led to the initial behaviours being generated again. Such observations challenged the linear distinction between cause and effect. Furthermore, they led some therapists to view a person's symptoms as functional, in that they maintained the status quo in the overall functioning of families (Jackson, 1957).

Research into family life cycles gained popularity at around the same time as systems theory. It was observed that many families followed a typical pattern of development throughout their lifespan (Haley, 1993). For example, common changes include the roles of couples as they move through marriage, the rearing of children from birth to leaving home, through to later life retirement. Milton Erickson noted that the onset of many problems coincided with major transition points in the family life cycle (e.g., adult children leaving home or death of a partner) (Haley, 1993). This encouraged some family therapists to see problems as resulting from failed attempts of family members to maintain stability during these transitions (Haley, 1993).

The emphasis on systems theory, circularity and life cycles was germane to several schools of family therapy, including structural, strategic and brief solution-focussed therapies. At the heart of these approaches was the assumption that there were normative patterns of interaction and development in the family. Thus, therapists took a directive stance in helping to change dysfunctional patterns of communication and interaction (Dallos & Draper, 2010). For example, structural family therapists suggest that in order to negotiate life transitions smoothly, families need to have clear rules,

roles and boundaries of interaction between members. Therefore, a major goal of these therapies is on mapping out the way in which problematic families are organised and introducing change, where necessary, to attain a more 'healthy' structure.

1.1.2. Second phase (mid 1970s to mid 1980s)

Just as the popularity of these family therapy approaches grew, people started to question their theoretical bases. Systems theory was criticised for taking an overly mechanistic view of the family by focussing on interactions between family members (Dallos & Draper, 2010). Furthermore, therapists began to consider their own roles in therapy.

The introduction of second-order systems theory/cybernetics pushed family therapists to examine the nature of the system itself. Importantly, therapists began to see themselves as part of, rather than external to the system. This challenged the assumption that therapists could take an expert (or 'knowing') stance in relation to families' problems.

Therapists also began to adopt constructivist ideas, thinking about the family less in terms of interactional patterns and more in terms of meanings (Boston, 2000). Since constructivism denied the existence of an objective reality, family therapists saw individual family members as having their own subjective views of reality. Furthermore, these views were limited by the 'stories' that members held about themselves and the family. The 'stories' not only reflected each person's view of reality but also gave meaning to the experiences of the family. Thus, they were self-reinforcing (Goldenberg & Goldenberg, 2008).

The main implication for practice was that an expert position was untenable. So rather than providing answers, therapists saw themselves as joining with the family, where together they helped to re-author new stories around an initial problem that were less pathologising. These ideas became influential in the Milan school of family therapy, which emphasised the role of beliefs in shaping people's experience (Palazzoli, Boscolo, Cecchin, & Prata, 1974).

1.1.3. Third phase (mid 1980s to 2000s)

A third phase of development was characterised by a growing awareness of societal and cultural pressures, which both first and second-order systems theory appeared to underestimate. The constructivist viewpoint was not acceptable to some therapists because it assumed that family members had equal power in defining meanings (e.g., White & Epston, 1990). In addition, it led to moral dilemmas concerning serious societal problems, such as sexual abuse and poverty, which could not be reduced to matters of perspective.

Post-modern theories, such as social constructionism, became more influential at this stage because they recognised that some 'stories' that family members held were necessitated by social and cultural constraints. For example, dominant discourses about the role of mothers in childrearing, may colour the meanings that people hold about certain experiences, such as mothers wishing to pursue a career. In this way, it was essential that therapies moved from simply exploring new stories, towards considering how these stories fit within wider societal beliefs. These ideas led to newer approaches, such as narrative, postmodern and feminist therapies (e.g., Anderson & Goolishian, 1988; White & Epston, 1990). Within these approaches, therapists continue to adopt a collaborative stance and are encouraged to reflect on their own assumptions in conversing with families. To aid this process, some therapies have introduced reflecting teams as part of sessions.

Dallos and Draper (2010) also suggest that this third phase of family therapy is characterised by an increasing integration of ideas from across the historical roots of family therapy. These authors recognise that newer therapies do not represent a straight rejection of early ideas, but accept that they may be more or less useful for families to consider. In addition, it seems that contemporary therapies are paying more attention to the role of intrapsychic events, such as personal beliefs and emotions in shaping family life.

In summary, family therapy emerged from an early application of systems theory to the family environment. An initial emphasis was on patterns of communication and behaviour between family members, which led to the development of treatments centred around changing maladaptive interactions (e.g., structural and

strategic therapies). At this time, therapists assumed a position of expertise in relation to the problems that families encountered.

Later theories placed the therapist within the system he or she was trying to affect and also questioned the existence of an objective reality. Family systems were now seen as involving the exchange of meanings, rather than interactions. Thus, therapies moved towards an exploration of 'stories' that brought meaning to people's experiences. Therapists started to adopt a less directive and more collaborative role.

Post-modern ideas came into the field when it was recognised that earlier views tended to underplay the influence of society and culture on the stories that families could tell. Therapies that developed in this most recent period aim to illuminate some of the dominant discourses that operate in the lives of families. This last period has also seen the emergence of therapies that are more integrative and accepting of earlier theories.

Many different types of family therapy have arisen during each of these phases. Whilst few continue to be practised in their exact original forms, current therapies are more or less influenced by these key ideas through time (Dallos & Draper, 2010).

1.2 The changing definition of family therapy

In the early days, 'family therapy' was frequently contrasted with individual therapy as though it represented a unitary form of therapy (Levant, 1980). However, over the last 60 years, a myriad of approaches towards working with families have developed and been subsumed under the umbrella term 'family therapy'. This means that the definition of 'family therapy' has continuously changed and expanded.

The evidence for changing definitions is apparent within the literature. In 1967, Mottola drew attention to the inconsistent ways in which the term 'family therapy' was being applied and suggested that it was best reserved for therapies where multiple family members were seen together on a regular basis (Mottola, 1967). This definition formed the basis of several attempts to classify the field for research at the time (e.g., Ritterman, 1977; Levant, 1980; as reviewed in chapter 2). However, by the 1990s, it was clear that this definition had become far less applicable to therapies of the day. For

example, the *Dictionary of Family Psychology and Family Therapy*, published in 1993, stated that family therapy could describe any intervention that *"viewed the family as the unit of treatment and where more than one member of a family was seen either individually or conjointly during the course of therapy."* (Sauber, L'Abate, Weeks & Buchanan, 1993). This suggested a more liberal use of the term, governed less by the format of sessions. There is further evidence in the last 20 years that the term has broadened to include interventions, in which wider support networks are involved, and not just the family itself. (e.g., Asen, 2002; Carr, 2006).

Changing definitions can create significant confusion for newcomers to the field. To be able to make sense of the literature, one needs to appreciate that the meaning of 'family therapy' may be different now to what it was half a century ago. In fact, several contemporary authors have described the continued use of the term 'family therapy' as misleading because it fails to capture the variety of work that family therapists do (Asen, 2002; Josephson, 2008). Instead, Asen (2002) proposes the alternative label of 'systemic therapy' to reflect the fact that therapists often work with wider systems, outside of the family constellation. Meanwhile, Josephson (2008) takes a more radical stance by calling for the term 'family therapy' to be dropped altogether from training programmes, citing a trend within the literature for a move towards the more general title of 'family interventions.' (Josephson, 2008).

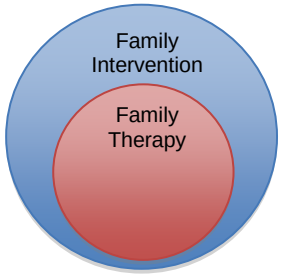
Few writers explicitly define 'family therapy' in their articles. When definitions are given, many feel inclined to explain the concept with disclaimers, such as family therapy 'in its broadest sense', family therapy 'in a strict sense', 'generic family therapy', 'traditional family therapy', or 'family systems therapy' (e.g., Campbell, 2003; Miermont, 1995; Carr, 2009a; Stratton, 2011). This is perhaps telling of the conceptual confusions that continue to surround the label.

It is also common to find family therapy mentioned alongside related terms, such as 'family-based interventions' or 'systemic therapy'. Even though the relationships between these terms are seldom explicated, they can often be inferred from the logic of the writing. Figure 1.1 captures some of these implicit relationships from the literature, which are briefly outlined here.

Figure 1.1 Visual representation of the term 'family therapy' as used in relation to similar concepts by different authors

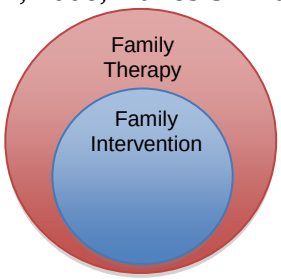
a. FT as subtype of FI

(Josephson, 2008; Campbell, 2003)



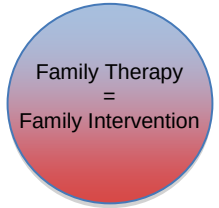
b. FI as subtype of FT

(e.g., Carr, 2006; Dallos & Draper, 2010)



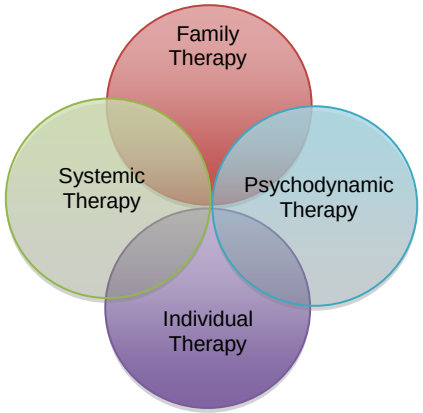
c. FT interchangeable with FI

(Stratton, 2011; Pilling et al., 2002)



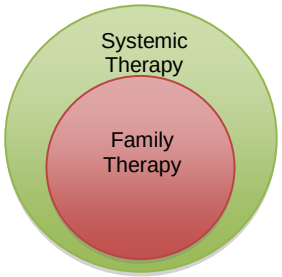
d. FT and ST as overlapping

(von Sydow et al., 2010)



e. FT as subtype of ST

(Asen, 2002; Dallos & Draper, 2010)



f. No FT, only different FTs

(Reimers & Street, 1993; Miermont, 1995)

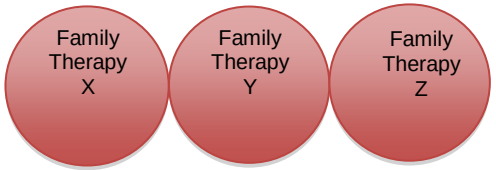


Figure 1.1a refers to articles that use 'family intervention' as a catchall term, subsuming all forms of family therapy (i.e. 'family therapy' is considered a subtype of 'family intervention.'). For example, in an article on family interventions for physical disabilities, Campbell (2003) stated an intention *"to review all family interventions……and not limit discussion to marriage and family therapy."* In this way, Campbell implied that family intervention could include treatments other than family therapy. This is made explicit in a later passage:

> *"In some studies, the authors may call their interventions one term (such as family therapy), but the intervention more closely resembles another category (such as family psychoeducation)."*
>
> (Campbell, 2003, p.267)

This conception of the relationship between the two terms is commonly found in literature of recent decades (e.g., Cottrell, 2003; Josephson, 2008; Kaslow, Broth, Smith & Collins, 2012; Shadish & Baldwin, 2003)

If figure1.1a conceptualises family therapy as a subtype of family intervention, then Figure 1.1b is essentially the reverse of this, where 'family therapy' is implied as the broader construct, and 'family intervention' as the narrower. Examples of this come from textbooks on 'family therapy.' Alan Carr's (2006) introduction to family therapy begins with the following definition: *"Family therapy is a broad term given to a range of methods for working with families with various biopsychosocial difficulties."* (Carr, 2006, p.3) Later, Carr goes on to list some of these methods, which includes 'family intervention' based on psychoeducational approaches.

Figure 1.1c refers to instances where it is unclear which one of 'family therapy' or family intervention is the broader term. Instead, the terms are used interchangeably at certain points in the text. For example, Stratton (2011) points towards an evidence-base suggesting that 'family therapy' is effective. He then goes on to state: *"family interventions are clearly efficacious compared to no treatment"* (p.9). Similarly, Pilling et al (2003) review family interventions for the treatment of schizophrenia. In their results section, they state: *"family therapy had clear preventative effects on relapse,"* leading them to summarise a few lines later: *"family intervention should be offered to people with schizophrenia…"* Is the reader to assume from these passages that family therapy is synonymous with family intervention?

Perhaps some of these paradoxical uses can be explained by von Sydow et al. (2010). These authors make a distinction between ‘family therapy’ and ‘systemic therapy’ and suggests that most reviewers confound the setting of therapy with the model of therapy. The paper implies that ‘family therapy’ refers to a setting in which therapy takes place, much like individual, couples or group therapy. On the other hand, ‘systemic therapy’ refers to a theoretical model, in the same way that cognitive-behavioural or psychodynamic approaches also describe models of therapy. This representation is illustrated in fig 1.1d.

However, the representation by von Sydow and colleagues is problematic for a number of reasons. In the first place, conceiving ‘family therapy’ as a setting, runs counter to descriptions from within the field that present it as *“more than a novel therapeutic technique, but as an entirely new approach for understanding human behavior.”* (Sauber, L’Abate, Weeks & Buchanan, 1993, p. 167). In this sense, ‘family therapy’ is clearly a setting *and* a model. Second, von Sydow et al. point out that some authors have a broader understanding of systemic therapy, which imply that all forms of family therapy are systemic (e.g., Asen, 2002) (see figure 1.1e).

Finally, some writers have suggested that the label ‘family therapy’ is inaccurate on the basis that there has never been one type of ‘family therapy’ (e.g., Reimers & Street, 1993). Instead, these writers refer to a collection of ‘family therapies’ (see figure 1.1f). In a similar way, Miermont’s *Dictionary of Family Therapy* only contains an entry for ‘family therapies’ and not the singular form of the phrase (Miermont, 1995).

In this section, I have drawn attention to some of the inconsistent ways that the term ‘family therapy’ has been defined and applied within the literature. For some, this may seem a matter of picking apart what may be trivial quirks of language. However, I am inclined to believe that language is constitutive, giving meaning to our experiences and shaping our understandings and attitude towards topics (e.g., Gergen, 1985), and from this perspective, it matters very much how we define terms. In the next section, I will argue that insufficient attention to the definition of ‘family therapy’ has had significant consequences for the development of the field. Specifically, I will highlight some of the controversies around family therapy outcome research that may relate to inconsistent definition. In doing so, I will make the case for a closer examination of how experts define and classify family therapy in the here and now.

1.3 Relationship between family therapy and research

Commentators often reflect on a long and turbulent relationship between family therapy and research (e.g., Cottrell, 2003; Piercy, Wetchler & Sprenkle, 1996; Stratton, 2007). During the first two decades, practicing family therapists grew increasingly disillusioned with research because they saw its methods as inadequate and incompatible with systemic ideas. For example, whilst systemic theory emphasised circular causality, most research designs sought to uncover linear patterns of cause and effect. Furthermore, the influence of post-modern thinking challenged the position that reality could be objectively measured at all. Instead, family therapists saw themselves as part of a complex system involving the family. So, the very act of observation was thought to perturb the system and alter the processes under scrutiny. Goldenberg and Goldenberg (2008) reflected on an early polarisation between family researchers and clinicians, describing them as coming from *"different realms, with distinct languages, observational procedures and philosophical orientations towards inquiry."* (Goldenberg & Goldenberg, 2008, p.346).

In some sense, family therapy had become a victim of its own success: the initial enthusiasm that accompanied its emergence resulted in a rush to try new ideas before old ones could be properly evaluated. By the late 1970s, the field had attracted considerable criticism by researchers from both inside and outside, who lamented that *"most family therapists have never submitted their methods to empirical testing, and indeed, seem oblivious to the need." Wells and Dezen (1978; p.266)*.

1.3.1. Evidence-based practice and Empirically Supported Treatments (EST)

Despite early unrest, attitudes towards research have changed substantially over the last 30 years with the dawn of evidence-based practice. In the UK, the National Institute for Health and Clinical Excellence (NICE) was set up in 1999 to provide best practice guidance for the National Health Service (NHS). The aim was to evaluate the efficacy and effectiveness of health technologies, so that NHS services could make informed decisions about which treatments to commission, based on sound research evidence. A similar movement in the USA had begun a few years earlier, when the American Psychological Association (APA) assembled a task force, specifically to help

identify Empirically Supported Treatments (ESTs), defined as *"clearly specified psychological treatments shown to be efficacious in controlled research with delineated populations"* (Chambless & Hollon, 1998).

These initiatives generated massive interest to embrace both efficacy and effectiveness studies across psychological therapies. Major goals in this research were 1) to establish whether treatments produced significant clinical improvements beyond those expected to occur naturally through the passage of time, and 2) to identify specific treatments that work best for specific problems.

The political implications of evidence-based practice seemed to provoke a sea change in attitude towards research from family therapists. A raft of outcome studies appeared during the 1980s and 1990s, which concluded that family therapy, when broadly defined, was efficacious for a range of psychiatric complaints (see Shadish & Baldwin, 2003 for a review). The enthusiasm for research seems to have carried through to the present day, and it is now common to find new studies published each month in major journals of family therapy.

1.3.2. NICE guidelines and family therapy

A measure of the success of family therapy research is the variety of family-based interventions that feature within current NICE guidelines. The Association for Family Therapy (AFT) summarised NICE guidelines into three kinds: the first described guidelines that promote specific family therapies for specific disorders (see table 1.1). A second set of guidelines (see table 1.2) *"recommends the inclusion of family members in treatment, without specifying a form of family therapy"* (AFT, 2009). The last category refers to guidelines, which only mention family members or relationships as being relevant, without any recommendation of family therapy: only two conditions fall into this category, Generalised Anxiety Disorder (GAD) and adult Autistic Spectrum Disorder (ASD).

Table 1.1 NICE clinical guidelines that specify family therapy as treatment (adapted from AFT, 2009, p.5)

Conditions	**Terms used in recommendations for specific types of family therapy / intervention.**
Alcohol dependence & harmful alcohol use	Children & Young People • Brief Strategic Family Therapy • Functional Family Therapy • Multisystemic Therapy • Multidimensional Family Therapy Adults • Behavioural Couples Therapy /couples therapy
Antisocial behaviour disorder	Children & Young People • Brief Strategic Family therapy (BSFT) • Functional Family Therapy (FFT) • Multisystemic therapy (MST) • Multidimensional treatment for foster care (MTFC)
Bipolar Disorder	• Structured formal family interventions
Depression	Children & Young People • Shorter-term family therapy (Systemic Behavioural Family Therapy) Systemic family therapy Adults • Couple Therapy (normally CBT)
Depression in chronic health problems	• Couple-focused therapies • Family intervention (systemic, cognitive behavioural or psychoanalytic principles)
Drug misuse	• Behavioural Couples Therapy • Behavioural Family Interventions • Social-Systems interventions
Eating Disorders	• Family Interventions • Eating Disorder focused Family therapy • Combined individual and family work
PTSD	• Family Therapy
Schizophrenia	• Family Intervention • Single Family Intervention • Multigroup Family Intervention
Diabetes Type 1	• Family Systems therapy • Behavioural Family Systems Therapy /+ Group

Table 1.2 NICE guidelines that recommend the inclusion of family members in treatment without specifying the form of family therapy (reproduced from AFT, 2009, p.17)

Mental health topics	Treatments reviewed / mentioned in Full Guideline
ADHD	• Structural FT; Strategic FT; Brief solution focused therapy
Borderline Personality Disorder	• Full: Home treatment teams
Dementia	• Family therapy
Drug Misuse – Opioid Detoxification	• Family intervention • Social network interventions
OCD	• Marital / couple therapy • Family-based behaviour therapy
Pregnancy and complex Social Factors	• family therapy
Self Harm	• Home-based family therapy/interventions

Despite the wide range of disorders for which family-based treatments are recommended, only recently, the Department of Health, UK, concluded that there are *"substantial gaps in the knowledge base in the efficacy and effectiveness of family therapy"* (DOH, 2004, p.28). Moreover, it has taken concerted lobbying from the AFT to persuade NICE to include family therapy for a number of conditions (Stratton, 2007). Why should this be the case?

Perhaps one reason is confusion over definitions of family therapy. A simple count of items in table 1.1, reveals more than 15 terms that have been used to describe family therapy within NICE guidelines. Whilst this may reflect the considerable heterogeneity of approaches, it is also unclear whether or not some of these terms have been used interchangeably. If so, it is possible that the visibility of family therapy may be obscured. The multitude of headings also makes it difficult to appreciate what family therapy approaches may have in common with each other and how they may differ in terms of effectiveness, without taking a closer look at the underlying literature.

Furthermore, in describing the guidelines in table 1.2, the AFT document suggested that NICE made *"recommendations for including families or partners in treatments [or care] without using terms like 'family therapy'"* (AFT, 2009, p. 17). This raises the question of whether some authors are failing to identify their interventions as

a type of family therapy and, perhaps more importantly, what are the boundaries that determine whether or not an intervention can be considered a family therapy?

1.3.3. Levels of evidence

Another reason why family therapy research may have struggled to make its mark is the reliance on particular types of study to inform the evidence-base (Larner, 2004). A consequence of moving towards an evidence-based delivery of psychological therapies is that some types of research have become valued above others. NICE adopts a hierarchy of evidence published by the Scottish Intercollegiate Guidelines Network (SIGN) (see table 1.3). At the top of this list is the randomised controlled trial (RCT), which is generally held as the 'gold standard' for assessing efficacy. However, the highest level of evidence also includes systematic reviews and meta-analyses. Since therapies are more likely to become recommended treatments if they are supported by strong evidence, there has been a reliance on both RCTs and systematic reviews to inform guidelines. As we shall see, however, systematic reviews on family therapy have frequently suffered from problems of inconsistent definition, which limits their contribution to the evidence-base.

Table 1.3 Levels of evidence for research studies (reproduced from SIGN, 2002)

Level of Evidence	Type
1++	• High-quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias
1+	• Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
1-	• Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias
2++	• High-quality systematic reviews of case–control or cohort studies. • High-quality case–control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relationship is causal
2+	• Well-conducted case–control or cohort studies with a low risk of confounding, bias or chance and a moderate probability that the relationship is causal
2-	• Case–control or cohort studies with a high risk of confounding, bias, or chance and a significant risk that the relationship is not causal*
3	• Non-analytic studies (for example, case reports, case series)
4	• Expert opinion, formal consensus

*Studies with a level of evidence '-' should not be used as a basis for making a recommendation

1.4 Systematic reviews

Systematic reviews have been described as a *"scientific tool used to appraise, summarise, and communicate the results and implications of otherwise unmanageable quantities of research"* (Green, 2005, p.270). The tool is particularly useful for synthesising areas of research where there are multiple primary studies, some of which may have generated conflicting results. To this end, systematic reviews can also include a statistical technique, known as meta-analysis. However, meta-analyses are only used in cases where it is meaningful to combine results across several studies.

Unlike other reviews, which refer to any attempt to draw together results, a systematic review aims to comprehensively identify all literature on a given topic (Sackett, Rosenberg, Gray, Haynes & Richardson, 1996). Healthcare providers and policymakers often rely on systematic reviews to inform practice guidelines as they provide an efficient way of making sense of heavily researched areas and give an indication of the "state of the art" (Schlosser, 2007). In addition, systematic reviews overcome some of the biases that can affect smaller trials, where results are susceptible to chance variation of effect sizes. Finally, they can address the lack of generalisability associated with studies conducted on narrow populations by including the results of other studies, which may have recruited from wider populations.

1.4.1. Systematic reviews demonstrating the overall effectiveness of family therapy

There have been several attempts to document the overall effectiveness of family therapy (e.g, Hazelrigg, Cooper & Borduin, 1987; Markus, Lange & Pettigrew, 1990; Shadish et al. 1993). An early report by Shadish et al. (1993) represents one of the largest meta-analysis of family therapy to date. These authors only included trials with random assignment and subjects with clinically significant levels of distress. A total of 71 studies were identified between the years of 1963-1988, which were deemed suitable for analysis. After combining the results of a range of marital and family therapies targeting an equally diverse set of problems, the authors concluded that family therapy, when broadly defined, is clearly effective compared to non-treatment control groups (d=0.5). This central finding has been corroborated by more recent reviews of the literature. In a notable paper by Shadish & Baldwin (2003), the authors examined 20

meta-analyses of family therapy and found a mean effect size of *d*=0.65, when compared to non-treatment controls. Furthermore, the benefits of family therapy also seem to persist: at 6 or 12 months after treatment ended, the mean effect size was only slightly reduced, *d*=0.52.

1.4.2. Relative efficacy/effectiveness as evidenced in systematic reviews

Relative efficacy/effectiveness describes how treatments compare with each other. In the two reports described above, the authors examined the effect sizes of different forms of family therapy (versus no treatment). They found no evidence that any one form of family therapy was superior to another, apart from a trend for behavioural family therapies to have slightly larger effect sizes, which was non significant (Shadish et al., 1993; Shadish & Baldwin, 2003). They concluded that family therapies appear to be equally effective. However, they also acknowledged that this conclusion is tempered by the fact that there were only very few studies, which *directly* compared two family therapies against each other (Shadish et al., 1993).

Stratton (2010) suggests that the uniform effectiveness observed between family therapies is a result of treatments sharing much common ground with each other. But, it may be the case that evidence of relative effectiveness is yet to be uncovered. It is worthwhile to note that in his original report, Shadish was drawing on family therapy trials from within the first and second phases of the field's development. Furthermore, in performing their comparisons, the authors were using definitions of family therapy that are now almost thirty years old. Thus, the question of whether family therapies differ from each other in terms of effectiveness remains to be addressed.

1.4.3. Effectiveness for specific conditions

Whilst early reviews point towards the overall effectiveness of family therapy, they are of limited use for clinical practice. The combination of a huge variety of interventions and conditions into one analysis makes it difficult to comment on the format and content of therapy that might suit a particular presenting problem. More

recently, there has been a call for further evidence-based statements that would inform the question of what types of family therapy work best for whom. To this end, Carr provided a summary of all specific disorders for which systematic reviews, meta-analyses and RCTs of family therapy were available. The two companion reports were effectively narrative reviews of systematic reviews (Carr 2009a; 2009b). In these reports Carr concluded that there was sufficient evidence to support the effectiveness of family therapies for a wide range of conditions, including:

For children and adolescents:

- Attention Deficit and Hyperactivity Disorder
- Affective disorders
- Attachment problems
- Child Abuse
- Conduct disorders
- Delinqency
- Drug abuse
- Eating disorders
- Somatic problems

(Carr, 2009a)

And, for adults:

- Relationship Distress
- Domestic Violence
- Psychosexual problems
- Anxiety disorders
- Affective disorders
- Alcohol abuse
- Schizophrenia
- Adjustment to chronic physical illness

(Carr, 2009b)

This list parallels the one produced by AFT in tables 1.1 and 1.2. But, for each of these conditions, Carr also made recommendations for the mode(s) of family therapy indicated by the research. Some of these recommendations related only to the duration of intervention, whilst others alluded to the content of sessions. For instance, in the treatment of anorexia and bulimia for young people, Carr suggested that systemic interventions should *"span between six and twelve months, with the first ten sessions occurring weekly and later sessions occurring fortnightly, and then monthly."* (Carr, 2009a, p. 26). For anxiety disorders, "*family therapy of up to fifteen sessions should be offered, which allows children to enter into anxiety-provoking situations in a planned*

way and to manage these through the use of coping skills and parental support" (Carr, 2009a, p.20).

1.4.4. Limitations with reviews

Carr's summaries can give the impression that abundant, high-quality research on family therapy is available for most disorders. However, his synthesis of the research pays no attention to the quality of the systematic reviews cited. Despite the many benefits of systematic reviews, they are just as susceptible to methodological flaws as the primary studies under consideration. Key areas that contribute to the quality of systematic reviews include having well-defined questions, protocols, scope, sources, selection principles and data extraction methods (Schlosser, 2007). In addition, the challenges for ensuring that these quality criteria are met increase considerably with complex interventions, such as psychological therapies, because of the high number of variables that affect treatment delivery (Sheppard et al., 2009).

A crucial element that limits the quality of systematic reviews for complex interventions is the definition of the interventions themselves (Sheppard et al., 2009). This is especially relevant to the field of family therapy, where agreeing a definition of 'family therapy' has been described as *"one of the primary challenges to any survey of the family therapy literature."* (The Werry Centre, 2009). One reason may relate to the rapid proliferation of the field, which has blurred the boundaries of family therapy, as I have argued in chapter 1. An indication of the scale of the problem can be gleaned from systematic reviews available from the Cochrane Collaboration with the terms 'family therapy' or 'family intervention' in their titles, which target specific disorders.

1.4.5. Cochrane systematic reviews of family therapy

The Cochrane Collaboration is an international body, which has developed a rigorous protocol for conducting reviews, according to accepted standards (Scholten, Clarke & Hetherington, 2005). One of the stipulations of this protocol is a need to clearly specify the interventions under review, including the types of inclusion and exclusion criteria used when filtering the research literature. The criteria put forward by Cochrane reviews of family therapy and family interventions are presented in table 1.4.

Whilst each of the Cochrane reviews meet the stringent internal standards for publication, a comparison of inclusion criteria *across* reviews reveals significant discrepancies in how authors defined 'family therapy.' For example, Henken et al. (2009) seem to assume that the definition of family therapy is reflected in the labelling of interventions, which as discussed earlier, is insufficient for locating studies that do not identify themselves as family therapy, yet still fall within a modern understanding of the term. On the other hand, Gardner et al (2009) restrict the definition of family therapy to structural, systemic, strategic, Milan and post-Milan, functional FT, or interventions based on combination of above. This latter definition fails to capture a whole host of other well-established family therapies, such as psychodynamic, experiential or transgenerational FT.

In fact, in all of the reviews available from the Cochrane database, the authors adopted their own definitions of family therapy, which were informed by different aspects of theory and practice. This was also true for the categories of family therapy, which were used to assess relative efficacy between approaches. This can be clearly seen from table 1.5, which presents the inclusion and exclusion criteria from the reviews above, according to whether or not specific features of definition were used. For example, the table shows that Bjornstad and Montgomery (2010) only included studies based on specific family therapy approaches, whereas Fisher, Hetrick and Rushford (2010) did not stipulate any specific form of family therapy for their review. Similarly, it can be seen that Henken et al. (2009) excluded studies, which did not feature other family members in the majority of sessions, whilst Yorke and Shuldham (2009) did not have any exclusion criteria based on who participated in the therapy.

The frequent inconsistencies in the way that therapies are defined and compared in reviews means that they liable to criticism regarding their level of comprehensiveness, as some may omit valued family therapy approaches, whilst others may be overly inclusive of approaches that the rest of the field would not recognise as forms of family therapy. In addition, potentially large differences in efficacy of therapies may be obscured, thus limiting the usefulness of findings for clinicians.

Table 1.4 Definition and categorisation of 'family therapy' within Cochrane systematic reviews

Paper	Identified Problem	Inclusion Criteria	Exclusion Criteria	Categorisation/Comparison
Fisher, Hetrick & Rushford (2010)	FT for Anorexia Nervosa	Any intervention involving the family and labelled 'FT'. Interventions either delivered in isolation or in conjunction with other interventions	None specified	1. Structural FT 2. Systems FT 3. Strategic FT 4. Family-based therapy and variants, plus behavioural family systems therapy 5. Other
Bjornstad & Montgomery (2010)	FT for ADHD	'FT interventions including functional FT, cognitive-behavioural FT, behavioural FT' At least one parent/teacher participating with child and therapist during some of the therapy sessions.	Parent-training interventions (due to overlap with another review)	1. FTs that included teacher involvement 2. FTs without teacher involvement
Henken et al (2009)	FT for Depression	*"Different types of FT"* The term "FT" used interchangeably with "FI" The family intervention consists of: assessment, psychoeducation, improving functioning in multiple areas (cognitive, affective, interpersonal and adaptive behaviour) by cognitive, behavioural and/or systemic approaches and feedback, and closure. Intervention must be delivered by at least one experienced clinician or trained therapist. Majority of the sessions attended by the identified patient and (all or part of) the family members or primary caregivers. >6 sessions of therapy, with a length >1 hour.	Multiple family group interventions	1. Behavioural (including psychoeducation) 2. Psychodynamic (including object relations) 3. Systemic (including structural, post-Milan)

Yorke & Shuldham (2009)	FT for Asthma	FT based on systemic theories "which focus on the whole family and which aim to arrive at an understanding of the role of the symptoms of asthma within this system, in an attempt to understand dysfunctional family interaction and precipitate change." FT delivered by trained family therapists only	Interventions delivered by those other than trained family therapists	Did not compare FTs against each other
Gardner et al. (2009) (Protocol only)	FT for physical abuse in children	FT defined as structural FT, systemic FT, strategic FT, Milan and post-Milan FT, functional FT, or interventions based on combination of above. Includes the child and at least one other family member in sessions. Parent training which combines with FT models above, only if >50% of session content is FT	Parent training programmes using social learning theory or cognitive behavioural therapy (CBT) because these were reviewed elsewhere	None specified
Keogh et al. (2009) (Protocol only)	Family Intervention for Diabetes	"Family Therapy Interventions" defined as any intervention involving >1 other family member	Interventions delivered only to the identified patient. Interventions delivered only to the family members, without measuring outcome for identified patient.	None specified
Justo et al (2009)	FI for Bipolar Disorder	The term "FT" used interchangeably with "FI" *"Family psychoeducation methods, cognitive-behavioural FT, cognitive FT, behavioural FT, interpersonal FT,*	None specified	1. Cognitive Behavioural Family Therapy (CBFT) 2. Psychodynamic therapy 3. Systemic therapy (including structural and post-Milan)

		psychodynamic FT, systemic FT, a mixed modality between types (e.g. an intervention mixing psychoeducational and cognitive-behavioural techniques).” Couples therapy Family group therapy		
Pharoah et al (2010)	FI for Schizophrenia	The term “FT” used interchangeably with “FI” Any psychosocial intervention with relatives, requiring more than five sessions.	None specified	1. Behavioural FT vs. Supportive FT 2. Group FT vs. Single family FT
Woolfenden, Williams & Peat (2009)	FI for Alcohol and Substance use	Subset of FIs considered to be FT *“FT which may target the entire family, where the aim is to restructure family relationships so that the parents and child’s needs can be met in more constructive ways.”*	No specific exclusion criteria in relation to FT	None specified

Abbreviations; FI = Family Intervention, FT = Family Therapy

Table 1.5 Features stipulated within inclusion, exclusion and classification criteria of Cochrane reviews on family therapy

Paper	Identified Problem	Inclusion criteria				Exclusion Criteria				Classification for comparisons		
		Specific types of FT	Format of therapy	Participants in therapy	Therapist training	Specific types of FT	Format of therapy	Participants in therapy	Therapist training	Based on Theory	Based on Practice	Other
Fisher, Hetrick & Rushford (2010)	FT for Anorexia Nervosa		✔									✔
Bjornstad & Montgomery (2010)	FT for ADHD	✔		✔		✔					✔	
Henken et al (2009)	FT for Depression		✔	✔	✔		✔			✔		
Yorke & Shuldham (2009)	FT for Asthma		✔		✔				✔			
Gardner et al. (2009) (Protocol only)	FT for physical abuse in children	✔	✔	✔		✔						
Keogh et al. (2009) (Protocol only)	Family Intervention for Diabetes			✔				✔				
Justo et al (2009)	FI for Bipolar Disorder	✔								✔		
Pharoah et al (2010)	FI for Schizophrenia		✔	✔								✔
Woolfenden, Williams & Peat (2009)	FI for Alcohol and Substance use	✔										

1.4.6. Potential solutions to inconsistent definitions in systematic reviews

Sheppard et al. (2009) have proposed two potential methods to overcome difficulties in defining complex interventions for systematic reviews. The first is to gain supplementary evidence from protocols, policy documents and supporting qualitative studies connected with the RCTs being considered for review. An analysis of these documents would allow core aspects, or themes to emerge to inform a classification of interventions. However, this approach is potentially unwieldy if applied to family therapy studies due to the high number of different family therapies that are currently practiced. The second method proposed by Sheppard and colleagues is to form a definition and classification of interventions by consensus opinion of experts. This would allow interventions to be grouped by common elements agreed and deemed acceptable to the field of study. It is this second option that I will turn to in chapters 2 and 3.

1.5 Summary

In summary, there was a time when family therapists were heavily sceptical about the value of research. This led to a proliferation of approaches with an insufficient empirical basis. However, the move towards evidence-based practice in the 1980s and 1990s, which had political and financial consequences, meant that family therapists had little choice but to address the evidence in support of their practice. Since then, family therapy research has grown exponentially and therapies have come to feature within UK best practice guidelines in various guises. However, it is not easy to appreciate the differences or similarities between interventions by brief inspection. In addition, some guidelines fail to acknowledge interventions that might fall under the bracket of family therapy. As a result, the empirical basis for family therapy is still perceived to lag behind that of other therapies.

Perhaps a contributing factor is the reliance on RCTs and systematic reviews to inform the evidence-base. Although there are many systematic reviews on family therapy, the quality of reviews is suspect. In particular, researchers have used different definitions of family therapy to inform the selection of primary studies for reviews. This is starkly illustrated by comparing the inclusion and exclusion criteria used by Cochrane

reviews. Inconsistent definitions may obscure important differences in effectiveness between approaches and also lead to rejection from family therapists, who do not agree with definitions used.

A potential solution to help augment the quality of systematic reviews is to develop a definition and classification of family therapy by expert consensus. But, before I outline a method for how this might be achieved, the next chapter reviews early attempts to classify the field and evaluates their suitability for use in contemporary systematic reviews.

2. THE CLASSIFICATION OF FAMILY THERAPY

The classification of family therapies is not a novel initiative. In fact, family therapists saw the need to classify therapies for research and dissemination as far back as the 1960s. However, as the field proliferated during subsequent decades, classification schemes became quickly out-dated, with newer schemes replacing older ones before they could be operationalised for research. By the late 1980s, it seemed that researchers had abandoned classification altogether. Despite this, contemporary textbooks and training programmes continue to adopt their own ways of categorising family therapies for teaching purposes. In the following section, I will review early attempts to classify the field and highlight some of the limitations associated with these. I will then outline the main categories of family therapy that can be found in current texts.

2.1 Jay Haley (1962)

Perhaps the first attempt to classify family therapy coincided with the launch of the journal, *Family Process* in 1962, when Jay Haley, then editor, presented several caricatures of the field. Although these caricatures were intended to be a satirical way of describing family therapy, they nevertheless captured some essential divisions that were already apparent at the time.

Haley (1962) identified three schools of family therapy that dealt with moderately disturbed children. The first was *a Dignified School*, which was associated with the work of J. E. Bell on family group therapy (Levant, 1980). Haley described the dignified therapist as one who took a neutral stance towards family members at all times. A second division was *a Dynamic Psychodynamic School of Family Diagnosis*, in which the therapist was allied with different family members during different stages of therapy. Levant (1980) suggested that this school reflected the approach of Ackerman and colleagues. A further type of family therapy was named a *Chuck It and Run School,* where the family were left to deal with unfolding conflicts themselves, whilst therapists observed from the safety of another room, thus reflecting the work of strategic approaches.

Haley (1962) alluded to several other schools that concerned families coping with a child with schizophrenia. In the *Stonewall School*, families were badgered to health by their therapist, who exploited the family's paradoxical communication

patterns in an underhand way. This category captured early work by D. Jackson and colleagues. In contrast, the therapist from a *Great Mother School* took a universally benevolent stance, in an attempt to create a harmonious atmosphere within the family home. A final category was termed the *Multiplication Schools*, characterised by two or more therapists working with families during sessions. Levant (1980) later associated these schools with the approaches of R.D. Laing in England and A. Friedman, R. MacGregor and M. Bowen in America.

Haley did not intend for his humorous portrayal of the field to be used as a basis for evaluating family therapy at the time. However, it alerted authors to the need to bring some order to field to streamline research efforts (Levant, 1980). What followed were several formal efforts to classify family therapies, based on their underlying theory.

2.2 Early classification based on the theoretical underpinnings of family therapy

In 1965, the Group for the Advancement of Psychiatry (GAP, 1970) commissioned a survey suggesting that family therapies could be grouped into three broad theoretical orientations, *Positions A, Z* and *M*.

Position A described psychodynamic approaches that were mainly focussed on individuals, but would include family-based sessions as one way of working. This position conceptualised families as potential sources of stress that impacted on individual psychopathology. In terms of practice, *Position A* therapists emphasised taking a thorough history, diagnosing the problem, developing insight and expressing difficult emotions in the family setting.

Unlike *Position A*, therapists working from *Position Z* adopted a family-systems framework, where problems were considered to reside within relationships, rather than within individuals. From *Position Z*, the difficulties associated with an individual were thought to reflect dysfunction within the family. Thus, therapists would attend to current patterns of interaction within the family, rather than emphasising history or diagnosis. Furthermore, the expression of unpleasant emotion was seen as secondary to the task of resolving underlying relationship problems.

Position M family therapies were described as occupying the middle ground between *Position A* and *Position Z.* So, therapists working from this perspective would tend to use ideas from both psychodynamic and systemic models.

The GAP report concluded that Positions A and Z reflected an ideological struggle that was emerging at the time surrounding the aetiology of psychiatric problems. Furthermore, it observed that different professionals were allied with the two extreme positions. In particular, psychiatrists with an interest in family therapy were drawn to *Position A*, whilst social workers tended towards *Position Z*, with psychologists occupying the middle ground.

2.2.1. Guerin (1976)

The GAP report was the first of its kind to categorise family therapies according to their theoretical influences. However, Guerin (1976) built on this initiative, by adding several subcategories to the GAP schema. Approaches informed by psychodynamic theory were further divided into 'Individual', 'Group', 'Ackerman' and 'Experiential'. The 'Individual' category reflected the original *Position A*, whilst the other categories drew on the work of J. E. Bell, N. Ackerman and Whitaker, respectively.

Guerin divided *Position Z* into three subcategories, which he named 'Structural', 'Strategic' and 'Bowenian'. These were meant to capture the main schools of family therapy that were founded upon systemic theory. The structural approach was associated with the work of Minuchin, strategic with the MRI group, comprising of Haley, Jackson, Watzlawick and Weakland, and Bowenian with Murray Bowen.

Guerin argued that it was most important to categorise family therapies according to their theoretical orientation: what therapists did in practice should be examined once these theoretical schools had been identified. He further dismissed early attempts to categorise the field using alternative criteria as part of an idealised, anti-theory movement during the 1960s. Despite this, he offered no clear rationale for why classification should be based primarily on theory. Furthermore, recent critiques of psychological therapies have called into question the substantive role of theoretical approach on outcomes for service users. In a review of several meta-analyses, which looked at the contribution of theory, along with other aspects of practice, such as therapists' allegiance to their model, Wampold (2001) suggested that therapist factors

may have a greater impact on how well service users do in therapy than the model itself. These findings argue against the reliance on theoretical orientation as the principal basis for classification.

2.3 Early classification based on aspects of practice

It is difficult to identify efforts to classify family therapies according to criteria other than by theoretical model. However, Beels and Ferber (1969) and L'Abate and Frey (1981) offered two schemes based on the style of the therapist and also the types of intervention used during sessions.

Beels and Ferber (1969) made a distinction between therapists who directed sessions ('Conductors') and those who were more reactive in their approach ('Reactors'). 'Conductors' were observed to lead their sessions and present themselves in a charismatic way. They adopted a senior position in the generational hierarchy in relation to the family and would talk more than family members during therapy. They would also appear as though they were teaching or educating, giving the sense that they were imparting expert knowledge to the family. Within this category, Beels and Ferber included therapies associated with Ackerman, Satir, Minuchin and Bowen.

In contrast, 'Reactors' were therapists with *"less compelling public personalities"* (Beels and Ferber, 1969; p.3). 'Reactors' adopted varying positions in the hierarchy, which depended on the family dynamics during sessions. This was not equated with a passive stance, but rather one in which the therapist would gain control of sessions in covert ways, for example, by introducing paradoxical ideas or interventions that influenced families, without highlighting their intentions. The therapists that were included in this group consisted of both psychoanalysts, such as Wymann and Whitaker, as well as systemic-theorists, such as Zuk, Haley and Jackson (Beels and Ferber, 1969).

A somewhat different classification was produced by L'Abate and Frey in 1981, which was named the E-R-A model. Rather than focussing on the style of the therapist, these authors examined the interventions that were used during their sessions. They concluded that family therapies could be categorised by their predominant focus on 'Emotions (E)', 'Reasons (R)' or 'Actions (A)'.

According to this model, 'E' therapies promoted interpersonal awareness and expression of feelings through exercises like family sculpting, role-play and imaginary dialogues. 'R' therapies adopted interventions that supported conscious understanding and rational control of feelings and behaviours. For example, through teaching, providing information to families, developing insight to help differentiate emotions from actions, as well as through practising problem-solving techniques. Lastly, 'A' therapies emphasised solving and preventing specific family problems, through the use of behavioural techniques, such as homework assignment, or deliberately getting the family to change patterns of interaction. L'Abate and Frey (1981) asserted *"any therapy that focuses on any one or combination of these aspect(s) can be effective"* (p. 146). However, to justify their categorisation, they suggested that therapies tended to focus predominately on one of these three aspects during initial sessions. The types of family therapy categorised by their scheme are presented in table 2.1.

Table 2.1 The E-R-A model for classifying family therapy (L'Abate & Frey, 1981)

Emotions	Reasons	Actions (Behavioural-Systemic
Humanistic FT	Psychodynamic FT	MRI group's FT
Gestalt FT		Milan FT
Experiential FT		Haley's FT
Existential FT		Adlerian FT
		Strategic FT
		Structural FT

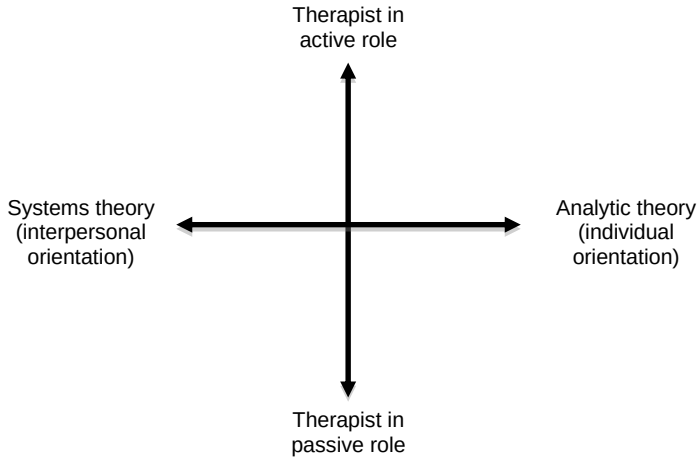
Both Beels and Ferber (1969) and L'Abate and Frey (1981) placed family therapies into different categories to those proposed by previous schemes. Theoretical distinctions were eschewed in favour of therapists' style or intervention technique, which meant that the classical distinction between psychodynamic and systems therapy were absorbed into alternative categories. Whilst these schemes presented family therapies in a different light, they were not widely accepted at the time of their publication, and there is no evidence that they were ever applied to outcome research.

2.4 Two-dimensional models of classification

Whilst many authors categorised family therapies along single dimensions, Foley (1974) and Ritterman (1977) proposed two-dimensional models of classification to tease apart the subtle differences between approaches. These models are briefly outlined in the sections below.

Foley (1974) examined the work of leading family therapists and compared them on 1) how they defined a family, 2) what they saw as relevant outcomes in therapy, and 3) what mechanism of change was proposed. Foley also highlighted eight aspects of clinical practice and examined the extent to which they were emphasised within the therapies. These aspects were: diagnosis, history, values, learning, affect, transference, conscious versus unconscious, and also teaching. Finally, Foley (1974) presented a two-dimensional model of classification that drew together both the GAP schema and also Beels and Ferber's (1969) idea of therapists' style (see figure 2.1).

Figure 2.1 A two-dimensional scheme for classifying family therapy (Foley, 1974, p.132)



An alternative two-dimensional model was proposed by Ritterman (1977). The first dimension of this model drew a distinction between therapies that focussed mainly on internal or subjective aspects of individuals, and those that examined external or objective behaviours of multiperson groups (i.e. families).

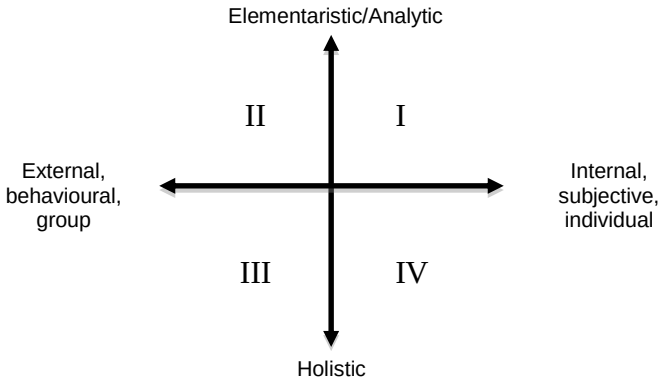
The second dimension categorised therapies according to their pre-theoretical assumptions. Ritterman (1977) argued that there were two classes along this dimension, which she labelled 'Elementaristic-analytic' and 'Holistic'. The first category described therapies adhering more closely to a mechanistic, or Newtonian understanding of

human behaviour. Assumptions were that all phenomena could be broken down to fundamental parts, and also that change occurred following stimulation (i.e. cause followed by effect). In contrast, 'Holistic' therapies viewed the whole as greater than the sum of its parts, due to way that these parts were organised, and assumed that causality was circular/reciprocal.

The first dimension in Ritterman's model bore some resemblance to Guerin's (1976) scheme, however, it placed less emphasis on theory. In addition, the dimensional model expanded the number of major categories in family therapy from two to four (see figure 2.2). Ritterman placed psychodynamic family therapies into category I (elementaristic/individual) because of their internal focus on individuals' experiences of the family, and also because they emphasised underlying (unconscious) elements, thought to give rise to (conscious) human experience. The work of the MRI group was placed into category II because it adopted a systemic frame, but nevertheless attempted to reduce family interactions into its constituent parts (bits of communication). On the other hand, the structural therapy of Minuchin was considered a holistic therapy, because it was less concerned with patterns of interaction, and more with the organisation of families. This emphasis on form governing function led Ritterman to place structural approaches in category III (holistic/group). The final category (holistic/individual) was identified with humanistic approaches, in particular, those therapies that focussed on people's internal, subjective representations of the family, such client-centred, or Gestalt family therapy.

Ritterman (1977) suggested that her model provided a chronological map of the field at the time, which had started in category I and had evolved through to category IV. However, the model was criticised by Levant (1980) because it accentuated the differences between structural and strategic family therapies, despite the approaches sharing many commonalities. Also, Ritterman placed greater value on newer therapies, assuming somewhat contentiously, that they were based on a more inclusive and accurate ('holistic') world-view.

Figure 2.2 Two-dimensional model of classifying family therapy according to Ritterman (1977)



Two-dimensional models of classification provide potential for a more precise categorisation of the field than models with a single-dimension. Despite this, the schemes proposed by Foley (1974) and Ritterman (1977) have received limited attention from the research community. There are many possible reasons for this, including the complexities involved in trying to operationalise multi-dimensional schemes. In addition, many family therapy approaches had already started to integrate ideas across the categories outlined by classification schemes: thus some categories and/or dimensions soon became irrelevant.

2.5 Levant's inductive classification (1980)

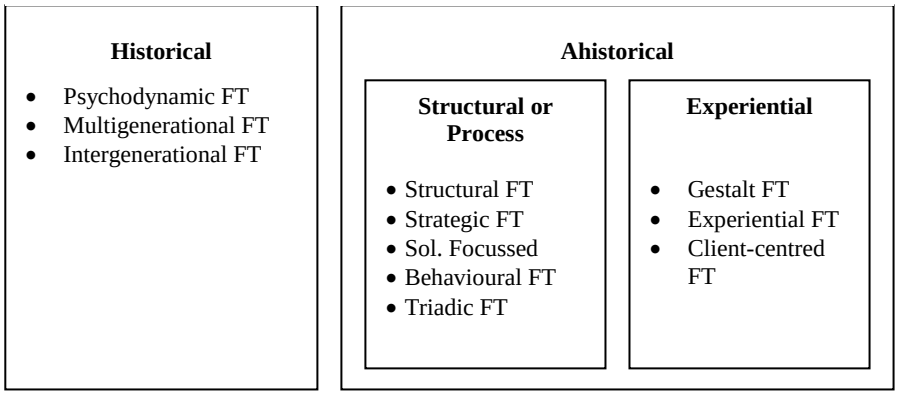
Up until this point, authors had taken a top-down approach to classifying family therapy: categories were formed a priori and therapies were then fitted into these. Levant (1980) suggested that this was appropriate in the early days when the distinctions between therapies were more obvious. However, the rapid cross-fertilisation of ideas meant that by the late 1970s, many of these classical distinctions had become irrelevant and so a more rigorous method was required to classify the field.

Levant's proposal was to use an inductive, bottom-up approach, which he described as a qualitative factor analysis. He first examined different family therapies to see if they *"clustered into conceptually and pragmatically meaningful groups, then determined the factors which distinguished these groups"* (Levant, 1980; p.13). Using this procedure, Levant identified two major categories, which separated therapies into those with a predominant focus on the past ('Historical') from those focussing on the present ('Ahistorical'). Several elements were found to underpin therapies in the 'Historical' group, including: an emphasis on history-taking, developing insight, the use of psychodynamic theory, and an overall aim of freeing people from over-attachment to

previous generations. On the other hand, the 'Ahistorical' group paid little attention to these elements. Moreover, it focussed on how relationships between people were linked with presenting problems, rather than individual psychology.

Levant (1980) also identified a second-order factor, which pertained only to the 'Ahistorical' category: this further split therapies into 'Structure or Process' and 'Experiential' groups (see figure 2.3). Common elements in the 'Structural or Process' group included a here-and-now focus on communication between family members, an expert stance taken by the therapist and removing dysfunctional elements thought to maintain symptoms. Meanwhile, therapies in the 'Experiential' group shared a focus on evoking an intensive emotional experience for family members, so that restorative processes could occur.

Figure 2.3 Classification of family therapy according to Levant (1980)



Levant's inductive approach offered a more rigorous way to categorise the field. However, his classification was limited by a lack of information about how he carried out his analysis. As such, it was unclear how the data was identified, what qualitative method of analysis was used and what potential biases may have influenced the coding and formation of Levant's final categories. Thus, it is impossible to evaluate the methodological quality of his work.

2.6 Classification of family therapy: the last 30 years

One of the early drivers for classifying family therapies was to enhance research on the effectiveness of different approaches. Some authors even saw this as *"a necessary first step in the process of a fine-grained examination of the outcome of family therapy"* (Levant, 1980; p.3). However, none of the schemes gained much

popularity, perhaps due to rapid development of the field and also the heavy reliance on categories based on the theoretical underpinnings of interventions. It is possible that many family therapists saw these classifications as irrelevant or unimportant to their practice, especially as most schemes were created by isolated research groups with their own agendas.

It seemed that by the 1990s, writers had all but given up on trying to categorise family therapies for outcome research, leaving us with a somewhat fragmented evidence-base outlined in the previous chapter. Some modern texts seem content on describing different forms of family therapy, without the need to bring any formal groupings to therapies, or attempts to highlight common strands between them (e.g., Gale & Long, 1996). Other textbooks have continued to utilise their own categories for the purpose of training and dissemination (e.g., Gurman, Kniskern & Pinsof, 1986; Carr, 2006).

Today, it is common to find a historical perspective on family therapy, such as the one outlined at the beginning of the thesis. This categorises family therapy by two or three phases of development associated with 'Modern' and 'Post-Modern' eras (e.g., Dallos and Draper, 2010). 'Modern' therapies are predicated on assumptions of rationality, objectivity and belief in universal structures that underlie human experience (e.g. structural, strategic and behavioural approaches). These are contrasted to 'Post-Modern' therapies, which are more sceptical about universal truths and value multiple perspectives, such as narrative and collaborative language systems approaches (for a discussion of the influence of post-modernism on family therapy, please refer to Boston, 2000).

In parallel to this, family therapies are sometimes described in relation to their influence from first and second-order cybernetic theory, although accounts differ in terms of which approaches are tied in with which phases (Dallos and Draper, 2010). Lastly, some authors contrast 'Established Models' with 'New Models of family therapy' (e.g., Goldenberg & Goldenberg, 2008; 2012) without articulating a process of how therapies come to be seen as either established or new.

Carr (2006) is one of the few contemporary authors who provides a rationale for classification, based on the extent to which therapies emphasise one of three factors: a) problem-maintaining behaviour patterns, b) problem-maintaining belief systems and narratives, and c) historical, predisposing and contextual factors.

With respect to the first category, Carr (2006) suggests that some therapies emphasise recursive patterns of behaviour thought to sustain problems in the family. These therapies typically adopt techniques to directly disrupt problematic interactions. In contrast, the second category focuses on systems of beliefs or narratives thought to underlie behavioural patterns. These therapies differ from the first category by prioritising interventions, which target cognitions and beliefs, rather than the behaviour itself. With respect to the final category, Carr describes a set of family therapies that highlight the influence of constitutional or contextual factors, which predispose people towards problematic belief systems and behavioural sequences. Therapies in this category all attempt to address these factors, for example, by involving wider networks (e.g., Multisystemic Therapy; Imber-Black, 1991).

Carr places a range of family therapies into his triadic-classification (see table 2.2), but also warns the reader about potential difficulties in construing the field in this way because of the growing trend towards the integration of approaches (Carr, 2006; p.69).

Table 2.2 A triadic classification of family therapy by Carr (2006)

A: Problem-maintaining behaviour patterns	B: Problem-maintaining belief systems and narratives	C: Predisposing historical, contextual and constitutional factors
MRI brief FT	Constructivist FT	Psychoanalytic FT
Strategic FT	Milan FT	Transgenerational FT
Structural FT	Social Constructionist FT	Attachment-based FT
Cog-Behavioural FT	Narrative FT	Experiential FT
Functional FT	Solution-Focussed FT	Multisystemic FT
		Psychoeducational FT

Although, Carr's scheme is one of the most comprehensive and up-to-date classifications in recent years, it faces the same problem as all those that went before it: it is unknown how widely accepted or useful this scheme is to the evaluation of family therapy as no reviews have attempted to adopt it for comparing outcomes.

2.7 Summary and aims

In summary, the diversity of family therapy approaches led early authors to classify the field for research purposes, using both single and multidimensional schemes. The majority of schemes based classification on the theoretical underpinnings of therapy, rather than on aspects of practice. In terms of methodology, classification schemes usually adopted a priori, external categories, into which therapies were

subsequently fitted. This can be described as a top-down, or deductive method. An exception was Levant's (1980) scheme, which was formed using a bottom-up, or inductive approach.

Regardless of the method used, classification schemes have several major limitations. First, none of the schemes have gained much currency within the research literature. Second, only one scheme by Levant (1980) was developed using an empirical method. Third, and perhaps most importantly, early schemes were based on an old definition of family therapy in which conjoint sessions were the principal mode of intervention. However, as discussed in chapter 1, the boundaries of family therapy have shifted over the years to take into account new ways of working, and not just conjoint therapy. Thus, systematic reviews based on old classifications of the field are not likely to be very useful or relevant to current practice.

Whilst contemporary classifications may address this issue to some extent, they are still potentially limited by a lack of universal acceptance from the wider field of family therapy. This presents a problem for establishing a coherent evidence-base, as different classes of therapy are compared each time a new systematic review is conducted (see above). A consequence is that we are not much closer to identifying the specific family therapies that work best for specific disorders despite the numerous studies already conducted and the availability of classifications.

What seems to be required are modern schemes that are grounded within a contemporary, consensus definition of family therapy, so that researchers can specify clearly the types of interventions that fall inside and outside the remit of reviews. Furthermore, it is difficult to discern from recent literature which major categories should form the basis for comparative reviews. In order to produce more useful family therapy reviews, there is a need to consider whether there can be any consensus amongst experts on the most important ways to classify therapies, so that existing studies can be filtered and synthesised appropriately to inform commissioners and practitioners.

The current thesis aims to tackle the following questions:-

1. Can experts agree on the common elements of family therapy to inform a 21st century definition of the field?

2. Can experts agree on the most useful ways to classify family therapy for research?

3. Can a brief tool be developed from consensus opinion of 1 and 2, that can be used to enhanced future systematic reviews of the field?

3. METHOD

Chapters 1 and 2 highlighted current controversies in the definition and classification of family therapy. Attention was also drawn to the potential value of establishing expert consensus in producing more informative systematic reviews of outcome research. This chapter describes how expert consensus opinion was sought in the current project.

There are three common methods for obtaining consensus amongst experts: consensus development conferences (McGlynn, Kosecoff & Brook, 1990), nominal groups (Delbecq & VandeVen, 1971) and the Delphi technique (Linstone & Turoff, 1975; 2010). The first two methods involve structured meetings, which require face-to-face contact between experts to generate ideas and opinions. The Delphi technique elicits opinions independently from experts, allowing participants to contribute to the discussion within a prescribed timeframe and also to remain anonymous to each other (Hsu & Sandford, 2007).

The Delphi technique was introduced by the RAND Corporation in the 1950s. It was originally employed by the U.S. air force as a systematic method to predict enemy movement when other approaches could not be used. Since then, Delphi has been applied to many disciplines, including nursing, economics, psychology, education and marketing (Linstone & Turoff, 2010). Researchers of family therapy have adopted the Delphi technique to address a broad range of question, for example, to elicit the perceived differences between structured and strategic family therapies and to examine the common elements of successful marriage and family therapy (Stone-Fish, 1989; White, Edwards, & Russell, 1997).

Delphi can be best described as a structured group communication process (Linstone & Turoff, 2010). It is based on the idea that joint decisions made by several people have greater validity than those made by an individual, going by the philosophy of *"two heads are better than one".* A standard Delphi design consists of three or four 'rounds' of questionnaires. The aim of the first round is to generate a wide range of opinions about the topic of interest. During this round the research team assembles an open-ended questionnaire, which is sent out to a group of experts. These opinions are synthesised into a second questionnaire to map out how the group sees the issue and to

highlight areas of agreement and disagreement. The third round is focussed on eliciting reasons for disagreement and evaluating these, if appropriate. In this round experts are asked to re-evaluate their initial responses in light of other expert opinions. Consensus is determined from a final analysis of updated responses.

The Delphi technique was chosen for the current research project because it had several advantages. First, since the questionnaires could be sent via email, a wide, international audience could be reached. Second, the pitfalls of holding large group meetings, such as interruptions and tangential debates, could be avoided. Third, the Delphi design provided experts with equal opportunities to express their opinions, avoiding the potential problem of dominant personalities being more persuasive during decision-making (Reid, 1988). Fourth, the method allowed control over the information that was fed back to participants, so that they could focus on the most relevant material to the research question. Fifth, the Delphi procedure allowed the group decision-making process to be articulated in a transparent way.

3.1 Establishing an expert panel

Whilst it was assumed that experts in the field of family therapy could be sampled from a pool of experienced academics, researchers, practitioners and trainers, there were no specific guidelines from Delphi studies in the family therapy literature to guide the process of assembling an expert panel.

However, several factors relating to the expertise of the panel were identified as priorities for the current study. Due to the diversity of family therapies acknowledged by reviewers (e.g., Stratton, 2011) it was decided that the panel should consist of experts from the widest range of orientations as possible. Experts were also targeted for their extensive experience in the field, as well as a high level of familiarity with the evidence-base on family therapy. For the latter aspect, it was crucial that experts had good knowledge of the literature on their own family therapy approach, *as well as* other family therapy approaches.

In order to provide some measure of the above aspects, all participants completed a proforma about their experience and knowledge (see Appendix A). Particular attention was paid to depth of knowledge, as several authors have implicated this as a key factor that distinguishes ‘expert’ therapists from ‘experienced non-experts’

(Meichenbaum, 2005; Orlinsky et al., 1999). It was assumed that this would be reflected in the number of years in practice, as well as the volume of research articles or book chapters that experts had authored. It was also assumed that the study would attract those experts with a high level of interest or commitment towards the development of the field.

3.2 Ethics

The study was approved by the University of Leeds ethics committee. All participants received a copy of an invitation email, which directed them towards an online information sheet. Informed consent was sought via the study website before access to the questionnaires was granted.

3.3 Recruitment

Participants were recruited into the study using two strategies. For the first strategy, potential participants were invited directly via email. The second strategy involved third-party recruitment, via family therapy training organisations.

A list of first authors from published systematic and narrative reviews on family therapy was assembled from screening two comprehensive narrative reviews by Carr (2009a,b). This was supplemented by names from the editorial lists of seven major family therapy journals. The email addresses for authors, editors and editorial board members were then located from the public domain using a Google Scholar search. The journal titles and number of email addresses that were identified by this method are displayed in table 3.1 below. The majority of contact details were retrieved from journal articles and the websites of universities or family therapy organisations.

Table 3.1 Identification of experts from journal editorial lists and review articles

Journal/Source	No. of Names identified from source	Email Addresses retrieved (as % of names identified)
American Journal of Family Therapy	44	30 (68%)
Australian and New Zealand Journal of Family Therapy	54	33 (61%)
Family Process	75	54 (72%)
Journal of Family Therapy	59	45 (76%)
Journal of Marital And Family Therapy	97	79 (81%)
Contemporary Family Therapy	25	14 (56%)
Journal of Feminist Family Therapy	46	29 (63%)
Authors of review articles (who were not already included in the lists of names above)	50	25 (50%)
Total	450	309 (69%)

For the second strategy, the researcher contacted the course directors from eleven family therapy training programmes across the UK to seek permission to invite trainers to the study. Only one of the courses declined, due to time constraints on staff. Unfortunately, since the study was reliant on course directors to pass on the invitation, it was not possible to quantify the number of trainers, who were reached in this way.

3.4 Materials

All experts received a standard invitation email (see Appendix A). Contained within the invitation was a link to the study website, where participants accessed the information sheet, consent form and proforma. The website was embedded with a computer script, which was designed specifically for online research, authored by Goritz and Birnbaum (2005). This script enabled the recording of consent and personal details onto a secure database.

3.4.1. Delphi Questionnaire 1 (DQ1)

The initial Delphi questionnaire was available to download from the website after experts had consented to take part in the study. All initial questionnaires were returned by email. The use of email provided the opportunity for experts to opt out through no response.

The aim of the first round of the Delphi exercise was to generate as many ideas as possible concerning inclusion and exclusion criteria for defining family therapies, and also for how therapies should be classified. Although some Delphi studies have omitted this first step, and based initial questions on a literature review of the topic area (e.g., Duffield, 1993), it has been suggested that this approach can prematurely limit the ideas available for consideration, or result in a biased selection of ideas to be debated (Jenkins & Smith, 1994, p. 416). Furthermore, given the breadth of the field, it was unfeasible to conduct a comprehensive literature review within the timeframe of the thesis. Therefore, a decision was made to allow experts to generate ideas, rather than to rely on the published literature.

The initial questions were developed through discussion with an experienced family therapist. During the first step, the researcher assembled a shortlist of potential questions on the topic of interest, which was emailed to the family therapist. A face-to-face meeting was then held, so that potential misunderstandings of the task or of the questions could be flagged-up. It was decided at this point that the three items below would be most appropriate for meeting the aims of the first Delphi round. Experts were asked to provide responses to the following open-ended questions and statements on the first questionnaire (DQ1) and to justify their responses.

1) For an intervention to be considered a type of 'family therapy' it must definitely involve….. *(Inclusion Criteria)*

2) For an intervention to be considered a type of 'family therapy' it must definitely **NOT** involve….. *(Exclusion Criteria)*

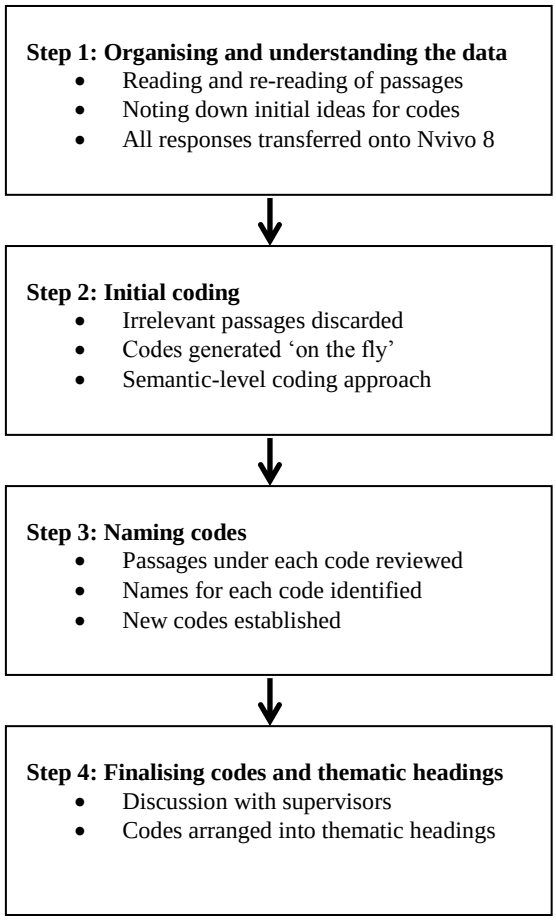
3) In your opinion, it is **MOST** important to classify family therapies by……. (e.g., theoretical model, format of sessions, etc.) *(Classification Criteria)*

Participants were asked to return the DQ1 within 5 weeks of the invitation email. A reminder was sent after 2 weeks.

3.4.2. Analysis of DQ1 responses

Initial responses from the DQ1 were summarised using a qualitative analysis, which involved coding experts' opinions. Jenkins & Smith (1994) observed that adequate coding of initial responses was critical to the validity of Delphi studies, as potential bias could be introduced at this stage. They suggested using an inductive coding approach to ensure that important material was not overlooked (Jenkins & Smith, 1994). For the current project, an inductive coding procedure was used, following the major steps outlined in figure 3.1, detailed below. The aim was to arrive at an exhaustive list of ideas for inclusion, exclusion and classification criteria that would form the basis for the second Delphi questionnaire (DQ2). Separate analyses were conducted on the responses to the three open-ended questions.

Figure 3.1 Outline of the major steps for the analysis of DQ1 responses



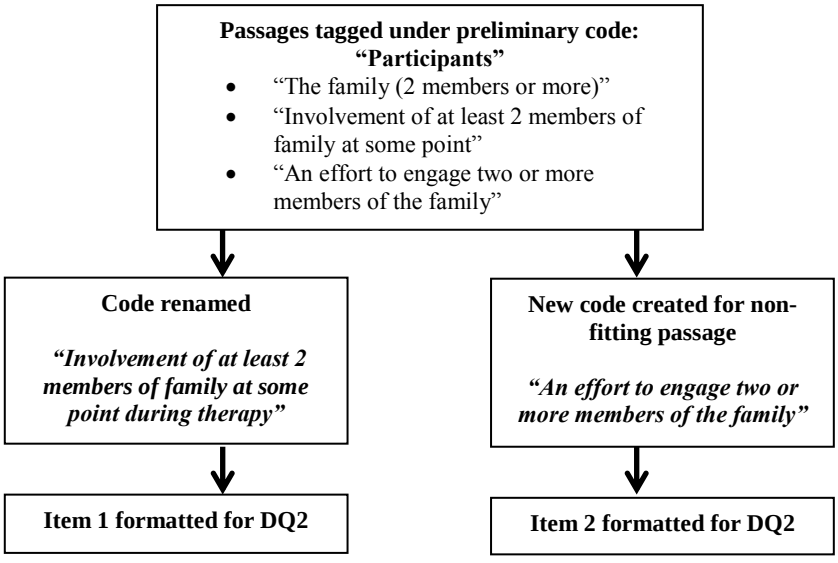
Step 1. DQ1 responses were read carefully several times over. Relevant passages were highlighted and preliminary ideas for coding were recorded into a reflective log.

Responses were then transferred verbatim onto the computer for initial coding, using Nvivo 8 software. Passages that did not directly address the questions were discarded. Examples of discarded passages included: opinions expressed about the validity of the study, the tensions between clinical practice and research, and views about the future of family therapy.

Step 2. Relevant passages were coded using an inductive approach, following guidelines from Braun & Clark (2006). New codes were generated 'on the fly', rather than specified a priori, to ensure that opinions were not limited prematurely by the preconceptions of the researcher. Furthermore, only semantic-level (surface-level) coding was employed, as the study was interested in the actual opinions of experts, rather than the latent meanings or assumptions behind them. Passages were included into more than one code where appropriate. The reflective log was consulted to help the researcher compare coding ideas from the earlier reading of opinions.

Step 3. Once all passages had been coded, the names of the codes were assigned: All passages tagged under one code were reviewed, and the passage that was deemed most representative of the code was chosen as the name. This meant that codes reflected the verbatim responses of experts. This review process was completed in a conservative way, such that any passage that did not seem to fit with the code was either accommodated in another, more suitable code, or established as a new code to help preserve nuanced differences between experts' opinions. An example of this process is given in figure 3.2, below.

Figure 3.2 Example of coding review process



Step 4. At this point, a meeting was held with the thesis supervisor to discuss a random sample of DQ1 questionnaires. The discussion generated some additional ideas for how to organise experts' responses. It was also decided from here that it would be helpful to group the codes/opinions into broader themes, so they could be presented in a more user-friendly way during subsequent Delphi rounds. Since this was a practical decision, codes were sorted into thematic headings based on ideas from the meeting, rather than on a rigorous grounded analysis of the text.

For classification criteria, 2 thematic headings were used:

- Classical/Theoretical Distinctions
- Distinctions Based on Practice

For inclusion criteria, there were 5 thematic headings:

- General Elements
- Elements Relating to Participants' Involvement
- Therapy Techniques
- Focus of Therapy
- Therapists' Factors

No thematic headings were employed for exclusion criteria as the expert panel presented relatively few ideas.

3.4.3. Delphi Questionnaire 2 (DQ2)

The aim of the second Delphi questionnaire (DQ2) was to ascertain experts' views on the ideas expressed during the first round of the study. Codes that were generated from the analyses above were transposed into statements to produce items for the DQ2 (see Appendix B). The 90 items were grouped into three major sections corresponding with the initial questions from the first questionnaire. Further sub-groupings followed the thematic headings from the qualitative analyses (see section 3.4.2 above). To ensure that the concepts contained in the second questionnaire accurately reflected those from the DQ1, the wording of experts was retained wherever possible. Statements on the DQ2 were also checked by a psychology postgraduate to flag up any inconsistencies with the original, coded passages.

Each item on the DQ2 was rated using a 7-point likert scale[1]. For statements relating to classification criteria (Section A), scales were anchored at 1= 'not at all useful', 4= 'unsure if useful or not', 7= 'extremely useful'. Experts were asked to give a rating for each statement, in response to the following question: *"In your opinion, how useful are the following distinctions for comparing different family therapies described in the literature?"*

Items relating to inclusion criteria (Section B) were split into two parts. In part "a" of the item, experts were asked: *"To what extent do you agree or disagree that it is essential for an intervention to include this element to be called a 'family therapy'?"* Ratings were given on 7-point likert scales anchored at: 1= 'strongly disagree', 4= 'neither agree or disagree', 7= 'strongly agree'. In part "b", experts were asked: *"Is this element unique to 'family therapy'?"* This was accompanied with a three-category response format of 'yes', 'no' or 'unsure'.

Items concerning exclusion criteria (Section C) were rated along 7-point likert scales anchored in the same way as those from Section B. Ratings were given in response to the following question: *"In the last questionnaire experts were asked: 'What must an intervention NOT include if it is to be considered a type of family therapy?' Their ideas are presented in the next section in the form of statements. We would like you to rate the extent to which you agree/disagree with each statement."*

Lastly, a free-response box was provided at the end of the DQ2 for experts to contribute new ideas or comments concerning any of aspect of the study.

The DQ2 was compiled online using "SurveyGizmo" (www.surveygizmo.com), a programme dedicated to the production of free and secure questionnaires for academic purposes. The online programme allowed sections A-C to be administered in a random order to counteract response bias, as recommended by Okoli and Pawlowski (2004).

An invitation for the DQ2 was sent out to *all* email addresses on the master list (apart from those who had declined to participate). Invitations were not restricted to

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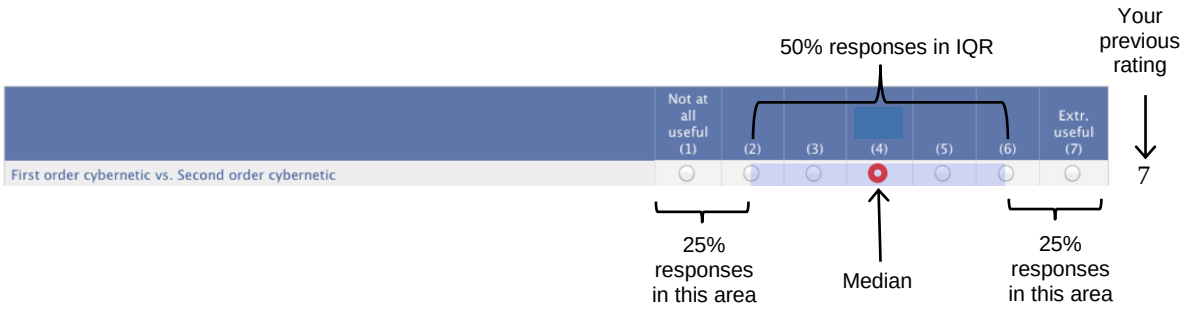
[1] A review by Preston & Colman (2000) suggested that 7-point scales produce optimal reliability for survey designs

experts who responded to the initial questionnaire. Although this departed from other Delphi studies (e.g. Stone-Fish & Osborn, 1992), the decision was justified on the basis of the low initial response rate (<9%) observed during round one. As such, it was an attempt to minimise the effects of attrition, which previous authors have highlighted as a potential limitation of Delphi studies (Hsu & Sandford, 2007). Experts were asked to complete the DQ2 online, within 4-weeks of the invitation email. They received a reminder email after 2-weeks, if they had not already responded.

3.4.4. Delphi Questionnaire 3 (DQ3)

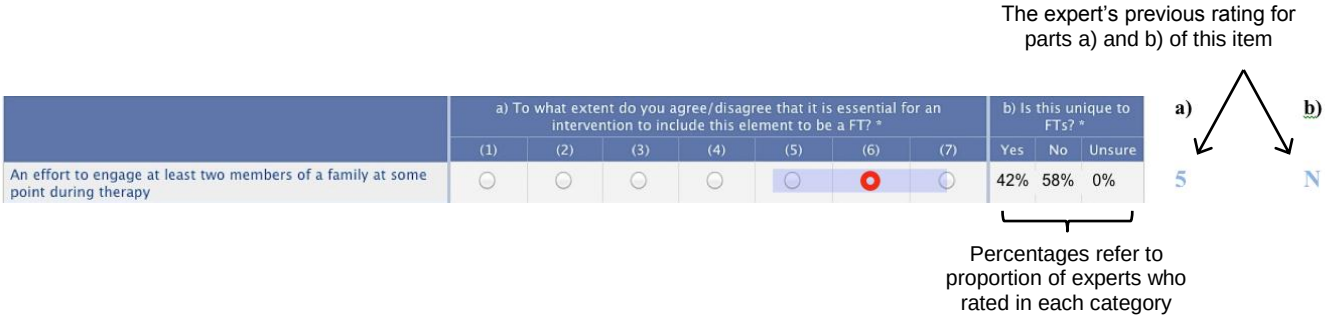
The aim of the DQ3 was to encourage experts to re-evaluate their previous ratings in light of new information concerning the collective response of the group. The DQ3 was essentially the same as the DQ2, except that it contained quantitative information gathered from responses to the second questionnaire. In line with traditional Delphi designs, three critical pieces of information were presented for each item in the DQ3: the median score of the group, the interquartile range, and the person's previous score. These data were presented visually in the format shown in figure 3.3, below.

Figure 3.3 Presentation of items on the DQ3



For the section on inclusion criteria (Section B), additional information concerning the percentages of responses in each category was given for part 'b', along with the expert's previous rating (see fig 3.4.)

Figure 3.4 Presentation of inclusion criteria items on the DQ3



DQ3 questionnaires were tailored for individuals with their previous scores displayed alongside each item. Unlike the last round, the DQ3 was only sent to experts who completed the second Delphi questionnaire, as the aim during this phase was towards consensus-building, rather than diversifying ideas.

3.4.5 Analysis of DQ3 responses

Determining Consensus. Deciding when consensus has been reached remains one of the most controversial aspects of Delphi surveys, as the definition of 'consensus' is open to interpretation (Hsu & Sandford, 2007). However, most Delphi studies define consensus using some quantitative measure of central tendency (e.g., means or medians), coupled with a measure of dispersion (e.g., standard deviations or IQRs) (Hasson, Keeney & McKenna, 2000). The major statistics used in the current study were the median and IQR, rather than means and standard deviations, as skewed distributions were expected, owing to the nature of the Delphi design (Jacobs, 1996). Furthermore, previous work has argued that non-parametric statistics better illustrate the convergence/divergence of opinions between rounds (Jacobs, 1996).

For all items with the 7-point response format, medians and IQRs were recalculated in light of revised responses from the DQ3. In line with previous studies, which have used predefined cut-off median scores to deduce when experts strongly

agreed with an opinion (e.g., Stone Fish & Osborn, 1992), items with a median of 6.00 or greater were retained. For classification criteria items, this score indicated that 50% of experts viewed an idea as somewhere between useful and extremely useful. For items relating to inclusion criteria, the same median score indicated that 50% of experts were absolutely certain or nearly certain that an item was an essential element underpinning all family therapies.

In addition to a median score of 6.00, an IQR of <1.50 was used to define consensus (in line with guidance from Stone-Fish & Busby, 2005). Since, lower IQRs indicate tightly-packed responses, a value <1.5, coupled with a median of 6.00, would suggest that at least 75% of all responses fell into the right-hand region of the scales. Thus, only items that met *both* criteria were considered as attracting consensus agreement. These items were retained for the final profile of inclusion, exclusion and classification criteria.

For inclusion criteria items that were answered on a 3-category response format (unique elements of family therapy), a 75% cut-off for consensus was used. This figure was chosen to maintain consistency with the other items.

3.5 Delphi follow-up

A follow-up was considered useful for elucidating reasons for non-consensus. The most controversial ideas were identified as those items with a high level of dispersion (IQR≥3) and medians falling around the centre of scales (4±1). The justifications given by experts for these items in the first Delphi questionnaire (DQ1) were examined. Experts, who scored at the extremes on controversial items were also invited to comment about their decisions in a Delphi follow-up email (DQF).

4. RESULTS

4.1 Participants

As described in section 3.3, the email addresses for 301 experts were located by screening author contact details from journal articles and by searches on Google Scholar. Ten email addresses were found to be incorrect or no longer active, which meant that 291 invitations were sent directly to experts. The response rate for direct invitations during the three Delphi rounds is shown in table 4.1.

Table 4.1 Responses to the Delphi study from direct invitations

Delphi Round*	*N* invited	*N* (%) responses	*N* (%) participated
DQ1	291	72 (25%)	27 (9%)
DQ2	274	39 (14%)	35 (13%)
DQ3	35	23 (66%)	23 (66%)

*Twelve experts participated in all three Delphi rounds

Seventeen (6%) experts declined to take part in the study at the outset. Reasons for declining were: 1. time constraints (10 respondents), 2. the expert did not consider himself/herself as possessing adequate knowledge to participate (6 respondents), 3. the expert considered the study to be unnecessary because a definition of family therapy could be found elsewhere[2] (1 respondent).

Of the remaining respondents, 28 (10%) completed the online consent forms and the initial proforma, but failed to return the DQ1. It was unclear why these individuals left the study at this stage. However, no significant differences were found when their characteristics (age, gender, region, years in practice, family therapy orientation, number of publications and conference addresses) were compared with experts, who returned the DQ1, DQ2 or DQ3 (all *p*-values >0.05 from two-tailed, independent t and chi-square tests).

For indirect invitations, 3 replies were received from the 11 family therapy training courses in the UK. Two courses were willing to pass the invitation onto their trainers and one course declined due to time pressures. Unfortunately, it was not

[2] The expert referred to a dictionary definition of family therapy by Sauber, L'Abate, Weeks & Buchanan (1993)

possible to calculate the response rate for indirect recruitment, as it was uncertain how many trainers actually received the invitation via their courses. It was also likely that some trainers had already been recruited via direct invitations.

4.2 Level and scope of expertise

Table 4.2 shows the characteristics of experts, who took part in the three Delphi rounds. Experts averaged over 20 years of experience in the field. Furthermore, the majority were qualified family therapists, whose activities included both live supervision of trainees and classroom teaching. In terms of research activity, 42.9% to 59.3% of experts in the three Delphi rounds had published more than 20 journal articles, books or book chapters on the topic of family therapy. Additionally, 51.4% - 56.5% had given more than 20 conference presentations.

Experts identified with a wide range of family therapies. However, the two most popular orientations for initial respondents were systemic (35.1%) and integrative (18.9%) family therapy. The range of therapies narrowed slightly from the second to the third round of the Delphi study, where notable omissions from the final sample included psychoeducational, multisystemic and psychoanalytic[3] approaches.

[3] Despite no experts citing psychoanalytic family therapy as one of their main orientations in the third Delphi round, several experts identified with Bowenian therapy, which draws on psychodynamic theory (Carr, 2006)

Table 4.2 Characteristics of experts responding to the Delphi survey

	DQ1 (N= 27)		DQ2 (N= 35)		DQ3 (N= 23)	
	n	*%*	*n*	*%*	*n*	*%*
Gender						
Male/Female	16/11	*59.3/40.7*	12/23	*34.3/65.7*	9/14	*39.1/60.9*
Region						
UK	7	*25.9*	7	*20.0*	4	*17.4*
Europe	4	*14.8*	5	*14.3*	5	*21.7*
North America	10	*37.0*	17	*48.6*	10	*43.5*
Australasia	6	*22.2*	6	*17.1*	4	*17.4*
FT Qualification Level						
None specific to FT	6	*22.2*	6	*17.1*	3	*13.0*
Licensing level qualification	18	*66.7*	16	*45.7*	10	*43.5*
PhD in FT	3	*11.1*	13	*37.1*	10	*43.5*
Number of FT publications[*]						
1-10	8	*29.6*	11	*31.4*	8	*34.8*
11-20	3	*11.1*	9	*25.7*	5	*21.7*
>20	16	*59.3*	15	*42.9*	10	*43.5*
Number of FT conference presentations						
1-10	10	*37.0*	12	*21.3*	7	*30.5*
11-20	3	*11.1*	5	*27.3*	3	*13.0*
>20	14	*51.9*	18	*51.4*	13	*56.5*
Activity						
Teaching/Research only	4	*14.4*	3	*8.6*	2	*8.7*
Live FT supervision only	2	*7.4*	4	*11.4*	2	*8.7*
Both	21	*77.8*	28	*80.0*	19	*82.6*
Orientation[**]						
Bowenian	2	*5.4*	3	*5.0*	3	*13.0*
Brief/Solution-Focussed	0	*0.0*	8	*13.3*	1	*4.3*
Cognitive/Behavioural	2	*5.4*	2	*3.3*	1	*4.3*
Experiential	1	*2.7*	3	*5.0*	2	*8.6*
Integrative	7	*18.9*	4	*6.7*	4	*17.4*
Milan/Post-Milan	2	*5.4*	6	*10.0*	2	*8.6*
Multisystemic/Ecosystemic	1	*2.7*	2	*3.3*	0	*0.0*
Post-Modern	4	*10.8*	9	*15.0*	2	*8.6*
McMaster Approach	1	*2.7*	1	*1.7*	0	*0.0*
Psychoanalytic	1	*2.7*	2	*3.3*	0	*0.0*
Psychoeducational	1	*2.7*	1	*1.7*	0	*0.0*
Strategic	1	*2.7*	2	*3.3*	1	*4.3*
Structural	1	*2.7*	6	*10.0*	1	*4.3*
Systemic	13	*35.1*	11	*18.3*	6	*26.1*
	Mean *(SD)*	Min-Max	Mean *(SD)*	Min-Max	Mean *(SD)*	Min-Max
Age	57.7 *(7.8)*	41-71	55.2 *(9.6)*	38-81	55.5*(10.0)*	38-81
Years practicing family therapy	23.7 *(9.9)*	8-38	21.4 *(8.7)*	7-38	21.7 *(9.7)*	7-38

[*] Journal articles, book chapters and books only [**]Experts specified up to three main orientations

4.3 Round 1

Participants generated a large number of responses to the three items on the DQ1.

4.3.1. Inclusion criteria.

Experts' replies varied in length for the first item *("for an intervention to be considered a type of 'family therapy' it must definitely involve…"*), which was designed to elicit inclusion criteria (essential elements) for selecting potential studies for systematic reviews (average number of words per expert= 98.7, SD= 73.6, range 7-307). In total, 74 passages were deemed relevant and were extracted from the text. These passages were assigned to 53 unique codes. Codes were then compared across the data set, re-coded and merged where necessary, following the procedure outlined in chapter 3, until the final analysis produced 41 codes that could be used as items in the second Delphi questionnaire (DQ2). Codes were grouped into 5 categories for ease of presentation (see table 4.3 for a breakdown of codes in each category).

Table 4.3 Categories relating to essential elements of family therapy

Category	Number of coded passages per category	Number of items generated for DQ2
General elements	21	7
Elements relating to participants' involvement	13	5
Therapy technique	16	13
Therapists' factors	7	6
Focus of therapy	17	10
Total	**74**	**41**

Of the final 41 items, 30 (73%) were generated from the account of one of the experts, whilst the number of experts providing responses under the remaining 11 (27%) codes ranged from 2 to 9. Table 4.4 displays the codes that were present in the replies of multiple experts.

Table 4.4 . Inclusion criteria (essential elements) for family therapy: codes identified from the replies of multiple experts

Code	Category	Number of experts coded (as % of DQ1 panel)
A systemic conceptualisation of the problem	General element	9 (33%)
Problems treated by changing system, not individual	General element	6 (22%)
The actual involvement of at least 2 family members	Participants' involved	6 (22%)
Focus on relationships	Focus of therapy	5 (19%)
Techniques for changing relationships	Therapy technique	4 (15%)
Circular questions	Therapy technique	3 (11%)
Therapist who can encourage reconciliation between perspectives of family members	Therapists' factor	2 (7%)
A focus on context	Focus of therapy	2 (7%)
A focus on shared meanings of people	Focus of therapy	2 (7%)
Hypotheses that include all family members	General element	2 (7%)
An effort to engage at least 2 family members during therapy	Participants' involved	2 (7%)

4.3.2. Exclusion criteria.

Compared to the section on inclusion criteria, experts provided shorter responses to the exclusion statement (*"for an intervention to be considered a type of 'family therapy' it must definitely **NOT** involve…."*) (average words per response= 31.1, SD= 24.5, range 0-80). Much of the text highlighted general issues around answering the statement: For example, 3 (11%) experts commented on the difficulty of locating proscribed practices, with one individual suggesting that there were probably no exclusion criteria that could be applied to the term 'family therapy'. Two (7%) other participants did not post any ideas for this statement. Furthermore, 5 (19%) experts responded by giving the opposite answer to the one they provided for the inclusion statement. For example, one expert answered *"systemic components"* to the inclusion statement, and *"no systemic components"* to the exclusion statement.

Although the intention of the DQ1 exclusion statement was to generate specific ideas for elements that should be proscribed from family therapy (e.g., *"family therapy should not include an analysis of dreams"*) many experts gave general views on what they thought should not constitute family therapy (e.g., *"family sensitive practice is great, but not family therapy"*). Rather than discarding comments of the latter type, they were retained for analysis on the basis that they were still potentially useful for defining

family therapy. However, this meant that the items generated for the corresponding section of the DQ2 included both ideas for proscribed elements, as well as more general propositions relating to the boundaries of family therapy. In total, 52 passages were extracted from the text. The coding process gave rise to 23 different codes, which were transposed into items for the DQ2. Sixteen codes (70%) were generated by a single expert, whilst 7 codes were found in the replies of two or more experts (see table 4.5).

Table 4.5 Elements excluded from family therapy: codes identified from the replies of multiple experts

Code	Number of experts coded (as % of DQ1 panel)
Approaches that see problems residing entirely in an individual	10 (37%)
Not considering problems in context	6 (22%)
Blaming relational problem on one party	5 (19%)
Linear explanations of problems	4 (15%)
Every intervention can be FT as long as the family is involved.	3 (11%)
Systemic individual interventions where the intention is always to work just with the individual	2 (7%)
Therapist seen as the 'expert'	2 (7%)

4.3.3. Classification criteria

Experts' responses for the classification item (*"in your opinion, it is **MOST** important to classify family therapies by…"*) varied considerably in length and scope (average words per response= 102.6, SD= 165.7, range 0-793). Many of the experts provided a commentary around the issue of classification, rather than direct ideas for categorising the field. Five experts (19%) considered the categorisation of family therapy as unhelpful, except for the loose purposes of teaching, or for historical interest. Two respondents (7%) added that a move towards integration in the field meant that comparisons in the literature were irrelevant to practice. Another expert seemed to suggest that it was more important to focus on theories surrounding problems, rather than schools of therapy:

> *"I think there is too much focus on schools of family therapy. I think we should keep focused on the science of solving human problems rather than on schools of thought. We need particular theories of problems not grand theories of the human condition."*

Three other experts (11%) used this section of the questionnaire to highlight tensions between family therapy and evidence-based practice. One expert, in particular,

produced a long, 793-word reply, suggesting that the field still fails to recognise the importance of distinguishing between family therapies that are empirically supported and those that are not. The expert reflected on some of the barriers to this, which included a criticism of family therapy programmes for not emphasising training in empirically supported modes of therapy.

Nevertheless, 58 statements, relating to ways of categorising family therapies for comparison in the literature, were extracted from the text. The coding procedure generated a total of 26 items that were transposed into items for the DQ2. Some of these items described specific categories of family therapy (e.g., *"modern vs. postmodern"*), whilst other items described criteria that could be used to classify the field (e.g., *"classify according to the position adopted by the therapist"*). There were substantial overlaps in the responses of experts, with 13 (50%) codes present in the accounts of more than one expert (see table 4.6).

Table 4.6 Classification of family therapy: suggestions identified from the replies of multiple experts

Code	Number of experts coded (as % of DQ1 panel)
Classify by proposed mechanism of change	13 (48%)
Classify by position that therapist adopts during therapy	5 (19%)
Single family vs. Multi-family	3 (11%)
Modern vs. Post-modern	3 (11%)
Parent-child vs. Child/Adolescent-focussed vs. Adult-focussed FT	2 (7%)
Conjoint FT vs. FT where family members can be seen separately	2 (7%)
Evidence-based vs. Non evidence-based	2 (7%)
Directive vs. Collaborative	2 (7%)
Focus on predisposing, contextual/historical factors vs. Focus on belief systems/narratives vs. Focus on problem-maintaining behaviour patterns	2 (7%)
Focus on emotional interchanges vs. Focus on cognitive/behavioural	2 (7%)
Focus on relationships vs. Focus on specific disorders	2 (7%)
Modern vs. Post-modern vs. Integrated	2 (7%)
Classify by structure of sessions	2 (7%)

4.4 Round 2

Two hundred and seventy-four experts from the original distribution list[4] were re-invited to complete the second Delphi questionnaire (DQ2). From this, 35 (13%) DQ2 were returned and analysed. Twelve out of the 35 (34%) respondents also participated in the first Delphi round. Although reasons for no response were not actively sought, 3 individuals emailed to say that they did not have time to take part in the study.

4.4.1. Inclusion criteria

Part A: Identifying essential elements. As described in chapter 3, experts rated items in this section on whether or not they were essential to family therapy, using a 7-point likert scale, where 1= *"Strongly disagree [that the element is essential]"* and 7= *"Strongly Agree [that the element is essential]"*. To identify essential elements, only items with a median of 6 or above were selected. Additionally, items were required to have an IQR <1.5, which was taken to indicate consensus of opinion amongst the expert panel. Of the 41 items rated, 24 (59%) had a median of 6 or more, and 10 of these also achieved an IQR <1.5 (see table 4.7, columns for round 2). None of the items with medians falling below 6 achieved consensus.

Twelve items were identified as controversial, according to the criteria outlined previously (i.e., median of 4±1 and also IQR ≥3), suggesting divergent opinions amongst the expert panel (see table 4.8, columns for round 2)

Part B: Identifying unique elements. In this part of the question, experts rated the items above on their uniqueness to family therapy, using a 3 category response format (*"yes", "no", "unsure"*). A criterion for consensus was set at >75%. Out of the 41 items, only 3 (7%) gained consensus *"yes"* votes, suggesting the panel regarded these items as unique to family therapy (see figures 4.3a, c & d, top bars). On the other hand, 14 (34%) items attained >75% *"no"* votes, indicating a consensus that they were not unique to family therapy (see figures 4.4a-m & 4.4o).

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[4] Seventeen experts were not invited for round 2 as they had expressly declined to take part during the first stage of the study

4.4.2. Exclusion criteria.

Since items in this section of the DQ2 were rated on 7-point scales, the same criteria as above were used to select items with most agreement and consensus (medians of 6 or more and IQR <1.5). Ten out of the 23 items (43%) had a median of 6 or higher: i.e., experts agreed that the element should be excluded from family therapy. Three of these items (13%) further achieved consensus amongst the panel (see table 4.9, columns for round 2). None of the items with medians less than 6 achieved consensus. Finally, 8 (31%) items in this section had a median of 4±1, whilst 7 (27%) of these also had an IQR ≥3 and so were considered controversial (see table 4.10, columns for round 2).

4.4.3. Classification criteria.

Experts rated 23 items on the DQ2 for perceived usefulness. Items comprised suggestions for how family therapy should be categorised for comparison in the literature, and also specific categories of family therapy. Three (12%) items obtained a median of 6 or more (indicating a high degree of perceived usefulness). However, none of these items returned an IQR <1.5, suggesting that there was no consensus amongst the panel (see table 4.11, columns for round 2). In addition, no items with medians of less than 6 achieved consensus.

Twenty-two (85%) items had medians around the middle of the scale (4±1), and 11 (42%) of these had IQRs of 3 or more (table 4.12, columns for round 2). Thus, approximately half of the suggestions that experts gave were identified as controversial.

4.4.4 Additional comments.

Nine (26%) experts returned additional comments about the DQ2. Five (19%) wrote to express their intrigue about the topic, whilst another stated that they had found the exercise extremely thought-provoking as it highlighted the difficulties with defining family therapy. One expert expressed his surprise at the narrow views of family therapy, deducing that every item on the questionnaire must have been strongly advocated by at least one expert in the field by virtue of the Delphi design. A further comment queried whether the study was concerned with any intervention focussing on the family, or specifically with systemic family therapy: This individual suggested that an exploration

of that particular boundary could be valuable in future work. There were two further comments concerning the wording of the introductory question for classification criteria, which the experts had found difficult to understand. Since this may have contributed to the high number of controversial items identified from this section of the DQ2, a minor adjustment was made to the wording for the next Delphi round (see section 4.5.3, below).

4.5 Round 3

In round 3, all experts who completed the DQ2 were sent a copy of the DQ3. The DQ3 contained the same items as before, but included additional information describing the group response (see chapter 3 for details). Of the 35 questionnaires sent out, 23 (66%) were returned and analysed.

Experts varied on the number of ratings that they changed on the DQ3: two individuals kept all their answers unchanged from the previous round. However, the mean number of ratings altered per expert was 10.5 (SD = 10.2, range= 0-36).

4.5.1. Inclusion criteria

Part A: Identifying Essential Elements. Twenty-five (61%) items in this section had a median rating of 6 or above, with 14 (34%) also attaining IQRs <1.5. Thus, a further 4 (10%) items achieved consensus when compared to the previous round (see table 4.7). Of the remaining items, only one attained an IQR of less than 1.5 and a median of 4.5 (*"using questions or coaching to bring about change, but not direct advice only"*), suggesting there was consensus amongst experts that they were unsure whether this was an essential element of family therapy, or not.

Of the 12 items that had been classed as controversial on the DQ2, 5 (12%) maintained IQRs of 3 or more. One additional item (*"An effort to engage the whole family in therapy"*) showed a widening IQR from 2.5 to 3.0, and so was also identified as controversial. Table 4.8 displays the changes in ratings between rounds for items identified as controversial.

Table 4.7 Changes in ratings between rounds for inclusion criteria items with medians ≥6 (essential items)

Inclusion Criteria (Items with medians ≥6)	Round 2 (N= 35)		Round 3 (N= 23)	
	Median	*IQR*	*Median*	*IQR*
1. A systemic conceptualisation of the problem	7	1.0*	7	1.0*
2. Idea that problems treated by changing system rather than specific member	7	1.0*	7	1.0*
3. A view that resources for change reside in individuals attending therapy & in their relationships with others	6	1.0*	6	0.5*
4. The idea that all behaviour communicates something about its context	6	2.0	6	1.0*
5. An influence from the core traditions of family therapy	6	3.0	5	2.5
6. Non-blaming or non-pathologising formulations or conceptualisations	6	3.0	6	2.0
7. Hypotheses that include all family members	7	1.0*	7	2.0
8. An effort to engage at least two members of a family a some point during therapy	6	2.0	6	2.0
9. At least one member who is concerned about his/her relationship with another family member	6	3.0	6	1.0*
10. Attempts to connect behaviours to a context	7	1.0*	7	1.0*
11. Acknowledging the family's struggles and strengths	6.5	3.0	7	1.0*
12. Techniques for changing relationships	6	2.0	6	1.8
13. Bringing new information into system that will be helpful or healing for those involved	6	2.3	6	2.0
14. Inviting clients to explore patterns and feedback loops	6	3.0	6	2.0
15. A focus on relationships	7	1.0*	7	0.8*
16. A focus on context	7	1.0*	7	0.8*
17. A focus on shared meanings between people	6	1.3	6	1.0*
18. Exploring people's ideas and explanations about the problem	6	3.0	6	2.8
19. A frame that considers the largest most meaningful system	6	3.0	6	2.8
20. A therapist trained in FT, not simply applying manual without being skilled at this general style of therapy	7	1.0*	7	0.8*
21. A therapist who can take account of his/her impact on the system	7	1.0*	7	1.0*
22. A therapist who can manage his/her own anxiety in order to help clients do the same	6	2.3	6	1.0*
23. A therapist who can identify & encourage reconciliation between perspectives of participants	6	2.0	6	1.0*
24. A therapist who takes control of the session to a certain extent	6	3.0	6	3.0

*Consensus item (IQR<1.5)

Table 4.8 Changes in ratings between rounds for inclusion criteria items with medians 4±1 (controversial items)

Inclusion Criteria (Items with Medians 4±1)	Round 2 (N= 35)		Round 3 (N= 23)	
	Median	*IQR*	*Median*	*IQR*
1. The idea that instructive interactions are less effective than a collaborative approach	3	3.0*	3	3.0*
2. An effort to engage the whole family in therapy	5	3.0*	5	3.0*
3. The actual involvement of at least two members of a family at some point during therapy	5	5.0*	5	3.0*
4. Use of reflexive questions	4.5	5.0*	5	3.5*
5. Use of circular questioning	4.5	3.3*	5	3.0*
6. Taking a thorough family history	4	3.0*	3.5	2.0
7. Using a genogram	4	3.3*	4	2.8
8. A structural diagnosis and boundary processes	4	3.0*	4	2.8
9. Exploring effects rather than causes	5	3.0*	5	2.0
10. Exploring the onset of the problem and its context at that time	5	3.0*	6	2.8
11. Evoking and amplifying any changes between sessions, or exceptions described during sessions	5	3.3*	6	2.0
12. Positioning of the therapist as non-expert	4	3.0*	4	3.0*

*Items identified as controversial (IQR ≥3 and median 4±1)

Part B: Unique Elements. Six (15%) items attracted >75% "yes" votes on the DQ3. Thus, compared to round 2, there were 3 (7%) more items, which achieved consensus for being unique to family therapy. Meanwhile, 19 (46%) items had >75% "no" votes, which meant that 5 (12%) additional items reached the consensus threshold to be considered non-unique to family therapy. Figures 4.3 and 4.4 (top and bottom bars for each item) display the percentages of experts voting across the final two rounds of the Delphi study.

4.5.2. Exclusion criteria

In this section, 8 (35%) items attained a median of 6 or above (indicating strong agreement), with 3 (13%) of these meeting the criterion of IQR <1.5. Thus, no additional items with strong agreement reached consensus, apart from those already identified from the previous round (see table 4.9). One further item returned a median

score of 5.5 and an IQR of 1.3 (*"an intervention is not family therapy if it has an exclusive focus on one level of explanation, e.g., bio, social, or social"*). A visual inspection of the distribution of ratings suggested that there was convergence of opinion around moderate agreement on this item.

Of the 7 items classed as controversial from the DQ2, 5 (22%) maintained IQRs of 3 or more on the DQ3. However, an extra item was identified as controversial during this round of the questionnaire (*"an intervention is not a FT it has a sole focus on psychodynamics."*). Statistics for controversial items are displayed in table 4.10.

Table 4.9 Changes in ratings between rounds for exclusion criteria items with medians ≥6 (items with greatest agreement)

Exclusion Criteria (Items with medians ≥6)	**Round 2 (N= 35)**		**Round 3 (N= 23)**	
	Median	*IQR*	*Median*	*IQR*
1. An intervention is not a FT if sees problems and solutions as residing entirely inside an individual	7	0.0*	7	0.0*
2. An intervention is not FT if it does not consider problems within a context	7	0.0*	7	0.0*
3. An intervention is not a FT if it blames a relational problem on one party	6	1.0*	7	0.0*
4. An intervention is not a FT if it has a sole focus on intrapsychic aspects	7	2.0	7	2.0
5. An intervention is not a FT if it has an exclusive focus on one level of explanation (e.g. bio, psycho, or social)	6	3.0	5.5	1.3**
6. An intervention is not a FT if it involves interpreting symptoms solely in relation to past individual trauma	6	2.0	6	3.0
7. An intervention is not a FT if it uses linear explanations of problems	6	2.0	6	2.0
8. A Rogerian style of counselling is not FT unless the therapist was trained to think systemically	7	2.8	6	2.0
9. Family sensitive practice is great but not FT	6	2.8	6	2.0
10. An intervention is not a FT if it has a sole focus on psychodynamics	6	3.0	5	3.0

*Consensus item (IQR<1.5) **Item excluded from final profile due to median falling below 6, despite IQR<1.5

Table 4.10 Changes in ratings between rounds for exclusion criteria items with medians 4±1 (controversial items)

Exclusion Criteria (Items with medians 4±1)	Round 2 (N= 35)		Round 3 (N= 23)	
	Median	*IQR*	*Median*	*IQR*
1. Every intervention can be FT as long as the family is involved	4	3.0*	5	3.0*
2. Talking at the family about family dynamics is not family therapy	5.5	3.0*	5	3.0*
3. An intervention is not a FT if it involves taking sides	4.5	5.0*	4	2.0
4. Systemic individual interventions where the intention is ALWAYS to work just with the individual is not FT	4	3.8*	4	3.0*
5. Behavioural therapy or CBT conducted with the family is not FT	3.5	4.0*	4	3.0*
6. Employing a manualised, branded treatment isn't FT: Family-based intervention is a better term	3	3.0*	3	2.0
7. An intervention is not a FT if it conceals its process from clients	3	3.8*	4	4.0*
8. An intervention is not a FT if it has as sole focus on psychodynamics	6	3.0	5	3.0*

*Items identified as controversial (IQR ≥3 and median 4±1)

4.5.3. Classification criteria

As mentioned earlier, the question that was used to introduce this part of the DQ3 was modified following feedback from the panel. On the DQ2, the question had read: *"How useful are the following distinctions for comparing the effectiveness of different family therapies from the literature?"* On the DQ3, this was changed to: *"How useful are the following distinctions for comparing family therapies described in the literature?"* Experts were alerted to the change in the invitation email, which they received for the DQ3.

Despite the alteration, there were only a few changes to consensus items in this part of the questionnaire. Two (8%) items obtained a median of 6 or more (indicating a high degree of perceived usefulness), with both items also achieving an IQR <1.5. Thus, compared to the previous round, there were two extra items that gained consensus amongst the panel as being highly useful (see table 4.11).

One item attained a median of 2 and an IQR of 1.0, suggesting the panel agreed that this item was not useful for comparing family therapies (*"classifying family therapy according to the number of therapists usually involved during the therapy").*

Two items with medians of 4 and 5 both had an IQR of 1.0, suggesting there was consensus opinion that it was uncertain how useful these distinctions were for comparing family therapies. The respective items were: *"categorising family therapy by how sessions are usually structured"* and comparing *"unimodal family therapy versus multi-modal family therapy"*

Of the 11 (42%) items that had been identified as controversial in the previous round, 5 (15%) maintained IQRs of 3 or higher (see table 4.12). The remaining 7 items showed narrowing IQRs that fell beneath the criteria to be classed as controversial.

Table 4.11 Changes in ratings between rounds for classification criteria items with medians ≥6 (classifications deemed most useful)

Classification Criteria (Items with medians ≥6)	**Round 2 (N= 35)**		**Round 3 (N= 23)**	
	Median	*IQR*	*Median*	*IQR*
1. Categorise FT according to their proposed mechanism of change	6	1.5	6	1.0*
2. Focus on relationship changes vs. Focus on specific disorders	6	1.5	6	1.0*
3. Systems-focussed vs. Non systems-focussed	6	3.5	5	2.0

*Consensus item (IQR<1.5) **Item excluded from final profile due to median falling below 6, despite IQR<1.5

Table 4.12 Changes in ratings between rounds for classification criteria items with medians 4±1 (controversial items)

Classification Criteria (Items with Medians 4±1)	Round 2 (N= 35)		Round 3 (N= 23)	
	Median	*IQR*	*Median*	*IQR*
1. Modern vs. Post-modern vs. Integrated	5	3.0*	4	3.0*
2. Evidence-based vs. Non evidence-based	5	3.0*	3	4.0*
3. Focus on the historical vs. Focus on structure/process vs. Focus on the experiential	4	3.0*	4	2.0
4. Systems/Structural vs. Psychoanalytic	4	3.0*	4	2.5
5. Parent-infant therapy vs. Child-focussed vs. Adolescent therapy vs. Adult therapy	4	3.0*	4	2.8
6. Focus on looking forward vs. Focus on looking back in order to look forward	3	3.0*	3	2.5
7. No. of family members present within sessions (Conjoint vs. Members can be seen separately)	4	3.0*	4	3.0*
8. Modern vs. Post-modern	4	3.5*	4	2.5
9. Model-derived vs. Eclectic	4	4.0*	4	3.5*
10. First-order cybernetic vs. Second-order cybernetic	4	4.0*	4	2.5
11. Individualistically orientated vs. Dynamic vs. Humanistic vs. Attachment approaches	4	4.0*	4	4.0*

*Items identified as controversial (IQR ≥3 and median 4±1)

4.6 Delphi follow-up

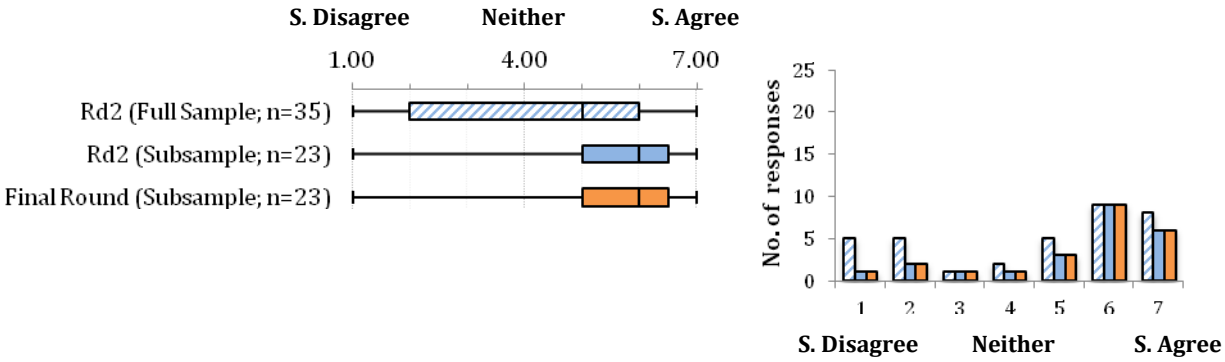
Items that were identified as controversial were included on a brief follow-up email (DQF). This was circulated to 10 selected experts, who had returned extreme scores on controversial items, in order to elicit reasons for specific ratings. Out of the ten emails sent, only 4 (40%) replies were received. Due to the limited number of responses a full qualitative analysis was not possible. Instead, these responses will be incorporated as part of the discussion of results (see chapter 5).

4.7 Post-hoc analyses

Previous Delphi studies have been criticised for overlooking the effects of attrition, which can lead to the emergence of consensus without any significant shift in experts' opinions (Sinha, Smyth & Williamson, 2011). A hypothetical example can be observed from the boxplots and histogram below (figure 4.0), where an artificial

consensus has resulted from experts, who previously rated at the lowest end of the scale, dropping out during the final round. In this example, none of the experts completing both rounds changed their opinions (as can be seen from the solid blue and orange boxes). Thus, the representativeness of the final round consensus is questionable.

Figure 4.0 An example of artificial consensus opinion resulting from attrition



Key: For boxplots, IQR is displayed as boxes, median score as vertical bar inside boxes. The response range is displayed as whiskers.

In order to assess whether or not this effect was present in the current study, the medians and IQRs from the DQ2 were recalculated for a subsample of experts, who completed *both* rounds 2 and 3 (*n*=23). These results were compared with the DQ2 responses from the full sample (*n*=35). The analyses did not reveal any substantial differences between the subsample and the full sample for the majority of items that attained consensus (see figures 4.1-4.9, compare blue-striped boxes with solid blue boxes). However, on 2 items, the subsample attained consensus when the wider group did not (see figures 4.1m and 4.1n). A closer examination revealed that for both items, there was no narrowing of responses from the subgroup on the final questionnaire. Therefore, it was likely that an artificial consensus had developed as a result of attrition for these items. For this reason, the two items were excluded from the final profile (displayed in table 4.7).

A similar analysis was performed for data on unique elements of family therapy, to identify consensus items, which may have been affected by attrition. This analysis found that one item (*"a structural diagnosis and boundary processes"*) reached consensus due to a disproportionate number of experts dropping out of round 3, who did not consider this element to be a unique aspect of family therapy (see figure 4.3e). Thus, the item was excluded from the final profile of unique elements, shown in table 4.13.

Figure 4.1. Inclusion Criteria: Items with consensus opinion as essential to family therapy

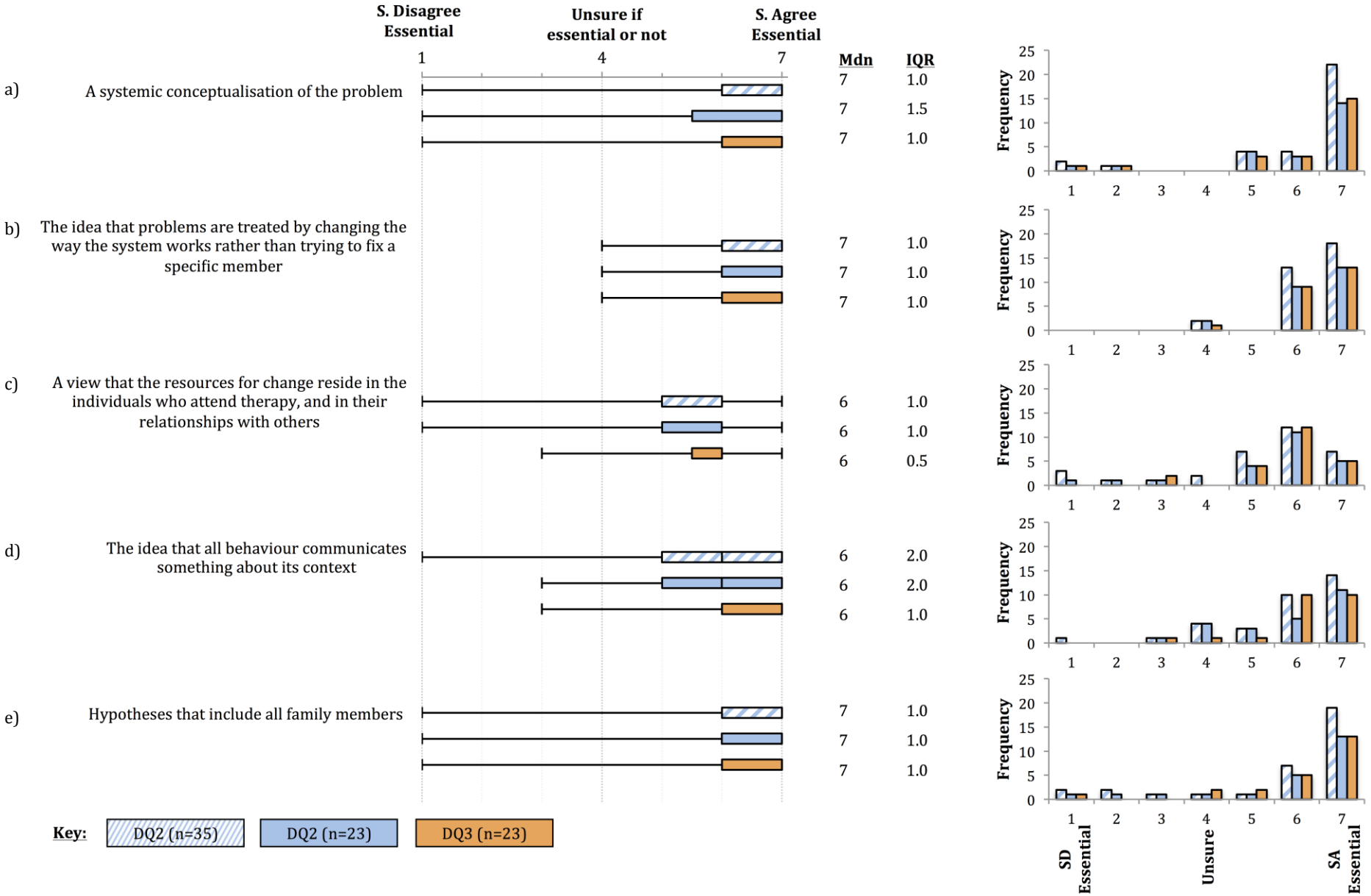


Figure 4.1. Inclusion Criteria: Items with consensus opinion as essential to family therapy (continued)

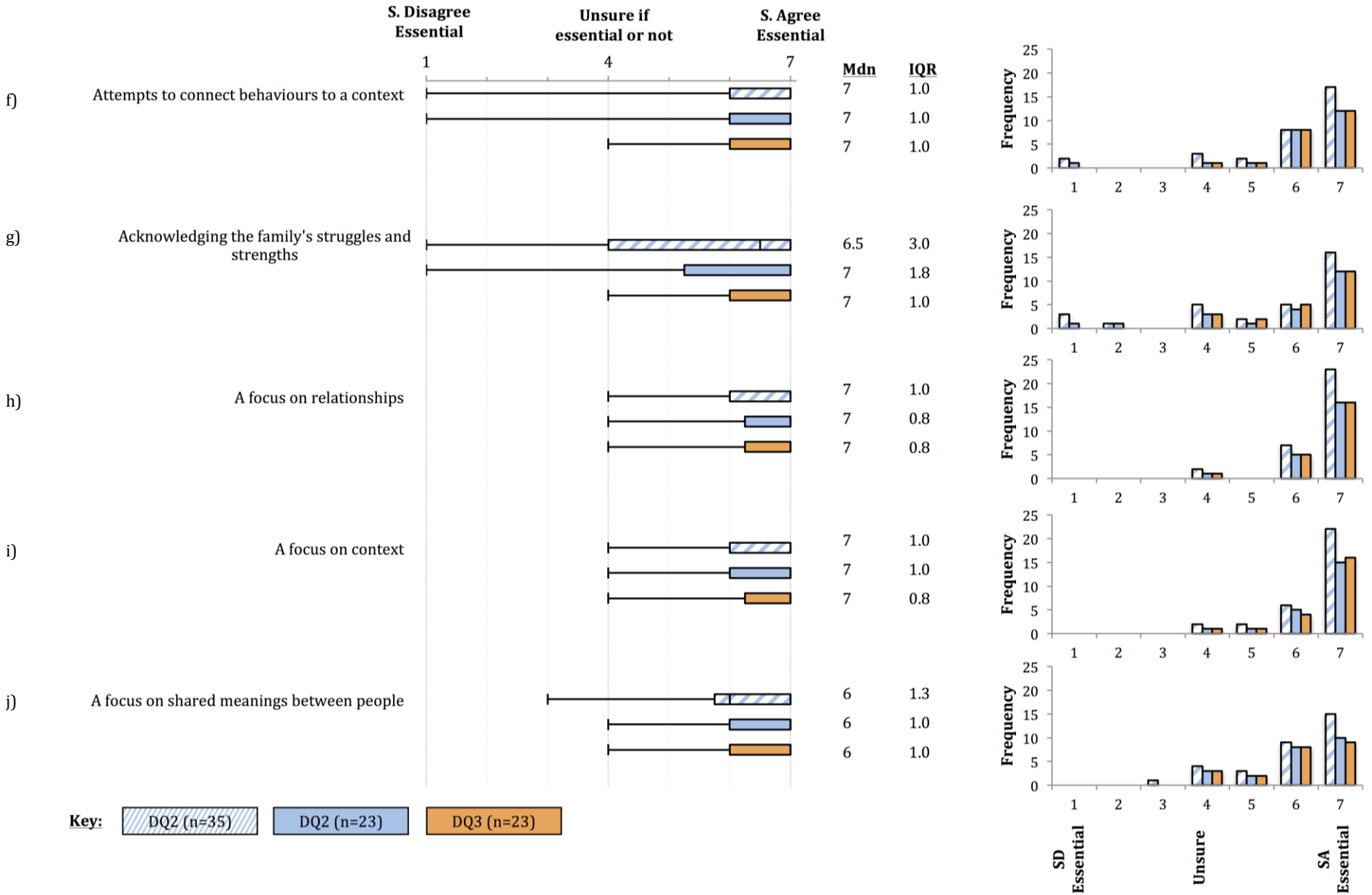


Figure 4.1. Inclusion Criteria: Items with consensus opinion as essential to family therapy (continued)

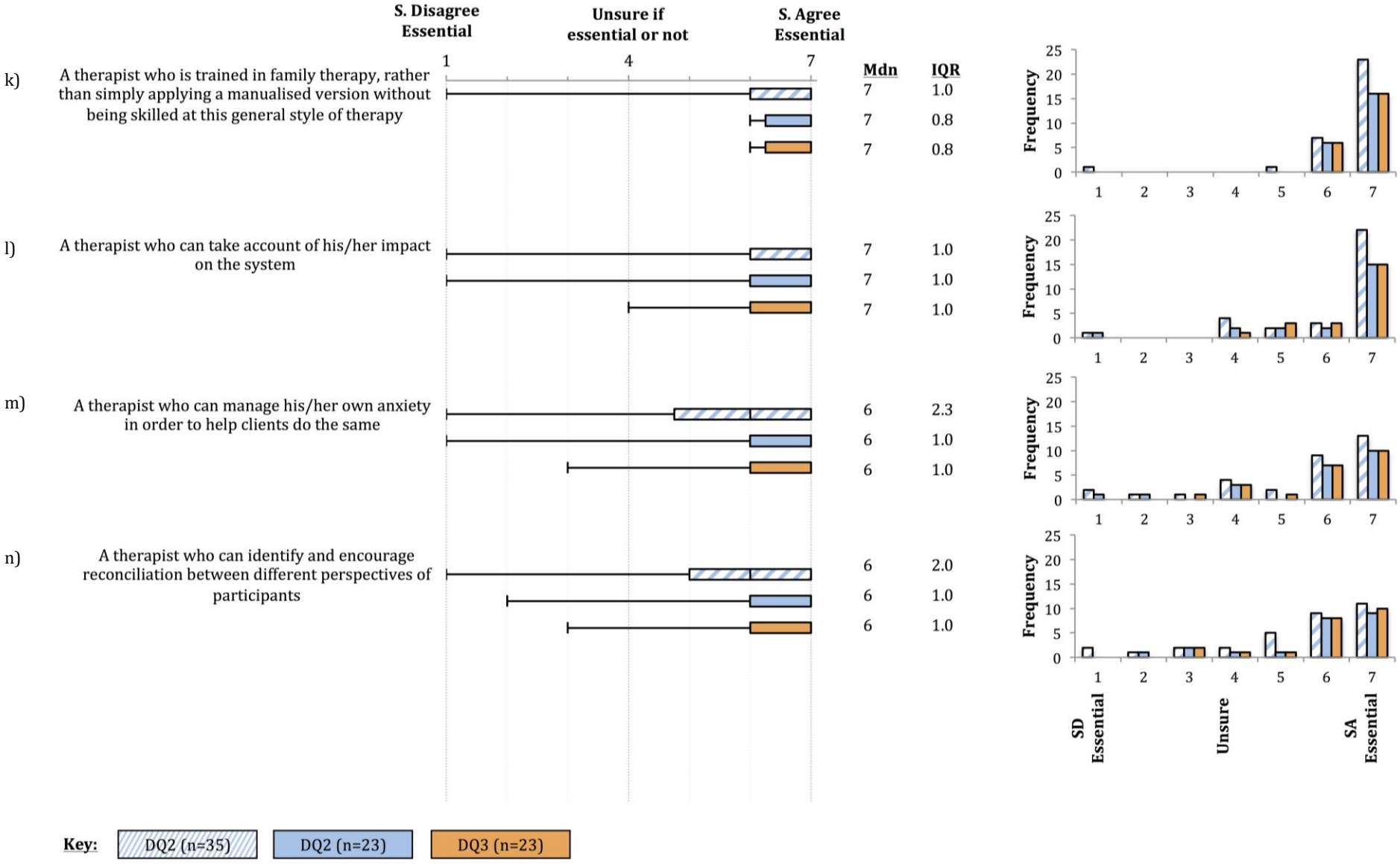


Figure 4.2. Inclusion Criteria: items identified as controversial

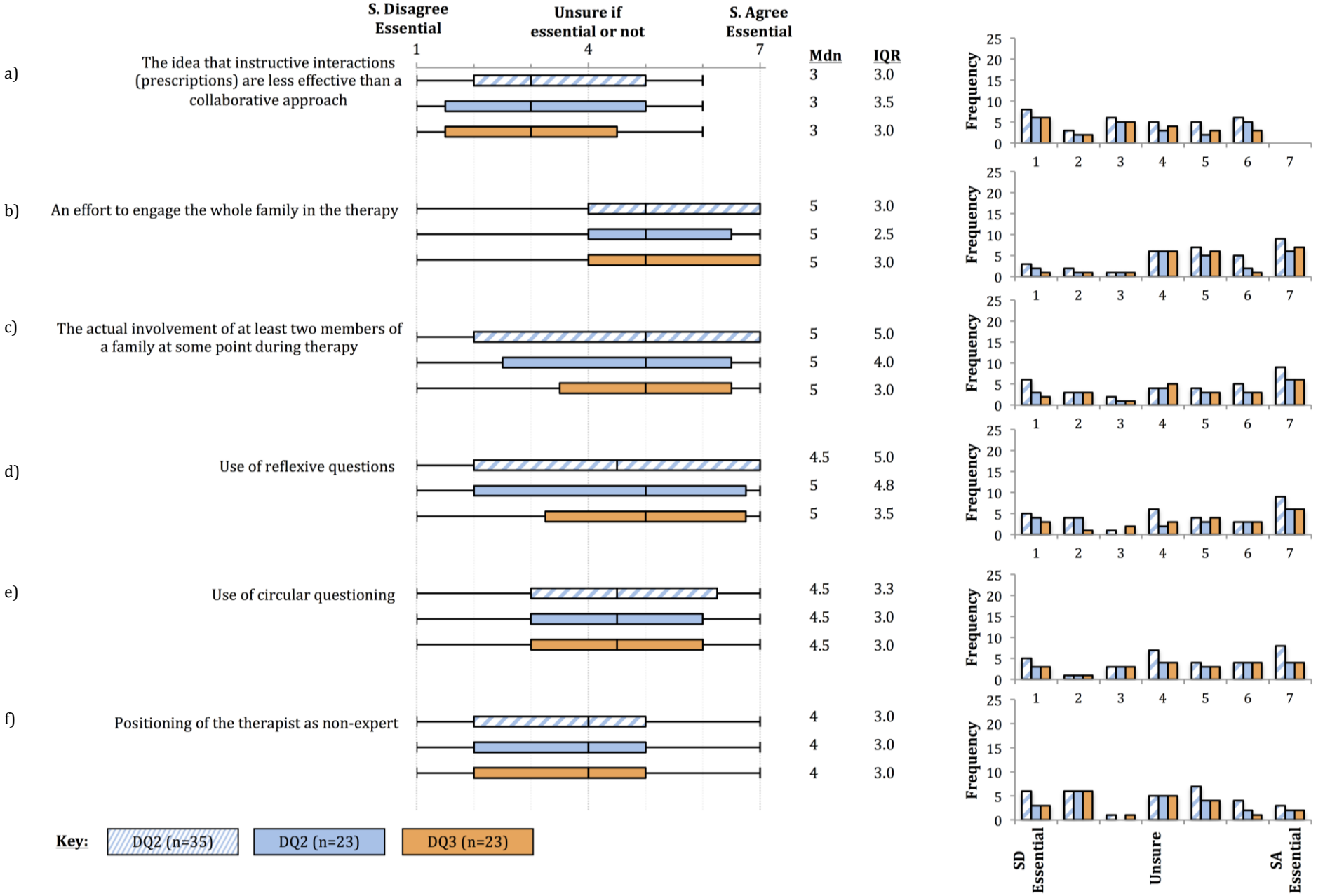
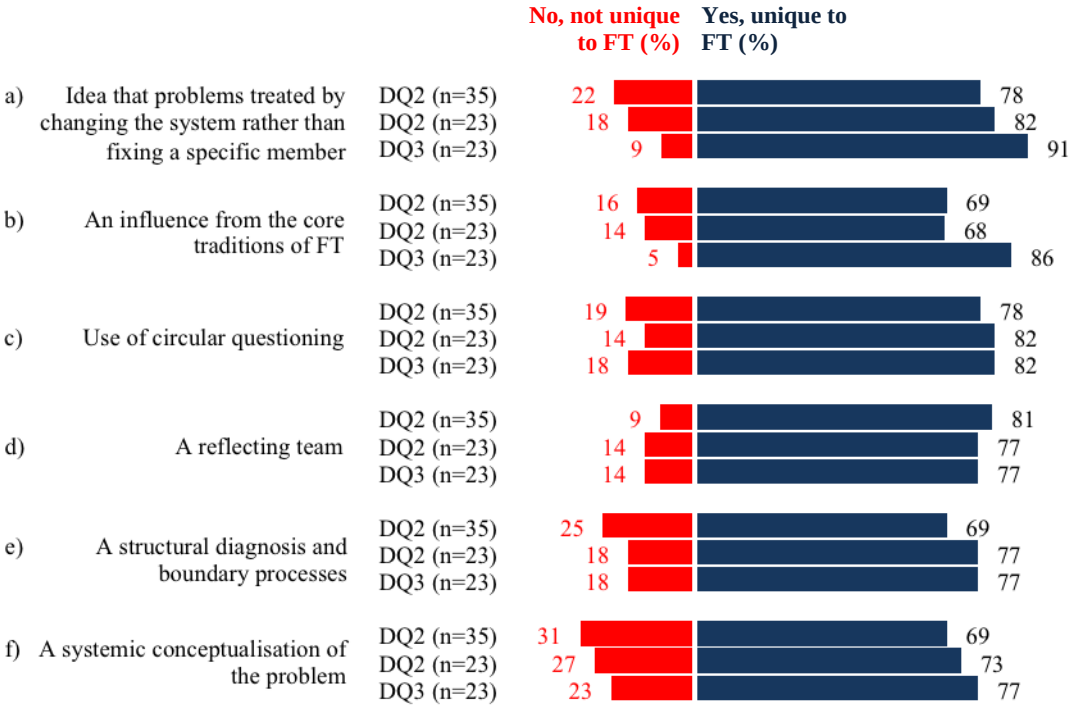
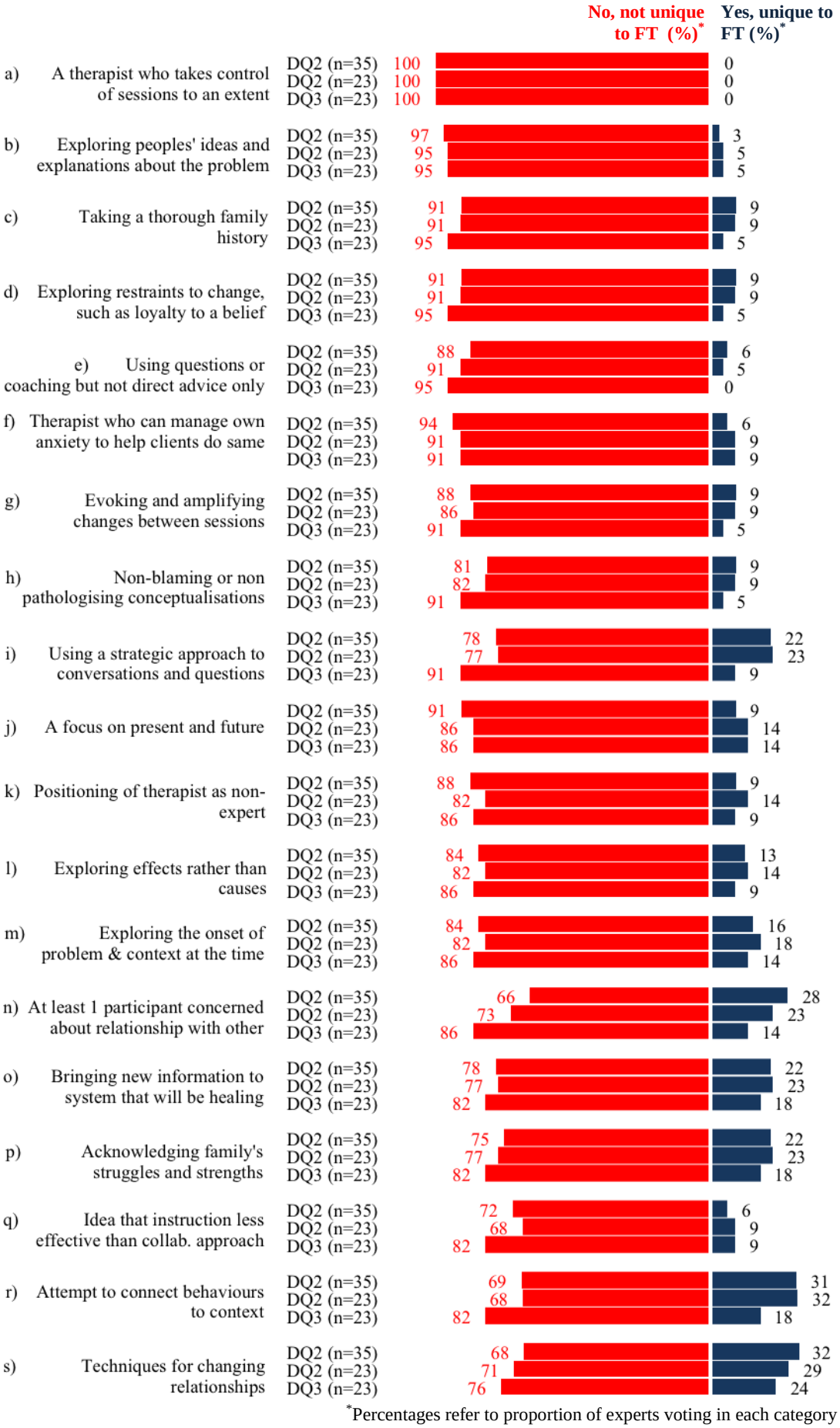


Figure 4.3 Items with consensus agreement as unique to family therapy



*Percentages refer to proportion of experts voting in each category

Figure 4.4 Items with consensus agreement as not unique to family therapy



*Percentages refer to proportion of experts voting in each category

Figure 4.5. Exclusion Criteria: Items with consensus agreement

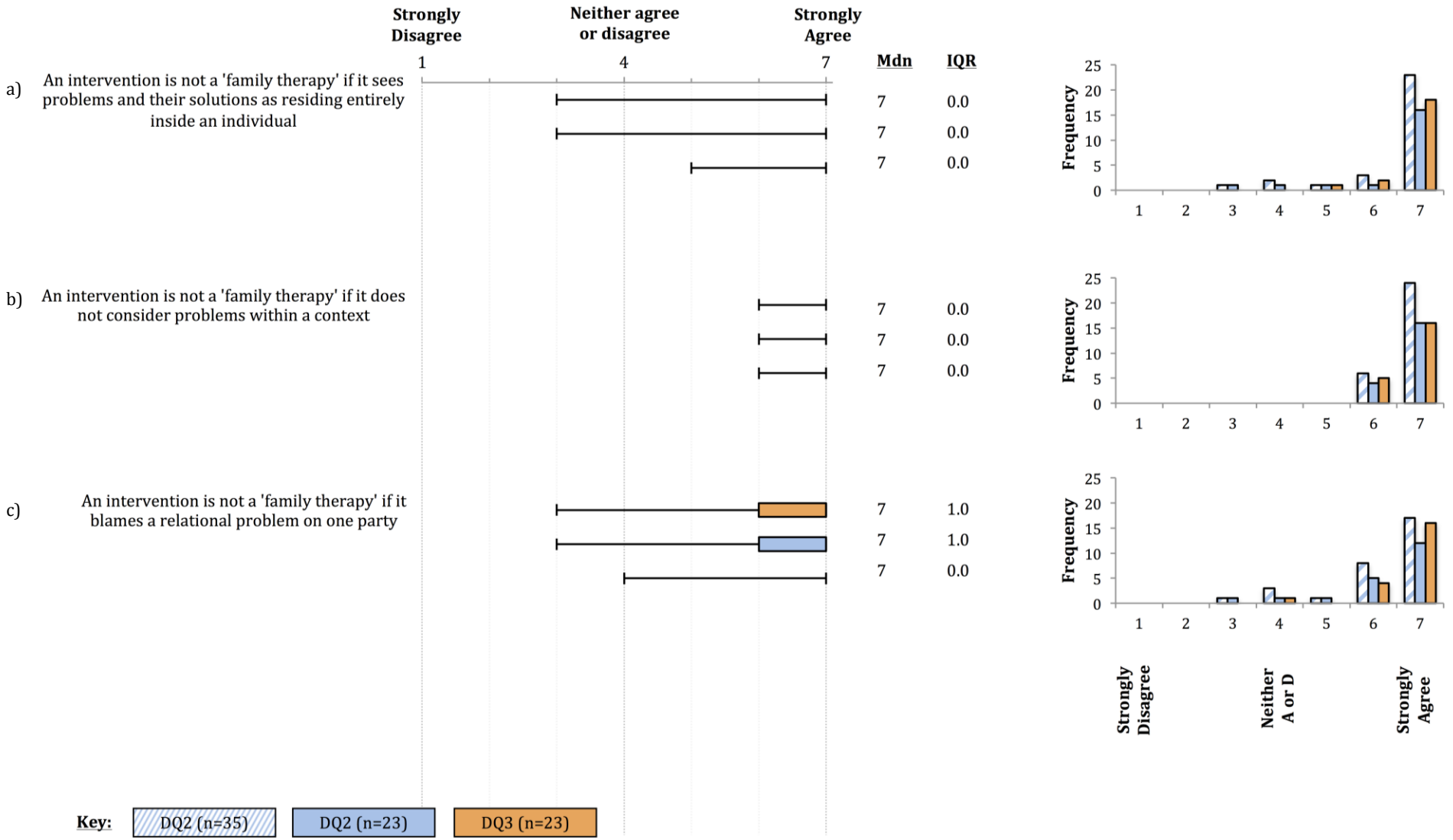


Figure 4.6. Exclusion Criteria: Items identified as controversial

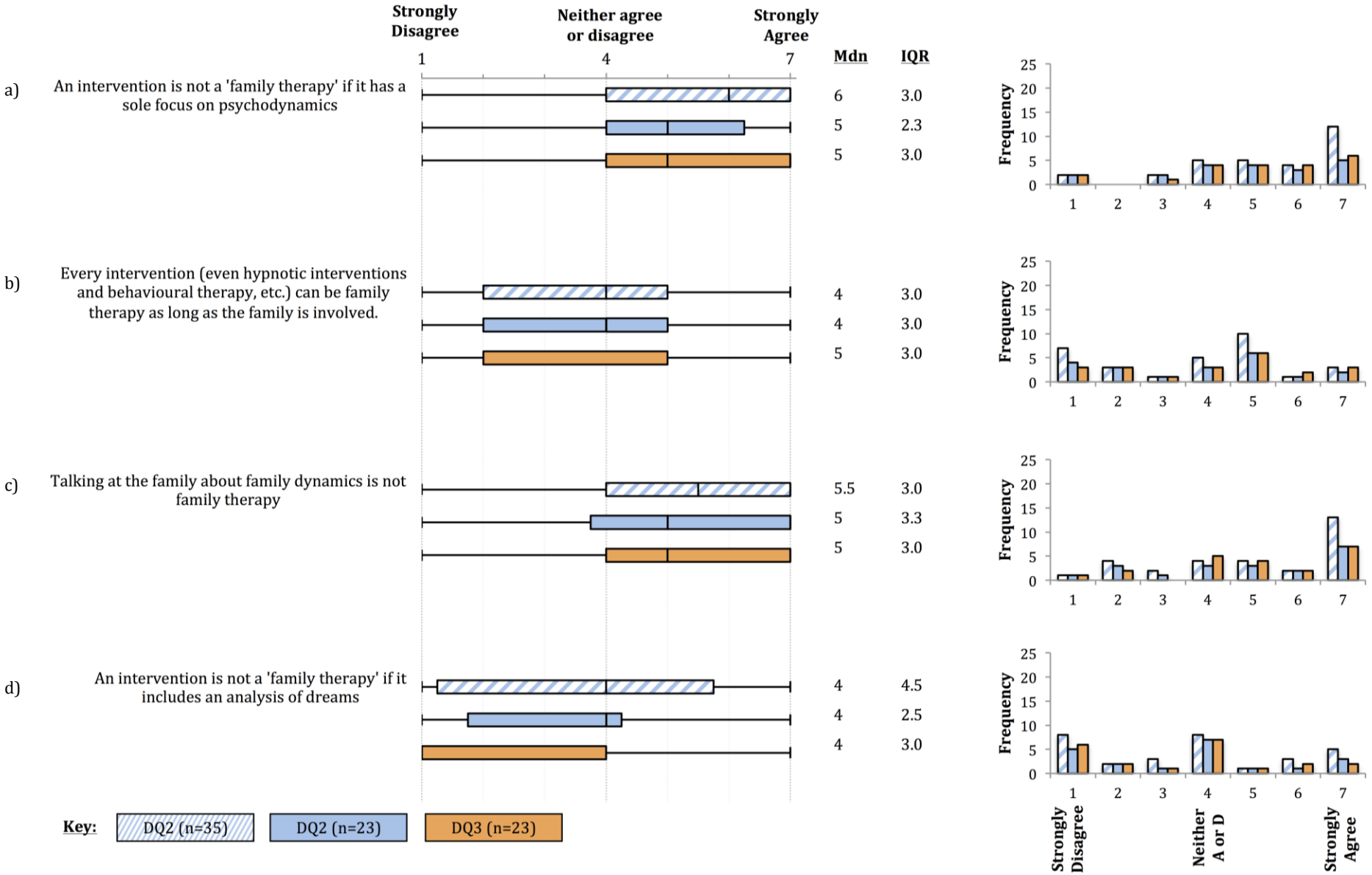


Figure 4.6. Exclusion Criteria: Items identified as controversial (continued)

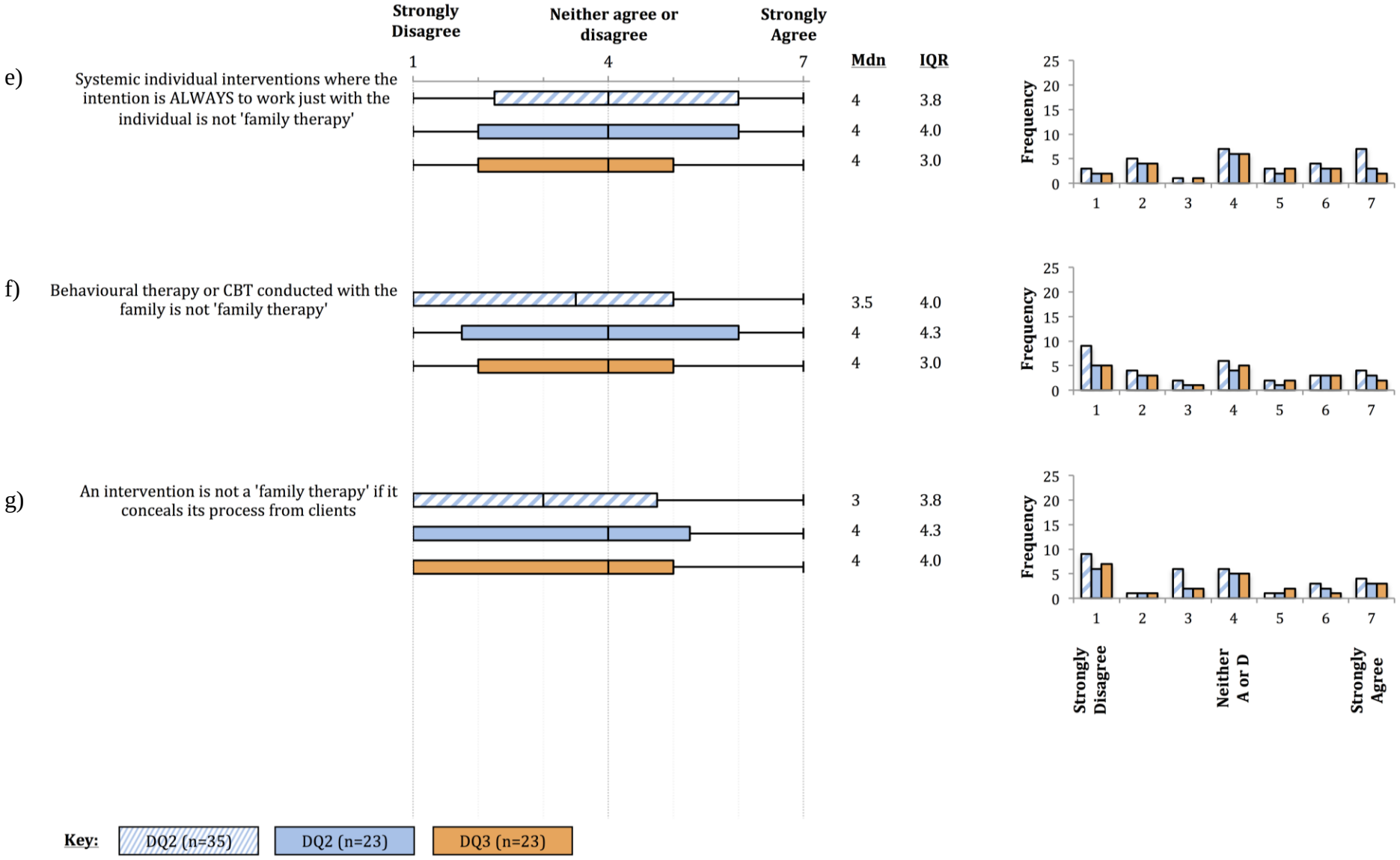


Figure 4.7. Classifications of family therapy with consensus opinion as most useful

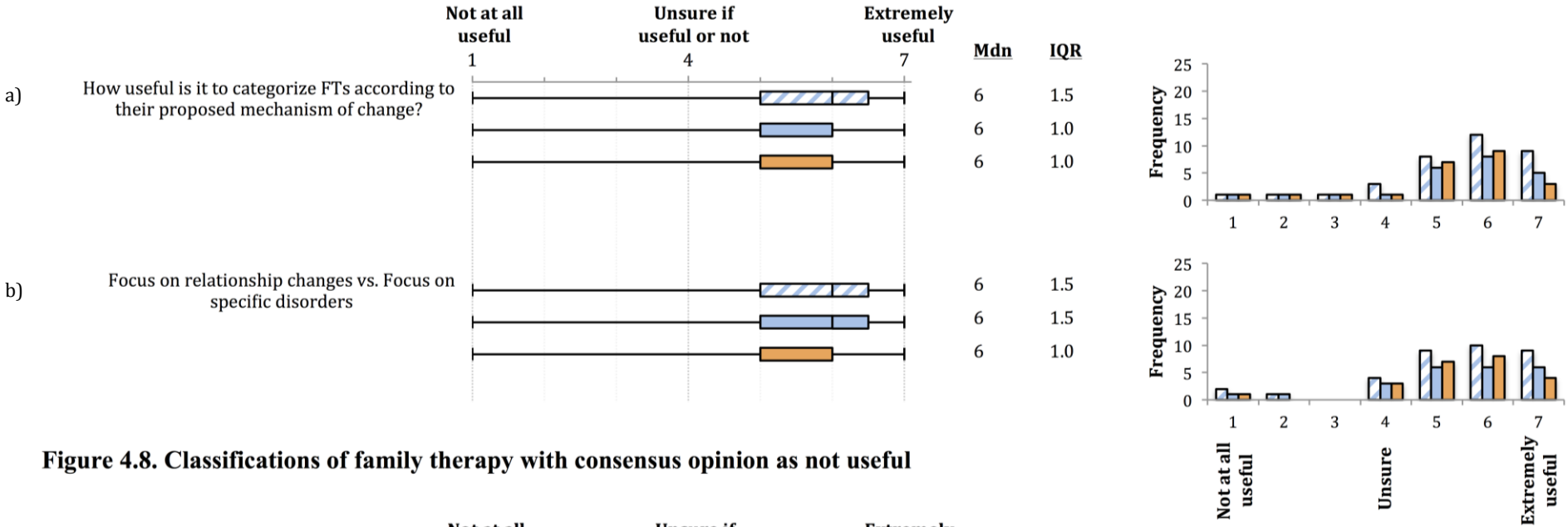


Figure 4.8. Classifications of family therapy with consensus opinion as not useful

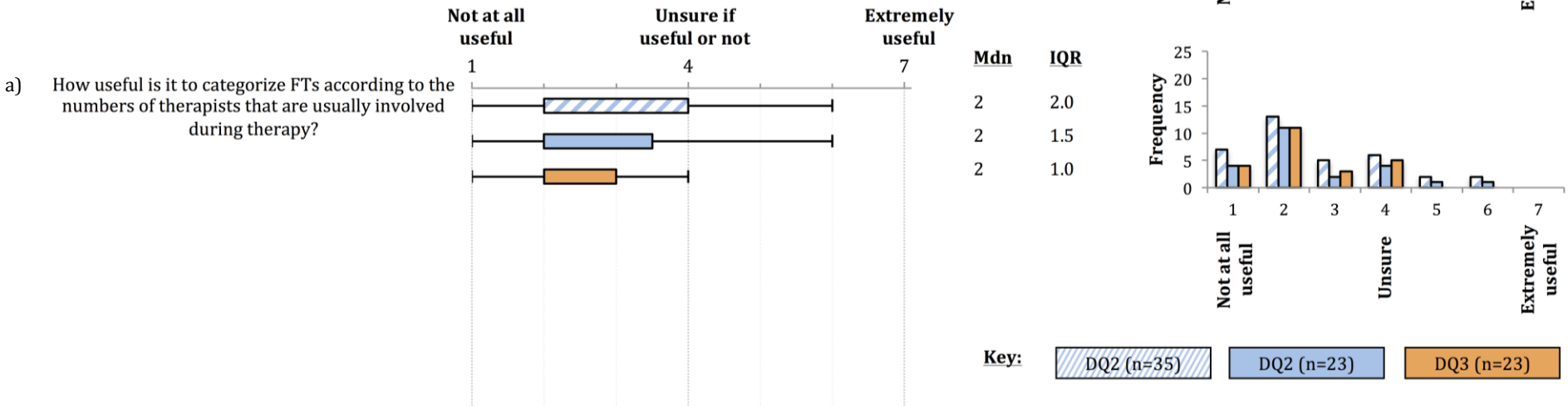
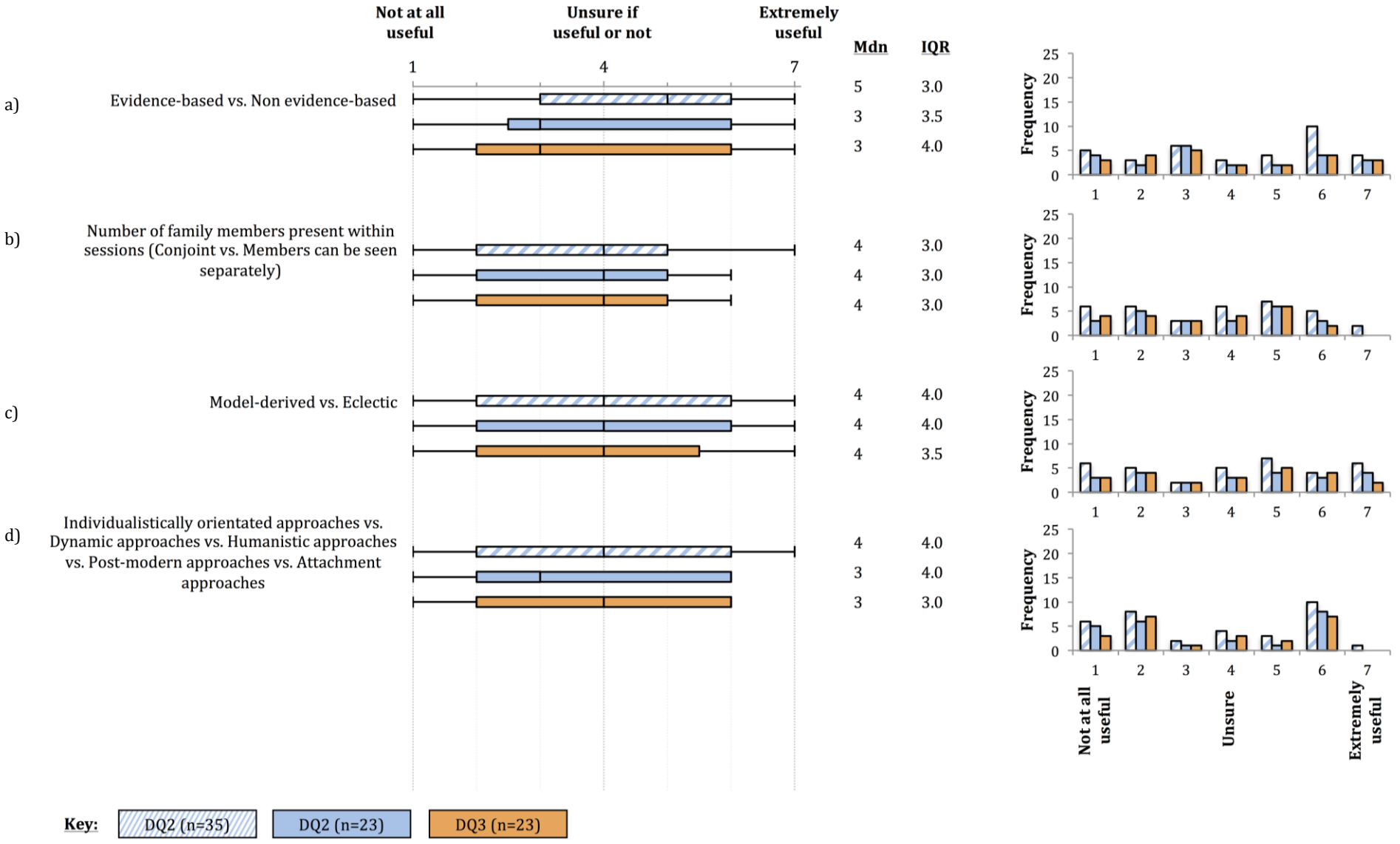


Figure 4.9. Classifications of family therapy identified as controversial



4.8 Final profile of consensus items

A final profile of items for inclusion, exclusion and classification is displayed in table 7 below. As can be seen from this final profile, only two elements considered as essential to family therapy were also seen as unique to the field.

Table 4.13 Final profile of consensus items

Item and Category	Unique to FT?
Inclusion Criteria (Essential Elements of Family Therapy)	
A systemic conceptualisation of the problem	✓
The idea that problems are treated by changing the way the system works, rather than fixing a specific member	✓
A view that the resources for change reside in the individuals who attend therapy, and in their relationships with others	**?**
The idea that all behaviour communicates something about its context	**?**
Hypotheses that include all family members	**?**
Attempts to connect behaviours to a context	✗
A focus on relationships	**?**
A focus on context	**?**
A focus on shared meanings between people as part of a system	**?**
A therapist who is trained in family therapy, rather than simply applying a manualised version without being skilled at this general style of therapy	**?**
A therapist who can take account of his/her impact on the system	**?**
Inclusion Criteria (Non-essential, but unique to family therapy)	
An influence from the core traditions of family therapy	✓
A reflecting team	✓
Use of circular questioning	✓
Exclusion Criteria	
An intervention is not family therapy if it sees problems as residing entirely inside an individual	N/A
An intervention is not family therapy if it does not consider problems within a context	N/A
An intervention is not family therapy if it blames a relational problem on one party	N/A
Most useful Classification Criteria/Comparisons	
Classification of family therapies by proposed mechanism of change	N/A
Family therapies that focus on relationships vs. Family therapies that focus on specific disorders	N/A

✓ = consensus that element is unique to family therapy; ✗ = consensus that element is not unique to family therapy; **?** = no consensus achieved regarding uniqueness to family therapy

5. DISCUSSION

The current project set out to explore whether experts could agree on a definition and classification of family therapy for comparing different approaches from the literature. The question was addressed with a Delphi study, aimed at identifying the essential, unique and proscribed elements of family therapy, to inform a contemporary definition of the term. The study also attempted to highlight useful classifications of the field, so that a tool could be developed to aid the selection of studies for systematic reviews. Due to the broad nature of ideas put forward by experts, it was not possible to assemble a specific tool for these purposes. However, the Delphi process did generate a consensus profile for family therapy, along with some potentially useful ways of categorising the field. These are discussed in relation to the literature, along with implications for research and practice.

5.1 Definition of family therapy

The final profile of family therapy highlighted a set of essential theories, principles for practice, and aspects of therapists' training. There was no consensus regarding the participants in therapy or the format of sessions, and no consensus on specific therapeutic techniques that should be proscribed from family therapy. Five unique elements were associated with the field, but only two of these were considered as essential features by the expert panel.

The consensus profile contains some similarities with early views of family therapy. An emphasis on a systemic formulation of problems and solutions seems to have survived from the 1950's and 1960's, when family therapists saw these ideas as departing radically from the psychotherapeutic approaches of the time (e.g., Mottola, 1967). The fact that these elements were identified as unique to the field, suggests that they still form the bedrock of current definitions.

Ideas stemming from later phases of the field's development are also emphasised, such as the need for therapists to be aware of their influence on the system. However, unlike some authors, who defined family therapy by conjoint sessions (e.g., Levant, 1980), there are no stipulations regarding participants'

involvement or the format of therapy, and so the current profile is broader than early definitions in these respects.

On the other hand, the profile is narrower than definitions found in many texts and systematic reviews of the last twenty years. Several authoritative texts, outlined in chapters 1 and 2, have considered any intervention that features family members to be family therapy (e.g., Gurman & Kniskern, 1981). These definitions have also informed comprehensive reviews of the literature, outlining the effectiveness of therapies (e.g., Carr, 2009a, b). However, it is likely that a substantial proportion of interventions included under the umbrella of 'family therapy' in these reviews would not meet all the essential elements outlined in the final profile.

In fact, the issue of who needs to participate in a family therapy proved to be particularly contentious. Experts were split in their opinions on three items: 1) Whether or not any intervention could be a family therapy by virtue of involving other family members? 2) Whether or not family therapy requires the attendance of at least two family members at some point during the intervention? And, 3) Whether or not systemic individual interventions are a form of family therapy? In relation to the first question, several experts provided impassioned replies in the follow-up questionnaire, stating that the inclusion of all interventions involving family members risked undermining family therapy's claim to be a coherent approach. In contrast, others suggested that sufficiently broad definitions were required for reviews, to ensure that all potentially relevant interventions are identified to inform the evidence-base.

Some experts argued that relational change was possible when working with just an individual. And, since this was the imperative of family therapy, interventions should not be excluded from the definition on the basis that no other family members were in attendance. This would also ignore the fact that it was not always possible, or appropriate, to engage the wider family in therapy, especially when interpersonal dynamics were challenging. These views are supported by the literature where researchers have started to evaluate family therapy conducted in different formats: for instance, Eisler et al. (2000) compared 'conjoint family therapy' with 'separated family therapy', where individuals were seen separately.

Studies such as this indicate that items 2) and 3) would not be acceptable criteria for defining the field. However, one respondent insisted, *"the involvement of family members should be the great preponderance of sessions…[for an intervention to be recognised as a family therapy]."* This seemed to capture a sentiment that the distinction between individual and family therapy was important and needed to be upheld, regardless of the therapeutic orientation.

What is clear from findings is that the number of participants remains a controversial issue, with implications for the selection of studies in systematic reviews. A proportion of family therapists may see the exclusion of certain individual interventions from reviews as ultimately limiting the evidence-base. On the other hand, there are concerns that taking an overly inclusive approach would dilute the usefulness of findings and risk devaluing the field.

In terms of practice details, experts agreed on several essential elements relating to how family therapy is conducted, however, these were not well defined. For example, although the panel considered it essential to have *"hypotheses that include all family members"*, it was unclear how these should be incorporated into interventions. For example, there is no indication on whether hypotheses should be shared with participants during sessions, or whether it is sufficient for therapists to entertain hypotheses to guide their work, without explicitly acknowledging them with family members. Likewise, there was no consensus over the format of interventions, or essential techniques that would constitute *"a focus"* on relationships, contexts or shared meanings between people. Two specific practices (the use of a reflecting team and circular questions) were deemed unique to the field. But perhaps it is a sign of the increasing diversity of family therapy that neither was seen as essential.

Meanwhile, several techniques were deemed especially controversial, such as the use of reflexive and circular questioning. One expert suggested that although these techniques were historically associated with systemic therapy, they have become signs of good practice across many psychological interventions. Consequently, they should be considered an essential component of all family therapy. By contrast, others saw circular and reflexive questioning as associated

with specific family therapy approaches, but not as a universal feature across the field.

So, despite consensus on a number of elements relating to practice, these tended to be poorly specified, and are perhaps best described as essential principles underlying the practice of family therapy. Experts did not agree on any essential techniques or format to sessions, and there was considerable controversy regarding the use of reflexive and circular questions. These findings perhaps reflect a difficulty in reconciling the diverse types of intervention, and suggest the need to maintain a loose definition in this area. One implication is that some inclusion criteria that have been adopted by reviewers are too restrictive. For example, Henken and colleagues' systematic review of family therapy for depression only considered interventions that featured phases of assessment, psychoeducation, and interventions aimed at improving functioning in cognitive, affective and interpersonal domains (Henken et al., 2009). Such specific criteria regarding the format of therapy are unlikely to do justice to the range of family therapies available in the literature.

An interesting finding was that experts considered it essential for family therapies to be delivered by trained family therapists, rather than by practitioners adhering to a manualised treatment, without formal skills in that style of therapy. It is not uncommon for interventions in randomised controlled trials to be delivered by psychology graduates, or other personnel without qualifications in family therapy: such trials would not fit the profile developed from consensus. This suggests that some family therapists may be sceptical about published research that does not employ practitioners with a background in the field. At the same time, it is rare for systematic reviews to take into account the training of therapists. Of the 9 systematic reviews on family therapy located from the Cochrane database, only the reviews of Henken et al. (2009) and Yorke & Shuldham (2009) outlined a requirement for interventions to be delivered by qualified family therapists in their inclusion criteria. The findings of the present study suggest that prospective reviewers may want to attend to this aspect in future.

5.2 Exclusions from the definition of family therapy

The low number of initial ideas generated for exclusion criteria suggests that the panel had difficulty in identifying elements that should be proscribed from family therapy. Instead, final consensus items tended to reaffirm the systemic bases of family therapy outlined in the first part of the questionnaire. This provides some evidence for the internal consistency of the study. However, it may also reflect openness to new practices, such that none could be readily excluded from a current definition.

Despite this, a number of ideas concerning exclusion criteria divided the opinion of the panel. In particular, there was low consensus over the proposal for CBT that involves family members, to be defined as a 'family-based intervention', rather than a 'family therapy'. Experts who agreed with the proposition cited the need to protect the boundaries of family therapy from interventions that have emerged from altogether different traditions. However, a counter argument was that family-based CBT is similar to systemic practice in many ways, for example, in its ability to address relationships and its focus on patterns of interaction. In fact, the difficulty in discerning CBT from family therapy has already been highlighted by Cottrell (2003), who provided a list of elements common to both modalities.

The controversy surrounding proscribed practices overlaps with the earlier observation regarding participants in therapy. The main dilemma seems to be a fear that family therapy will be devalued when overly inclusive definitions are adopted, versus the potential limiting of the field's development when definitions are too strict. It is uncertain whether these points of view can ever be reconciled, but perhaps the closing comments of one expert offers some advance on this debate:

> *"What matters is the function of any intervention, not its form, i.e, what it looks like or where (in the broader field of psychotherapy) it comes from. And it is not the involvement of the family that matters, i.e., their mere presence, it is the effect of the intervention carried out in their presence. This is a truly contextual definition of family versus non-family [therapy]." (Expert 1001)*

5.3 Classification of family therapy

Experts generated many ideas for how the field could be classified for comparison, but only two suggestions attained consensus as useful: a categorisation based on mechanisms of change and a categorisation based on the focus of intervention (family therapy focusing on relationships versus family therapy focusing on specific disorders).

The emphasis on mechanisms of change resonates with original attempts to classify the field by the theoretical underpinnings of therapy, which lost popularity during the late 1960s and 1970s. However, there was little agreement about what the specific mechanisms or major categories of change should be, despite a plethora of ideas from experts (e.g., cognitive versus experiential, modern versus post-modern). Furthermore, the classical distinction between systemic and psychodynamic models, which had formed the basis of early schemas (e.g., GAP, 1970), was considered to be of limited use. As one expert suggested, it is likely that the integration of ideas in clinical practice has blurred the boundaries between models. Consequently, family therapists may see little point in redrawing these boundaries when filtering the literature.

Moreover, the findings highlight the persistent challenges that confront reviewers when deciding how to categorise family therapy by their theoretical underpinnings, and it is no surprise that Cochrane reviews have failed to establish consistent groupings (see chapter 2). Although one expert seemed convinced that *"classification [by theoretical model] will always be arbitrary"* future efforts would need to clarify this issue. Even if experts cannot agree on major mechanisms using consensus-building studies, empirical approaches,such as Levant's 'qualitative factor analysis' may still be useful (Levant, 1980).

The only other classification deemed as useful was the differentiation of family therapy aimed at specific disorders, from family therapy with a relationship focus. An example of the former is the Maudsley Approach (Dare, 1985; Rhodes, 2003), a structured programme developed specifically for treating adolescents with anorexia nervosa. The latter category would, presumably, include traditional approaches, e.g., structural, strategic and systemic family therapies, which do not target a particular diagnosis. So far, these types of comparison seem to have been

overlooked by reviewers, and none of the Cochrane reviews on family therapy have utilized these categories.

Nevertheless, there seems to be a general trend towards developing specific therapies for specific disorders, as evident through the growing number of studies and training programmes targeting a range of diagnoses. The SHIFT project (http://www.hta.ac.uk/1733) is an example of an RCT, in which the treatment arm uses a systemic family therapy manual, with components tailored specifically towards the management of self-harm. Similar RCTs have evaluated well-defined psychoeducational family therapies developed especially for the treatment of psychosis (for a review see Pitschel-Walz et al., 2001). The success of these trials has led to several leading universities in the UK offering training in family-based interventions for psychosis (e.g., masters degrees in psychosocial interventions for psychosis at the University of Manchester and Kings College London). These courses aim to induct practitioners into particular forms of family therapy that have been adapted for narrow populations. Whilst these types of intervention may be very effective, the current findings suggest that family therapists are eager to evaluate how they compare with more generic or traditional types of family therapy.

There was no consensus support for remaining classifications of the field, including several contemporary schema found in the literature. In particular, experts could not agree on the usefulness of the triadic model by Carr (2006) (focus on predisposing factors, focus on constraining beliefs/narratives and focus on problem-maintaining behaviour patterns), Levant's (1980) model (focus on historical, focus on structure and focus on experiential) or the distinction between first-order versus second-order therapies, which is frequently cited in introductory textbooks (e.g., Dallos & Draper, 2010). However, this does not rule out the possibility that family therapists might still find these classifications useful for other purposes, such as for teaching, as acknowledged by a couple of respondents in the Delphi survey.

It was notable that many ideas for categorising family therapy centred on the format and also technical aspects of interventions, e.g., unimodal versus multimodal therapy, brief versus extended therapy, etc. Perhaps this reflects a curiosity about the effectiveness of widespread practices. Classification by these aspects may also

appeal those, who see it as less useful, or less desirable, to distinguish current family therapies by theory alone.

Unfortunately, only a few follow-up comments were received regarding the most controversial ideas for classification. Several comments were simply a reiteration of the expert's opinion about the usefulness of the idea. However, one expert pointed out that certain categorisations seemed ambiguous (e.g., individualistically orientated approaches, dynamic approaches, humanistic approaches, post-modern approaches, attachment approaches) which meant that it was difficult for them to rate the item. Another expert also questioned the usefulness of splitting family therapy into those that are evidence-based versus those that are not, on the basis that much depended on what constituted 'evidence'. These results imply that a range of factors might have influenced ratings on these items, including confusion about categories and insufficient detail.

Lastly, it was interesting to receive responses from individuals, who thought that classification was unnecessary. One expert suggested that that the field was becoming more integrated and that there were many commonalities between approaches. Thus, an emphasis on difference would not be useful for informing practice. There is an irony here, considering that family therapists are generally curious about difference, and believe that difference provides valuable information that can catalyse change (Brown, 1997). Whilst there are indeed many common factors between therapies, the number of new family therapy approaches is still expanding. It could be argued that classification is necessary, *precisely* because it allows commonalities to be appreciated and evaluated.

5.4 Limitations

In recruiting experts for the current study, a difficult balance needed to be struck between depth of knowledge (e.g., years of experience in the field) and breadth (e.g., international representation and familiarity with a wide-range of family therapy approaches). Despite inviting experts from parts of Asia, South America and Africa, no responses were returned from these areas. Thus, it is possible that some culturally specific views of family therapy may have been overlooked.

One of the advantages of using Delphi is that it focused experts onto the most relevant material for the purpose of consensus development. However, the process also sacrificed some diversity in opinion. For the majority of items, experts expressed views across the range of the rating scales. Thus, even in areas where consensus was attained, there were opposing opinions. In addition, some individuals used the free response sections to provide their thoughts *around* the issue of classification and definition, rather than to answer the question directly. Although these issues may be pertinent to the field, it was not possible to explore all of these within the design of the current study due to resource constraints.

At the start of the project, it was hoped that a specific tool could be assembled from the Delphi exercise, which would aid the selection of studies for systematic reviews. However, a decision was taken not to pursue this, as many of the concepts achieving consensus were extremely broad and, thus open to interpretation. Before concepts can be operationalised, future work would need to address how they can be reliably defined for the appraisal of interventions described in the literature. For example, what does a focus on context look like? And how much focus does there need to be? Is it enough just to recognise that the problem may be affected by the immediate social context, or does there need to be detailed consideration for wider social and political contexts?

5.5 Strengths

The final profile of family therapy was derived from the consensus of a group of diverse family therapists. Thus, the resulting definition is likely to be more acceptable for the wider field than a priori definitions used by historical reviews (e.g. Shadish et al. 1993). The Delphi process also allowed experts to generate ideas informed by their own clinical and research experience. This has the advantage of tapping into knowledge, which may not be articulated in published material.

Furthermore, the Delphi design was a relatively efficient approach, especially when considering the diversity of the field: other qualitative methods might have involved collating a great range of manuals, articles and research protocols for analysis. This would have been unfeasible in the timescale of the current project.

The validity of the Delphi method was supported by the nature of responses from the panel. Many experts changed their ratings in light of new information from the group. Whilst some items moved towards consensus during iterative rounds, there was evidence of increasing diversity of opinion on other items. Therefore, it was unlikely that experts were merely conforming to the majority opinion. Instead, experts appeared to carefully re-evaluate their opinions. This was supported by the replies of several participants, who commented on how thought provoking they had found the process. These observations affirm the suitability of the Delphi design for exploring the current topic.

5.6 Implications

The findings from this study open up several potential avenues for future research. With regard to developing a tool for systematic reviews, researchers would need to clarify how the broadest concepts can be operationalized. Similarly, researchers should attempt to identify the major mechanisms of change that underlie family therapies to help develop a meaningful classification. There is no reason to believe that similar consensus-building methods could not be used for these purposes, as the study has shown that senior family therapists are willing to engage in the Delphi process, despite heavy pressures on their time. However, researchers need to be wary of potential attrition across rounds and consider methods for minimising this.

Several areas of controversy that emerged during the study could be explored in greater detail. In particular, it would be helpful to elicit further perspectives about who participates in family therapy, and what types of practice should be excluded from the field. Delphi designs that allow opposing arguments to be presented in quantitative *and* qualitative form may assist in the development of consensus by exposing experts to a variety of viewpoints for consideration.

Although the study emphasised the importance of consistent definitions for systematic reviews, there are implications for practice. Ultimately, it is hoped that reviewers will adopt the consensus profile to produce reports with greater appeal and relevance to practitioners. This would enable family therapists to make better use of the literature to inform their work in clinical settings, and inspire them to develop new approaches using the evidence-base.

It is hoped that reviews based on a consensus definition and classification of family therapy would help elucidate useful differences and similarities in the effectiveness of interventions. Whilst this pursuit may be seen as unnecessary by some family therapists, there is also an ethical argument for it. The flexibility of family therapy training allows highly skilled practitioners to adjust their work according to the families they see. If it is shown that some ways of working are more effective for certain conditions, family therapists have an ethical responsibility to contemplate these methods in their practice, to better meet the needs of families seeking help.

5.7 Recommendations

- Although it was not possible to create a specific tool, reviewers interested in reviewing the evidence-base on the effectiveness of family therapy for specific disorders may nevertheless want to refer to the final profile as a checklist to guide the selection of studies.

- What is apparent is that one cannot select studies for review, based on how interventions are labeled. Reviewers should take an inclusive approach to ensure interventions that would qualify as family therapy (according to the profile) are not omitted.

- Reviews should continue to group family therapies by their intended mechanisms of change for comparison. However, researchers would need to clarify what the major mechanisms of change are. This could be achieved by adopting consensus-building designs such as Delphi, or by other empirical methods.

- When comparing interventions, systematic reviews should endeavour to evaluate the effectiveness of family therapy focussing on relationships versus family therapy tailored to the specific disorder.

- Finally, the adequate definition of interventions is only one element for creating better systematic reviews (Centre for Systematic Reviews, 2009). Even if family therapy is well defined, much depends on how well interventions are described by authors, so that they can be properly appraised

against any definition. To help with this, reviews of family therapy should be conducted with input from trained family therapists.

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APPENDIX A

A.1 Invitation Email

Dear Sir/Madam,

We would like to ask for your help in our study, which we hope is of significant interest to researchers of Family Therapy. We are aware from our own attempts to review the literature that there is much controversy over the types of interventions that reviewers consider as Family Therapy. We believe that there is a need to develop a more evidence-based definition of the field, to promote more rigorous reviews of the literature and aid clinical decision-making.

We are asking experts in the field to share their opinions on this issue for our study. Each of the three questionnaires that comprise the study will take no more than 30-45 minutes of your time.

The study uses a Delphi technique, which allows experts to share opinions anonymously with each other, in order to establish group consensus. The technique is a time-saving method that also reduces the pressure for conformity. Your participation in the current research as an expert in the field of Family Therapy will be greatly appreciated. As a token of our appreciation, a summary of the findings will be sent to you at the end.

Your opinions will help to clarify the types of Family Therapy and their definitions in current practice and how they might be similar or different from each other. You can access the participant information for further details of the study via the link below. We hope you will take the opportunity be a part of this project in weeks to come and look forward to your response.

To find out more and to take part in the study, please visit:

www.familytherapystudy.com

Yours sincerely,
Gary Lee & Prof. David Cottrell
University of Leeds, UK
(umgl@leeds.ac.uk)

APPENDIX A

A.2 Proforma Questions

The following questions ask about your level of expertise in Family Therapy. The information you provide on this page will not be fedback to the expert group.

1. What type of Family Therapy would you consider yourself most familiar with (e.g., Systemic FT, Multisystemic FT, Psychoeducational, Parenting Programmes, Milan, Narrative FT, etc.) (Maximum 3)

2. For how many years have you researched or provided training in your area Family Therapy?

3. Please indicate the number of articles you have authored on the topic of Family Therapy

4. Please indicate the number of conference addresses you have given on the topic of Family Therapy

5. Do you have any specific Family Therapy qualifications (select option: Licensing level only, Licensing level +PhD in family therapy)

6. Are you involved in providing teaching for Family Therapists? If so, please indicate what type a) classroom teaching b) live supervision c) both

APPENDIX B

B.1 Delphi Questionnaire 2 (Online Form)

Family Therapy Study
Delphi Questionnaire 2

This questionnaire summarises the ideas from an initial survey completed by a panel of 27 international experts on family therapy. Your responses in this part of the study will allow us to gain some information about the level of consensus amongst experts on these ideas.

There are three sections to the questionnaire: **A) Distinctions between Family Therapies, B) Inclusion Criteria, C) Exclusion Criteria.**

We have retained the original wording from experts as far as possible, which means that some questions may seem repetitive. However, we would still appreciate your opinions on these questions.

You can save your answers at any point by clicking on 'Save and continue survey later' at the top of each page and return to the questionnaire by signing-in with your email address

Please supply an email address so we can send you confirmation of receipt (we will not share your email address with third parties) *

Email: _____

Section A: Distinctions between Family Therapies

Experts put forward the following ideas when asked about the most important ways to categorise the field of family therapy. We would like to get your views on how useful these suggestions might be if they were applied to the literature, for the purpose of evaluating the effectiveness of different family therapies (or their components).

PTO

In your opinion, how useful are the following distinctions for comparing the effectiveness of different family therapies from the literature?

Classical/Theoretical Distinctions

Please use the following rating guide for your answers: 1 = Not at all useful, 4=Unsure if useful or not, 7 = Extremely useful

	Not at all useful (1)	(2)	(3)	Unsure if useful or not (4)	(5)	(6)	Extr. useful (7)
First order cybernetic vs. Second order cybernetic	○	○	○	○	○	○	○
Modern vs. Post-modern	○	○	○	○	○	○	○
Modern vs. Post-modern vs. Integrated	○	○	○	○	○	○	○
Modern vs. Post-modern vs. Post- structural	○	○	○	○	○	○	○
Model-derived vs. Eclectic	○	○	○	○	○	○	○
Systems-focused vs. Non systems- focused	○	○	○	○	○	○	○
Systems/structural vs. Psychoanalytic	○	○	○	○	○	○	○
Evidence-based vs. Non evidence- based	○	○	○	○	○	○	○
Focus on predisposing, historical, contextual and constitutional factors vs. Focus on belief systems and narratives vs. Focus on problem maintaining behaviour patterns	○	○	○	○	○	○	○
Focus on the historical vs. Focus on structure/process vs. Focus on the experiential	○	○	○	○	○	○	○
Individualistically orientated approaches vs. Dynamic vs. Humanistic vs. Post- modern vs. Attachment	○	○	○	○	○	○	○
How useful is it to categorize FTs according to their proposed mechanism of change?	○	○	○	○	○	○	○

Distinctions Based on Practice

Please use the following rating guide for your answers: 1 = Not at all useful, 4=Unsure if useful or not, 7 = Extremely useful

	Not at all useful (1)	(2)	(3)	Unsure if useful or not (4)	(5)	(6)	Extr. useful (7)
Focus on relationship changes vs. Focus on specific disorders	○	○	○	○	○	○	○
Parent-infant therapy vs. Child- focused vs. Adolescent therapy vs. Adult therapy	○	○	○	○	○	○	○
Focus on looking forward vs. Focus on looking back in order to look forward	○	○	○	○	○	○	○
Length of therapy (Brief vs. Extended)	○	○	○	○	○	○	○
How useful is it to categorize FTs according to the numbers of therapists that are usually involved during therapy?	○	○	○	○	○	○	○
Directive (e.g., Structural, Strategic) vs. Collaborative (e.g., Sol.focused, Narrative)	○	○	○	○	○	○	○
Single family therapy vs. Multiple family therapy	○	○	○	○	○	○	○
Number of family members present within sessions (Conjoint vs. Members can be seen separately)	○	○	○	○	○	○	○
Unimodal (FT as standalone treatment) vs. Multimodal (FT in addition to other treatments, e.g., medical, social, etc.)	○	○	○	○	○	○	○
Focus on emotional interchanges vs. Cognitive or behavioural interchanges	○	○	○	○	○	○	○
Interventions that allow therapist to adopt different models vs. Single model	○	○	○	○	○	○	○
How useful is it to categorize FTs according to the types of questions asked by the therapist?	○	○	○	○	○	○	○
How useful is it to categorize FTs according to the ‘position’ that the therapist adopts during therapy?	○	○	○	○	○	○	○
How useful is it to categorize FTs according to how the sessions are usually structured?	○	○	○	○	○	○	○

Inclusion Criteria

Section B: Inclusion Criteria

Experts provided many ideas in response to our initial question: “What must an intervention include if it is to be considered a type of family therapy?” These ideas are presented in the next section in the form of statements. We would like you to consider two questions when approaching each statement in this section:

a) To what extent do you agree or disagree that it is essential for an intervention to include this element to be called a ‘family therapy’?
b) Is this element unique to ‘family therapy’?

Your rating for a) should reflect the degree of certainty/conviction with your answer. The lowest, middle and highest ratings are defined here:

***1 = Strongly Disagree** - You are definitely sure that an intervention can still be a 'family therapy' without this element, i.e. you consider this a non-essential feature of ‘family therapy’*

***4 = Neither agree or disagree -** You are unsure if it is essential or not for an intervention to include this element to be considered a 'family therapy.'*

***7 = Strongly Agree -** You are definitely sure that this element is essential to a ‘family therapy’, i.e. you are convinced that an intervention cannot be a form of ‘family therapy’ in the absence of this element*

Examples:
If you think that X is desirable in a 'family therapy', but definitely not an essential feature, you would give a rating of 1. If you think that Y is probably essential to a 'family therapy', but you are not completely certain, you would give a rating 5 or 6.

Theoretical Elements

	a) To what extent do you agree/disagree that it is essential for an intervention to include this element to be a FT? *							b) Is this unique to FTs? *		
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	Yes	No	Unsure
A systemic conceptualisation of the problem	○	○	○	○	○	○	○	○	○	○
A view that the resources for change reside in the individuals who attend therapy, and in their relationships with others	○	○	○	○	○	○	○	○	○	○
An influence from the core traditions of family therapy, e.g. structural, systemic, narrative, Bowen, strategic.	○	○	○	○	○	○	○	○	○	○
The idea that problems are treated by changing the way the system works rather than trying to fix a specific member	○	○	○	○	○	○	○	○	○	○
The idea that instructive interactions (prescriptions) are less effective than a collaborative approach	○	○	○	○	○	○	○	○	○	○
The idea that all behaviour communicates something about its context	○	○	○	○	○	○	○	○	○	○
Non-blaming or non- pathologising formulations or conceptualisations	○	○	○	○	○	○	○	○	○	○

Elements Relating to Participants' Involvement

1 = Strongly Disagree *- You are definitely sure that an intervention can still be a 'family therapy' without this element, i.e. you consider this a non-essential feature of 'family therapy'*

4 = Neither agree or disagree - *You are unsure if it is essential or not for an intervention to include this element to be considered a 'family therapy.'*

7 = Strongly Agree - *You are definitely sure that this element is essential to a 'family therapy', i.e. you are convinced that an intervention cannot be a form of 'family therapy' in the absence of this element*

	a) To what extent do you agree/disagree that it is essential for an intervention to include this element to be a FT? *							b) Is this unique to FTs? *		
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	Yes	No	Unsure
An effort to engage at least two members of a family at some point during therapy	○	○	○	○	○	○	○	○	○	○
The actual involvement of at least two members of a family at some point during therapy	○	○	○	○	○	○	○	○	○	○
An effort to engage the whole family in the therapy	○	○	○	○	○	○	○	○	○	○
Hypotheses that include all family members	○	○	○	○	○	○	○	○	○	○
At least one participant who is concerned about his/her relationship with another family member	○	○	○	○	○	○	○	○	○	○
An effort to engage at least two members of a family at some point during therapy	○	○	○	○	○	○	○	○	○	○
The actual involvement of at least two members of a family at some point during therapy	○	○	○	○	○	○	○	○	○	○

Therapy Techniques

1 = Strongly Disagree *- You are definitely sure that an intervention can still be a 'family therapy' without this element, i.e. you consider this a non-essential feature of 'family therapy'*

4 = Neither agree or disagree - *You are unsure if it is essential or not for an intervention to include this element to be considered a 'family therapy.'*

7 = Strongly Agree - *You are definitely sure that this element is essential to a 'family therapy', i.e. you are convinced that an intervention cannot be a form of 'family therapy' in the absence of this element*

	a) To what extent do you agree/disagree that it is essential for an intervention to include this element to be a FT? *							b) Is this unique to FTs? *		
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	Yes	No	Unsure
Use of reflexive questions	○	○	○	○	○	○	○	○	○	○
Using a genogram	○	○	○	○	○	○	○	○	○	○
Taking a thorough family history	○	○	○	○	○	○	○	○	○	○
Use of circular questioning	○	○	○	○	○	○	○	○	○	○
Inviting clients to explore patterns and feedback loops	○	○	○	○	○	○	○	○	○	○
Using a strategic approach to conversations and questions	○	○	○	○	○	○	○	○	○	○
Techniques for changing relationships	○	○	○	○	○	○	○	○	○	○
Using questions or coaching to bring about change but not direct advice only	○	○	○	○	○	○	○	○	○	○
Bringing new information into the system that will be helpful or healing for those involved	○	○	○	○	○	○	○	○	○	○
A reflecting team	○	○	○	○	○	○	○	○	○	○
A structural diagnosis and boundary processes	○	○	○	○	○	○	○	○	○	○
Acknowledging the family's struggles and strengths	○	○	○	○	○	○	○	○	○	○
Attempts to connect behaviours to a context	○	○	○	○	○	○	○	○	○	○

Focus of Therapy

1 = Strongly Disagree *- You are definitely sure that an intervention can still be a 'family therapy' without this element, i.e. you consider this a non-essential feature of 'family therapy'*

4 = Neither agree or disagree - *You are unsure if it is essential or not for an intervention to include this element to be considered a 'family therapy.'*

7 = Strongly Agree - *You are definitely sure that this element is essential to a 'family therapy', i.e. you are convinced that an intervention cannot be a form of 'family therapy' in the absence of this element*

	a) To what extent do you agree/disagree that it is essential for an intervention to include this element to be a FT? *							b) Is this unique to FTs? *		
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	Yes	No	Unsure
A focus on relationships	○	○	○	○	○	○	○	○	○	○
A focus on context	○	○	○	○	○	○	○	○	○	○
A focus on shared meanings between people	○	○	○	○	○	○	○	○	○	○
A focus on the present & future	○	○	○	○	○	○	○	○	○	○
Exploring effects rather than causes	○	○	○	○	○	○	○	○	○	○
Exploring people's ideas and explanations about the problem	○	○	○	○	○	○	○	○	○	○
Exploring the onset of the problem and its context at that time	○	○	○	○	○	○	○	○	○	○
Evoking and amplifying any changes between sessions, or exceptions described during sessions	○	○	○	○	○	○	○	○	○	○
Exploring restraints to change, such as loyalty to a particular belief	○	○	○	○	○	○	○	○	○	○

Therapist Factors

1 = Strongly Disagree *- You are definitely sure that an intervention can still be a 'family therapy' without this element, i.e. you consider this a non-essential feature of 'family therapy'*

4 = Neither agree or disagree - *You are unsure if it is essential or not for an intervention to include this element to be considered a 'family therapy.'*

7 = Strongly Agree - *You are definitely sure that this element is essential to a 'family therapy', i.e. you are convinced that an intervention cannot be a form of 'family therapy' in the absence of this element*

	a) To what extent do you agree/disagree that it is essential for an intervention to include this element to be a FT? *							b) Is this unique to FTs? *		
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	Yes	No	Unsure
A therapist trained in FT, rather than simply applying a manualised version without being skilled at this general style of therapy	○	○	○	○	○	○	○	○	○	○
A therapist who can manage his/her own anxiety in order to help clients do the same	○	○	○	○	○	○	○	○	○	○
A therapist who takes control of the session to a certain extent	○	○	○	○	○	○	○	○	○	○
A therapist who can take account of his/her impact on the system	○	○	○	○	○	○	○	○	○	○
Positioning of the therapist as non-expert	○	○	○	○	○	○	○	○	○	○
A therapist who can identify and encourage reconciliation between different perspectives of participants	○	○	○	○	○	○	○	○	○	○

Exclusion Criteria

Experts were also asked: *"What must an intervention NOT include if it is to be considered a type of family therapy?"* Their ideas are presented in the next section in the form of statements.

We would like you to rate the extent to which you agree/disagree with each statement.

Your rating should reflect your degree of certainty/conviction with the statement. The lowest, middle and highest ratings are defined here:

1 - Strongly Disagree - *You are definitely sure that the statement is false or not valid*

4 - Neither agree or disagree - *You are unsure whether the statement is true/valid or not*

7 - Strongly Agree *- You are definitely sure that the statement is true or valid*

	Strongly disagree (1)	(2)	(3)	Neither agree disagree (4)	(5)	(6)	Strongly agree (7)
An intervention is not a 'family therapy' if it sees problems and their solutions as residing entirely inside an individual	○	○	○	○	○	○	○
An intervention is not a 'family therapy' if it blames a relational problem on one party	○	○	○	○	○	○	○
An intervention is not a 'family therapy' if it does not consider problems within a context	○	○	○	○	○	○	○
A Rogerian style of counselling is not 'Family Therapy', unless the therapist was trained to think systemically	○	○	○	○	○	○	○
An intervention is not a 'family therapy' if it includes an analysis of dreams	○	○	○	○	○	○	○
An intervention is not a 'family therapy' if it conceals its process from clients	○	○	○	○	○	○	○
Behavioural therapy or CBT conducted with the family is not 'family therapy'	○	○	○	○	○	○	○
Employing a manualised, regimented branded treatment isn't family therapy: Family-based treatment is a better term	○	○	○	○	○	○	○
Every intervention (even hypnotic interventions and behavioural therapy, etc.) can be family therapy as long as the family is involved.	○	○	○	○	○	○	○
An intervention is not a 'family therapy' if it has an exclusive focus on one level of explanation, e.g., the bio, the psycho, or the social.	○	○	○	○	○	○	○
Family sensitive practice is great but not family therapy	○	○	○	○	○	○	○
An intervention is not a 'family therapy' if tasks are only given to one person	○	○	○	○	○	○	○

	Strongly disagree (1)	(2)	(3)	Neither agree disagree (4)	(5)	(6)	Strongly agree (7)
An intervention is not a FT if it involves interpreting symptoms/behaviours solely in relation to past individual trauma	○	○	○	○	○	○	○
An intervention is not a FT if it has a sole focus on intrapsychic aspects	○	○	○	○	○	○	○
An intervention is not a FT if only one person attends sessions over the course of therapy	○	○	○	○	○	○	○
An intervention is not a FT if it uses linear explanations of problems	○	○	○	○	○	○	○
An intervention is not a FT if it has notions about how change and dysfunction comes about	○	○	○	○	○	○	○
An intervention is not a FT if it has a sole focus on psychodynamics	○	○	○	○	○	○	○
Systemic individual interventions where the intention is ALWAYS to work just with the individual is not FT	○	○	○	○	○	○	○
An intervention is not a FT if it involves taking sides	○	○	○	○	○	○	○
Talking at the family about family dynamics is not family therapy	○	○	○	○	○	○	○
An intervention is not a FT if it gives direct specific advice	○	○	○	○	○	○	○
An intervention is not a FT if it the therapist is the 'expert'	○	○	○	○	○	○	○

Please feel free to provide any additional comments, suggestions or modifications to items arising from this questionnaire (optional)

Thank you for completing this second Delphi questionnaire. Once we have received all responses from the expert panel, we will provide you with feedback about the level of consensus amongst experts on these ideas, and you will have the opportunity to adjust your opinions, if you wish.
For further information about the study and to contact us please visit:

www.familytherapystudy.com