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Evidence-Based Treatments in Couple and Family Psychology

Report of the Task Force on Evidence-based Treatments in Family Psychology
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Abstract

The Recommendations for Evidence-based Treatments in Family Psychology, developed by the Division 43 (Family Psychology) Task Force on Evidence-Based Treatments in Couple and Family Psychology, and officially adopted by Division 43, are intended to help identify specific clinical interventions and treatment programs for couples and families according to their level of demonstrable absolute, relative, and contextual efficacy. The guidelines propose a three-tiered levels-of-evidence based scale that moves from broad (“evidence informed”), to specific (“evidence-based”), to “evidence based and ready for dissemination and transportation” within diverse community settings. The levels of evidence scale at the center of the Division 43 recommendations asserts that the most desirable treatments are those that provide have systematic models, with the most specific evidence, clinical relevance. The most useful are those that add demonstrated applicability in diverse clinical settings, and with diverse clients. The ultimate goal of these guidelines is to provide a system to more easily match clinical questions with research findings, identify important but neglected clinical research areas, and promote new treatment interventions and programs in order to improve services for clients who seek the help of Family Psychologists.
Guidelines for Evidence-Based Treatments in Family Psychology

Identifying the “best” methods to help the diverse clients who seek clinical help has always been of critical importance to psychology (APA Task Force, 2006). The hope is to identify and create psychological treatments that have a high likelihood of producing the changes sought by those who present for services when they are practiced competently with appropriate clients. Once identified, those treatments could be known by, accessible to, and used by the consumers, practitioners, and communities and thereby improve the outcomes of clinical work. In this way, the treatments would successfully move from the laboratory to community service centers to reach clients in need of help. Although a noble quest, finding effective psychological treatments has proven to be more difficult than originally anticipated. In fact, even determining what is a clinically “valid” prevention or intervention program has always been difficult. For many years, the world of psychotherapy relied either on what made sense (face validity), what experts told us (expert validity), or the zeitgeist of the time (consensual validity; Beutler, 2003). More recently, scientific evidence is being increasingly used for determining “valid” treatments (Chambless et al., 1996, 1998).

The increasing use of clinical research in psychological practice is being ushered in by a number of forces, including the dramatic growth in the depth and breadth of clinical change research, the increasing call for accountability in clinical practice, and the call from consumers to identify treatments that are effective and reliable. In this context, research has emerged as a valuable component in clinical decision-making and adds an important and necessary perspective beyond clinical experience. While this is not a surprising trend given the scientist-practitioner definition of professional psychology, it is indeed a controversial one given the long standing
A number of professional organizations (e.g., The American Psychiatric Association and divisions of the American Psychological Association) addressed this issue through the development of various types of evaluatory models intended to identify evidence-based interventions and treatment packages. This movement in psychology mirrors similar changes in other fields of clinical practice. For example, evidence-based medicine, a movement established in Canada and Great Britain, promotes the use of systematic research reviews for clinical decision-making with the aim of improving clinical effectiveness through, “…the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). Beginning in the early 1990s, Division 12 of the American Psychological Association established the Task Force on the Promotion and Dissemination of Psychological Procedures, which resulted in the establishment of criteria to evaluate treatments and the publication of a list of treatments deemed to be scientifically “well-established” or “probably efficacious” (Chambless et al., 1996, 1998). Division 17 (Counseling Psychology) then established a set of principles for evaluating the empirical status of psychosocial interventions for the purposes of informing counseling psychologists, training pre-doctoral and post-doctoral students, and informing the public about the value of services offered by counseling psychologists. Other efforts followed a similar process (e.g., Division 53: Society of Clinical Child and Adolescent Psychology, among others). The common thread among these efforts is the use of scientific evidence as the primary basis for the determination of valid clinical treatment and preventive interventions.
The Task Force for Evidence-based Treatments in Couple and Family Therapy is a group of researchers, practitioners, trainers, supervisors, and treatment model developers commissioned by The Family Psychology Division of the APA (Division 43) to develop recommendations for evidence-based practice standards appropriate to guide the clinical practice, research, and treatment model development efforts within Couple and Family Therapy. The composition of the Task Force was intended to be one that brought together diverse views on practice and research. The Division charged the Task Force with two major goals: develop a set of evidence-based practice guidelines relevant to the research and practice of Family Psychology and, use the guidelines to systematically review the literature so that a clinically based and systematic review of the research evidence for both present and potential clinical practices that have the greatest potential to help diverse clients in diverse settings. In this manuscript, we address the first of these tasks: guidelines for evidence-based treatments in family psychology.

Significant consideration was given to the need for a distinct set of evidence based practice guidelines for Family Psychology. In the end, the Division and the Task Force concluded that Couple and Family Therapy interventions are indeed unique in that they focus on relational systems as a primary intervention point, while aiming for clinically relevant changes in individual, couple, and family functioning at both broad and specific levels, considered from multiple perspectives, with work often involving multiple systems in (e.g., individuals, couples, families, schools, and medical providers (Gurman & Kniskern, 1978a). As such, the theoretical perspectives on the nature of clinical problems and the relevant outcomes of research, and thus the primary focus of understanding clients, may differ from those perspectives that form the basis of other practice guidelines. None of the previous clinical practice guidelines utilize a specific relational perspective in the guidelines and instead have focused focusing on particular
individual disorders as outcomes rather than the more systemic issues that couples and families present to clinicians. Thus, while it is likely that some of the broad common factors that are tied to successful outcomes in other types of therapy also are active in Family and Couple Therapy, the clinical work of Family Psychology is based on a unique set of relationally based principles and practices that require a different system of evaluation (e.g., change criteria, variability of methodological approaches, type of analyses) than does individual therapy.

Many issues surround evidence-based practice guidelines in psychotherapy. To create a proper context for the presentation of these recommendations we acknowledge some of the inherent difficulties in this task, and identify the assumptions and operational definitions regarding treatments, outcomes, and contexts that form the foundation of these recommendations. Then, we describe the recommendations themselves providing some examples of interventions and treatment programs that illustrate each category. We also provide examples of how these recommendations might be used by consumers, practitioners, and researchers in practice, supervision, and training. Finally, we consider future directions, caveats, and considerations for future iterations of these clinical practice-research recommendations.

Evidence-based Practice Guidelines in Psychology

The use of research as a critical component to clinical decision-making is gathering increasing support. Although constituting a major step forward in defining practices that have research support, practice guidelines developed to date also have brought philosophical and practical criticism. For example, in a recent comprehensive critique, Westen, Novotny, and Thompson-Brenner (2004) suggest that the existing practice guidelines overstate the value of research, particularly in regard to the complexities of clinical practice. Westen and colleagues’ concerns are leveled not at the role of research in clinical practice, but at the implicit
assumptions of the existing guidelines. They suggest that empirical support is not a decision made between a limited set of “lists,” but instead requires many types of evidence, as a way to account for the complexities of clients, therapists, and treatment settings in evaluating the research. Furthermore, they put forth that the current guidelines are limited due to the adoption of clinical trial research as the primary and most legitimate source of information suggesting that this focus does not embrace the contributions of other kinds of methods, such as qualitative or process-driven research, and thus, other potentially valuable clinical knowledge. They argue that the complexities confronted in clinical practice require a more “nuanced” view of treatment outcome that addresses the comorbidity of clients, and necessitates a focus on problems and/or profiles of clinical problems that extend beyond the categories of the restrictive and often ecologically invalid DSM.

The result of these and other criticisms has been an extensive discussion in the field regarding the role of practice guidelines, the composition of such guidelines, and the role that guidelines should play in actual practice, as well as active resistance to the adoption of these guidelines. In light of this growing debate, the American Psychological Association charged a task force to study evidence-based treatments to develop a policy statement on evidence-based practices (APA Task Force, 2006). The task force suggested that research evidence should be part of clinical decision-making processes in which clinicians integrate the guidance from research with other factors such as client characteristics and context and clinical judgment to determine treatment decisions. While the Division 12 Task Force used empirical evidence as an important criterion for determining effective treatment, the EBPP Task Force statement suggested a more “philosophical approach” in which research evidence is but one part of clinical decision-making, and essentially avoided the thorny matter of how research findings should be
weighted in such decision-making. The EBPP Task Force statement certainly succeeded in creating a legitimate place for both research-based evidence and practice experience. The position of the task force also made clear the complexity of clinical decision-making. Despite this philosophical integration, the policy statement did not address the principles needed for actually integrating research and practice, a way of utilizing existing and future research in practice, or a pathway for the development of future evidence-based treatments.

We suggest that both the criticisms of Westen and colleagues (2004) and the striving for the reliability of research-based evidence, can and should coexist peacefully without comprising the strengths of either perspective. Any set of “evidence-based” treatment guidelines must remain committed to research evidence as having a central place in the clinical decision-making process. However, the Division 43 Task Force believes that strategies for identifying empirically based therapies can be constructed in such a way that they are not limited to a single philosophical approach to research. Instead, the basis for construction would be the systemic inquiry of the highest methodological standards, regardless of the particular study design employed in evaluating treatments. Developing clinically useful practice recommendations would allow for the consideration of evidence in a dynamic way: using “levels of evidence” that can be used in clinical decision-making only to the degree that the research findings are found to be reliable and valid in the practice contexts for particular areas of practice. Furthermore, to become integrated into the real world of research and practice, task forces charged with identifying empirically based therapies must create a way of evaluating and thinking about clinical research such that it focuses on clinically relevant outcomes and practical contexts in which practices are used. For consumers and service providers, these task force efforts should identify interventions and programs that are useful to address actual clinical needs. For
researchers, the resulting recommendations are intended to highlight what we know and what we do not know about couple and family interventions and the degree of research evidence support for these approaches. In this way, the task force recommendations could fill three important roles: evaluating existing research evidence in a way that is useful to clinical practice, directing future research efforts by identifying missing areas of research needed to improve practice, and by providing a developmental path for evidence based treatments and serving as a model that could be used by a treatment-model developer. Thus, this model could serve as a map for a series of studies intended to develop an evidence-based intervention and ultimately promote the creation of new evidence based treatments for different clients, settings, and problems.

Identifying Evidence-Based Couple and Family Therapies

At the outset it is important to note that the Task Force’s primary assumption is that clients will be helped only through the use of both the wisdom of good professional practice and the guidance of clinical intervention research when delivered reliably to diverse clients across the various settings in which Family Psychologists practice. As a group of researchers, practitioners, and trainers, the Task Force is sensitive to and constructed these recommendations with appreciation of both the artfulness and individuality of effective clinical work and the invaluable role of research at all levels of clinical decision-making. However, the Task Force believes that not all treatments are helpful and not all treatments are helpful to all clients. The clinical decision making process is complex and to find the most “effective” treatments there must be a central place for research in the clinical decision making process. As a result, the development of recommendations for evidence based couple and family treatments are a legitimate, important, critical step for Family Psychology as a profession and a field of clinical practice.
There are, of course, parameters to even identifying the research that first must be considered. For example, these guidelines do not address a number of other important areas of family psychology (e.g., family/individual development, population studies that seek to establish prevalence rates) unless specifically linked to a treatment or prevention intervention of moderating conditions that may affect the outcome prevention or intervention. The guidelines focus only on reliable research on the interventions and treatment programs that specifically fall under the domain of Couple and Family Therapy. More specifically, these are interventions and models of practice that focus on the relational systems of couples and families as the basis of clinical assessment and intervention.

It is also important to acknowledge some of the major challenges of this task. The task force acknowledges that a potential weakness in any recommendations for evidence-based treatments is that they may unduly weight research-based practices over other viable treatment alternatives and thus exclude potentially important and functionally relevant controlling factors in a given clinical case. However, by considering diverse methodologies, viewing research knowledge as a dynamic and ever emerging process, and emphasizing not only randomized trials but also community-based studies focusing on systematic processes, the question of potential bias is greatly reduced because the field of consideration is substantially widened, rather than focusing on a narrow group of clinical studies. We also acknowledge that there will be varying degrees of evidence for new and existing interventions and treatment programs. Some interventions/programs will have clear evidence, while others will have none. Some programs will be supported solely by evidence-based principles and yet not provide full-fledged treatment outcome studies of their own.
We recognize the challenge involved in accounting for the complexity of studying increasingly comprehensive treatment interventions (from interventions to treatment programs), increasing specificity of client problem (from broad to specific), and increasing specificity of the agency or system contexts in which the practice takes place. At one level, the goal of such guidelines is to determine the depth and breadth of evidence necessary to meet the criteria of the various levels of evidence-based interventions/treatments. However, once a practice has established that it works, the more important questions might involve analyzing the client or therapist factors that moderate outcomes or specific within-model change mechanisms. Therefore, once evidence-based interventions or models are identified, the relevant criteria in the recommended guidelines focus on demonstrating that the intervention or model works with diverse clients and problems, and within varying service delivery contexts. We also appreciate that the therapist plays a vital role in the delivery of any clinical intervention or treatment program. Clearly, the role of the therapist, the therapist’s attitudes in relation to the specific interventions and intervention programs, and the therapist’s ability to competently demonstrate the requisite skills of a treatment program are complex and important to understand. We believe that there are critical elements of the therapist that, like common factors in therapy, are necessary for successful outcome. However, within evidence-based practice, more than general therapist skills are required. In addition to demonstrating general skills, therapists must also be able to demonstrate treatment model/intervention fidelity in delivering the treatment/intervention in question for positive outcomes to be achieved. As a result, these guidelines focus more upon validation of treatment than on consideration of therapist factors. One of the measures of contextual efficacy is, however, the fidelity of the model when implemented in community settings. It is in this area that therapist variables are critically important.
We understand that interventions and treatment programs will vary in specificity and comprehensiveness and in the extent of research that might be possible for them to accumulate. In some cases it may be difficult to clearly articulate interventions, treatments, and the relationship between the two. We suggest that, when available, those interventions or treatment programs with the most comprehensive and relevant evidence of success for a specific clinical problem of interest (i.e., substance-abusing, low-income adolescents referred to community mental health centers) to a therapist or consumer should be more valued than others.

In the end the task of identifying what is “effective” is complex. In fact, no degree of clarity or specificity can overcome the inherent ambiguity and difficulty in creating and applying clinical practice guidelines. Consequently, no set of practice guidelines can ever produce a clear and inarguable “list” or easy decision and there can never be a system that is simple to use, that produce clear-cut policy, service delivery, and clinical guidance. In the end, even with systematic practice guidelines the process of determining “what works” will be difficult, complex, and seem at times ambiguous. We suggest that this represents the complexity of clinical practice rather than anything inherently flawed in clinical practice guidelines.

Guiding Principles of the Division 43 Evidence-based Treatment Task Force

In this section the Task Force articulates both the basic assumptions and the specific definitions that influenced the development of these recommendations for identifying and evaluating evidence-based treatments for Family Psychology. In the spirit of the APA Evidence based Treatment Task Force (2006), the following assumptions were the basis for these guidelines and our attempt to be mindful of evidence, therapists, clients, and settings.

*The Best Available Treatments Are Treatments That Work*
All clients who seek services from psychologists deserve access to the most effective practices available. The best couple and family treatments are both scientifically sound and clinically relevant. Thus, Family Psychology interventions and treatment programs must be based on both science and the accumulated clinical knowledge of experienced practitioners in order to most accurately identify both the efficacy (reliability) and utility (contextual efficacy) of the clinical procedure. Determining the “best” treatment requires consideration of not only whether empirically based evidence exists but also the extent, utility, and clinical significance of the evidence. One way of considering utility and extent is to determine the absolute, relative, and contextual efficacy of the research and the clinical significance of the outcomes. Absolute effectiveness is a measure of the success of the treatment compared to no treatment (Wampold, 2004). This criterion is useful in determining if a treatment can even be considered evidence-based. Relative efficacy (Wampold, 2004) is based on a comparison of a treatment with a reasonable alternative (common factors, a treatment of a different modality, or a different treatment). Relative efficacy is critical to establishing that a treatment is the best choice for a specific type of client/problem as compared to reasonable alternative treatments. Contextual efficacy is the degree to which a treatment is effective in varying community contexts and with different clients (e.g. ethnicity, gender) and helps determine the clinical utility of a treatment program (Sexton, Mease, & Alexander, 2004). Clinical significance is critical in evaluating the evidence and must be a strong consideration in the evaluation of any clinical research studies. Taken together, these domains represent increasing degrees of evidence (does it work, does it work better than alternatives, and in what contexts and conditions does it help most) that, when addressed, provide increasing confidence that a well-described intervention or treatment program works.
High Quality Diverse Research Methods Best Captures Complex Phenomena.

Different research approaches bring different perspectives that are essential to understanding the complexity of family functioning and therapeutic change. Furthermore, different research methods may be needed at different phases in the developmental evolution of a treatment intervention or program. Regardless of the method, high quality research is defined as a systematic inquiry process in which the study abides by the principles of the chosen method, the rigor of which is to be evaluated by an agreed upon set of standards, and the information generated thereby is only used within the limits inherent in the methodological approach.

Given the appropriate use of diverse methods, no single standard of methodological excellence exists. Instead, the standard used to evaluate evidence must match the type of study. Furthermore, the standards applied to the evidence will change with time as the science of family psychology improves. At a minimal level, high quality studies of family psychology treatments should include: (a) clear specifications of the contents of the treatment model (e.g., treatment manual), (b) measures of model fidelity (therapist adherence or competence), (c) clear identification of client problems, (d) substantial descriptions of service delivery contexts in which the treatment is tested, and (e) the use of specific and well accepted measures of clinical outcomes.

Well-Defined Intervention(s) and Treatment(s) Are the Focus

Like all other domains of psychotherapy, couple and family therapy has a broad range of clinical perspectives, concepts, and procedures upon which specific therapeutic interventions are built. However, the more the treatment has been examined and refined based on the results of this examination, the higher the likelihood that the treatment will be clinically useful with a range of populations and settings. Thus, well-defined (or well-studied) treatments are more likely
to provide the best treatment and the most relevant and specific clinical evidence to the clinical question of interest. Specification also can occur at the level of the clinical procedure and in the details and complexity of the procedure. We used two levels to categorize the clinical procedures of family psychology: interventions (individual clinical activities) and treatment programs (multidimensional/multicomponent treatment packages). Interventions are circumscribed clinical interventions that address a single or group of clinical change mechanisms and which may be embedded in a broader treatment plan and may exist alongside other interventions. These interventions “stand on their own” in the sense that they can be used appropriately in various treatment processes and methods; an example might be communication skills training. A broader and more comprehensive clinical intervention is a treatment model. Treatment models are comprehensive approaches to clinical treatment with systematic treatment plans, interventions, and theoretical principles and outcome goals that are designed to address a related category of clinical problems. Treatment models have varying degrees of specificity with which they address treatment outcomes, therapist issues (treatment fidelity, therapist variables), the therapeutic relationship, and variations amongst clients and their problems. These varying levels of specificity allow for process and process-to-outcome research that systematically investigates the clinical mechanisms proposed by the model. Interventions are likely to address specific therapeutic goals while treatment programs are more likely candidates for interventions for defined groups of clinical problems and clients (Alexander et al, 1997).

Evidence-based practices are based, to varying degrees, on the common and core elements of clinical and family therapy practice (Sexton, Ridley, & Kliner, 2004). In fact, any good evidence-based treatment model should be based on the core common factors of effective family therapy. To be considered an evidence-based practice, the intervention/treatment model
must include clearly demonstrated evidence of the following: a) clinically meaningful problems being targeted and appropriately assessed; b) a coherent conceptual framework underlying the clinical interventions; c) specific, core interventions described in detail with an articulation of the therapist qualities necessary to follow them; and to the degree possible, d) process research that identifies how the change mechanisms work to produce positive change, and e) outcome research that demonstrates the absolute and relative effectiveness of the intervention or program (Alexander et al, 1994).

Positive, yet Clinically Relevant Outcomes

Evidence-based interventions and treatment models must demonstrate clinically relevant outcomes (i.e., outcomes with clinical significance) that produce a degree of absolute, relative, and contextual efficacy. However, the specific nature of the outcomes demonstrated is important. The most clinically relevant outcomes go beyond single measures and statistical improvement. Comprehensive and multidimensional clinical outcomes provide the most reliable basis of evaluating clinical change. These may include changes in individual functioning, couple/family relationship functioning, reduction of clinical symptoms, global measures of client well-being, or cost-benefit analyses of the community implementation of an intervention/treatment.

Regardless of the type, the important outcomes are those that are clinically meaningful and not merely statistically significant. In general, clinical outcomes are defined from very broad to specific measures. The most specific outcomes that speak to clinically relevant categories of clinical problems are most helpful in determining the efficacy/effectiveness and utility of an intervention/treatment. The most compelling evidence for an intervention or treatment program includes specific outcomes that address clinical changes in client functioning. Thus, to be an evidence-based treatment the treatment intervention or model must first demonstrate that it
produces outcomes in the primary measures for the clinical problems for which it is intended to help. Further evidence might be additional changes that add to these. For example, programs for adolescents with behavior problems must first demonstrate successful outcomes by showing changes in youth behavior problems (i.e. drug use, disruptive behavior, criminal behavior). If a treatment is designed to promote increased forgiveness following the discovery of an affair, the treatment research must be able to demonstrate that forgiveness actually changes following treatment. Studies demonstrating that marital trust increases, but forgiveness does not change, would not provide sufficient evidence that this treatment increases forgiveness. Furthermore, if a treatment can demonstrate that it changes the clinical construct of interest and it also has a positive effect on other related constructs, then this treatment is considered even stronger.

Clinical problems cannot simply be categorized or represented on a scale ranging from general to specific. To be clinically useful to the practitioner, the outcomes of empirical studies need to address the complexity of client problems in clinical settings. This requirement indicates that outcomes of research should address aspects of clinical problems that extend beyond broad classification systems (such as categories in the DSM-IV). While various types of outcomes have been proposed, we suggest that it is clinically useful to think of the degree to which there is evidence that the program works for specific measure of behaviors (behavior rates, recidivism change, cognitive changes, etc) that represent significant outcomes for clusters of psychological problems (e.g., behavior disorders). Thus, we suggest that relevant research should consider client problems as a clinically relevant whole. Rather than pinpointing one primary or discrete problem, syndrome, or disorder, attention should be given to indicating the multiple symptoms that reflect the same cluster or functional response class. Clinical rather than statistical significance should be the standard.
Clinical Utility

Clinical utility is enhanced when evidence-based practice guidelines provide a way of determining the differences in research evidence between models, the extent of research support for a model, and for the use of the intervention/treatment model in a particular treatment setting with specific clients. Given that different issues are important in different settings, it is impossible to create a single, ecologically valid hierarchy of what research is “best” or what approaches might ultimately be “best.” In fact, no treatment or intervention will likely have evidence that is relevant to every domain of clinical practice. However, the extent to which evidence exists in these domains is important in determining if, when, and how to use an intervention/treatment model. Thus, our approach is one that focuses on two criteria: reliability (“What is the level of reliable evidence for this intervention/treatment program?”), and utility-in-context (“Who does this work for, in what contexts is it effective, and what are the critical change mechanisms?”).

Determining the clinical utility of scientific research involves both a hierarchical and a matching process. Once evidence has helped generally determine “what works”, the more important question focuses on the clinical utility of the intervention/model. Having research evidence guide practice requires a matching of the evidence for a treatment/intervention with critical components of clients, problems and settings. Diverse research methods may produce evidence to help define clinical utility in ways that traditional clinical trial research or meta-analyses cannot. This level of matching is one that may be produced by a qualitative or quantitative literature review, or may require the skills of individual practitioners or policy researchers. In the final section of this paper, we illustrate how a “matrix” approach facilitates clinical utility of research findings.
Standards of Evidence-based Treatment/Intervention Programs

Within these guidelines, there are three levels, expressed as a levels-of-evidence based scale, which moves from broad ("evidence-informed"), to specific ("evidence-based"), to "evidence based and ready for dissemination/transportation" to community settings. The scale implies that the most desirable interventions/treatments are clinical approaches that provide systematic treatment models, with the most specific evidence, that have the most clinically relevant outcomes, yet, it is critical to know what ways they are applicable in diverse clinical settings, and with diverse clients. The three levels of increasing evidence provide a hierarchical index of confidence that the intervention/treatment model works. Within the evidence-based treatments (Level III) are four additional categories of evidence that demonstrate model specific change mechanisms, improved change when compared to other viable treatment options, and generalizability to broad clinical settings. The categories within Level 3 (evidence-based level) identify the contexts in which the effective program works, the extent that its core theoretical constructs are empirically linked, and the degree that is compares to other viable treatments and represents the extent of available research evidence for the intervention. We suggest that these levels are more contextual than hierarchical and the “value” of the model depends on the context and the questions asked of the research rather than an absolute standard. Figure 1 illustrates this model.

Insert Figure 1 about here

It is important to note that it is likely that when the evidence is evaluated some interventions and models do harm. Thus, we also identify an “iatrogenic” category of
interventions and models that, based on the research evidence, are shown to have harmful effects. In the following section, we provide illustrative examples of interventions and treatments that may fit the described level. We also want to be extremely clear from the outset that the following examples of the difference levels are intended only to illustrate and clarify the meaning of the domains, and are not to be viewed as exhaustive or complete listings of every available evidence-based treatment in couple and family therapy. We purposefully did not include any models or techniques associated with any member of the Task Force group.

**Iatrogenic Interventions/Treatments** are those models for which there are significant data to suggest that they have a harmful effect on clients. To fit into this category an intervention or treatment models would need to meet a very high standard of evidence to suggest that there is sufficient evidence to believe that when applied in a clinical setting, these approaches consistently produce clinical effects significantly worse than control/comparison conditions. We would expect that few models would fall into this category; however, it is important to make a place for those models that may have a harmful effect in order to emphasize that such models might exist.

**Pre-Evidence Informed Intervention/Treatments** are approaches without evidence, or without a basis in previously established empirically based intervention/models. Pre-intervention basic research, such as research on interaction processes that ultimately may become the basis of well-described interventions/treatment programs, might also fit into this category. To be appropriate for this level, this basic research must demonstrate proposed conceptual linkages that have not yet been translated into a clinical intervention. Clinical methods and approaches in this category may use basic general principles that are common to all models, however, the way they utilize such principles has yet to be systematically evaluated and tested. Examples of these pre-
evidence based treatments are many traditional theory-based models (e.g., Bowenian Family Therapy, Solution Focused Therapy).

**Level I: Evidence-informed interventions/treatments informed by psychological research or research on therapeutic common factors.** The evidence-informed intervention/treatment model uses interventions that are explicitly linked to pre-existing empirical or research-based evidence or to portions of an already validated evidence-based treatment models to suggest that they have an evidence base. The reasons that these programs do not achieve a higher level of evidence might be due to a less well-defined and articulated treatment program, lack of specification of targeted clinical problems (and appropriate outcomes), or a dearth of research on the program itself. As noted earlier, the need for construct validation and model description is critical and the burden falls to the developer to provide this clarity. Regardless of the reason, this is the weakest level of research evidence and so confidence that the intervention/treatment will produce desired clinical outcomes is lowest of the three levels. Examples of treatments that might fall into this category include: Structural Family Therapy, Gottman’s Marital Therapy.

**Level II: Promising Interventions/Treatments.** Promising treatments are specific interventions (that meet the criteria for a defined intervention) or treatment models that have either preliminary results, evaluation outcomes, or comparison-level studies of high quality, but have not been replicated or evaluated for specific outcomes with specific populations. These interventions/treatment models also may offer either a specific intervention/treatment model designed for an identified population with specific clinical problems that has a single study of high rigor or a specific intervention/treatment model with multiple studies of lower levels of methodological rigor, thus not meeting criteria for level III. Examples of specific interventions may include reframing (when used with adolescents: Robbins, Turner, & Alexander, 2006) and
paradox while illustrative treatment models include: Insight-Oriented Marital Therapy (Snyder & Wills, 1989; Snyder, Wills, & Grady-Fletcher, 1991), and Attachment Based Family Therapy.

**Level III: Evidence-Based Treatments.** Evidence-based treatments are specific and comprehensive treatment intervention programs that have systematic high-quality evidence demonstrating that they work with the clinical problems they are designed to impact. At a minimal level, such evidence should include multiple outcome studies (at least 2) to reliably demonstrate that the treatment program is replicable and produces outcomes greater than those gained from the normal development and improvement process typical in that treatment population (Category 1). Further evidence for efficacy can be demonstrated if the program can produce clinically significant outcomes greater than those obtained by clinically viable alternatives (Category 2), if the program provides clinically significant evidence verifying that the theoretically proposed change mechanism are linked to outcomes (Category 3) for various clients/problems/settings in various contexts (Category 4). The following categories are limited to treatment programs rather than interventions. The assumption is that to reach this level the treatment/intervention needs to have more than a single intervention and these should be embedded within the conceptual and theoretical aspects of a treatment package.

**Category 1: Absolute efficacy/effectiveness** evidence shows that the specific treatment intervention program produces reliably improved, clinically relevant outcomes when compared to the typical improvement rates for natural recovery of given clinical problems. These studies are efficacy studies with comparison, clinical trial evidence that shows clinically significant effects with specific clinical outcomes that have clinical relevance. These criteria form the basis of the minimal level of evidence required of an evidence-based
treatment. This level of evidence suggests that this intervention/treatment program is a clinically reliable treatment for a specific class of clinical problems.

Once established with credible outcomes, evidence programs (meeting the criteria of Category 1) should continue to develop a further research base including systematic study of change mechanisms and studies of the contextual efficacy and application of the model. Category 1 level evidence is the minimal level of evidence needed, but should not be considered sufficient to completely evaluate the efficacy and effectiveness of a treatment program. The remaining categories define evidence above and beyond these minimal levels by providing a systematic way to identify the evidence-based strengths and weakness of a treatment model. A family therapy example may be Brief Structural Family Therapy (Szapocznik et al., 1989) or IBCT (Christensen, Atkins, Yi, Baucom, & George, 2006).

**Category 2: Relative efficacy** studies show that the specific treatment intervention program produces reliably improved clinically relevant outcomes when compared to an alternative or viable treatment. This is a more difficult test than category 1 for demonstrating that the program works because it requires gains beyond those other treatments. Category 2 intervention programs should have reached the criteria of Category 1 and have efficacy studies with clinical trial evidence that show clinically significant effects with specific clinical outcomes with clinical relevance as compared to other reasonable treatments. This level of evidence suggests that this intervention/treatment program is a clinically reliable treatment for a specific class of clinical problems. As such, it is akin to the efficacious and specific designation used by Chambless et al. (1998). Examples of treatments that might be placed in this category would be Behavioral Marital Therapy (e.g., Jacobson & Margolin, 1979; R.B. Stuart, 1980) and Parent Management Training (Patterson & Chamberlain, 1988).
Category 3: Efficacious models with verified mechanisms show evidence that the model-specific change mechanisms operating within the specific treatment models are linked to relevant identifiable outcomes, as theoretically expected. The models meet the minimal criteria for evidence-based practice (category 1). The focus is primarily within the model, with evidence likely to emerge from process-to-outcome and process studies. This category demonstrates that the program works because it requires verification that the model-specific change mechanisms do indeed provide the pathway to improved client outcomes. This level of evidence would suggest that the treatment program is a clinically reliable treatment program for a class of clinical problems that operates through the described mechanisms to produce the demonstrated outcomes. One example of treatment models that might fit this category would be Behavioral Couples Therapy for depression, which demonstrates that changes in marital satisfaction changes levels of depression for particular clients (Beach & O’Leary, 1992). The second example might be family psychoeducation interventions for schizophrenia (Goldstein & Miklowitz, 1995), which has process work demonstrating its effective common ingredients: psychoeducation regarding schizophrenia, teaching of coping skills, communication training, problem-solving training, and crisis management skills.

Category 4: Effective models with contextual efficacy show evidence that, in addition to being efficacious (Category 1), the model has successful outcomes (absolute and relative) with a range of clients, clinical problems, and service delivery contexts. This level of evidence suggests that the program not only produces change, but that the outcomes are effective for specific client populations (i.e. gender, age, race, culture etc.), with specific clinical problems (e.g., behavior disorders, depression, school problems), and is successful in specific service delivery systems, which make up the context within which the program
must work. Thus, this level of evidence suggests that the treatment program is a clinically reliable treatment program for a class of clinical problems that is widely applicable. The evidence can demonstrate the degree to which the intervention model might be matched with the needs of a community. This category demonstrates the model to be robust enough to produce change within some range of clients, problems, and settings, and thus, might be more generalizable than treatments with less evidence. Examples for this category would be Multisystemic Therapy for adolescent problem behaviors (Henggeler, Melton, & Smith, 1992) and Behavioral Couples Therapy for Alcohol and Substance Abuse Disorders (O’Farrell & Fals-Stewart, 2006), both of which have work demonstrating their models’ effectiveness in a variety of community settings and treatment modalities.

Conclusions

All clients who seek services from psychologists ought to be offered the most effective practices available. Thus, the ultimate goal of the Guidelines for Evidence-Based Treatments In Family Psychology guidelines is to identify effective intervention programs for clients who seek treatment. The best couple and family treatments are both scientifically sound and clinically relevant. However, both clinical and scientific knowledge are often difficult to integrate and confusing to practice. These guidelines provide a hierarchy of increasing levels of evidence that focuses on effective outcomes of well defined and described clinical interventions or treatment programs at various levels of specificity and/or development (pre-evidence based, evidence informed, promising, and evidence-based). Interventions and treatment programs at Level I (evidence-informed) are those based on principles of evidence-based programs or interventions that have some evidence base. Those at Level II (promising) have better but more preliminary and less reliable evidence that they work as intended. Treatments classified at Level III
(evidence-based) are those models for which there is substantial evidence that the model works to improve the outcomes for the clients for whom it was designed.

Once it has been determined that a program is evidence-based, the role of research in guiding clinical practice and future research directions takes on a different form. At this point, the use of evidence in clinical settings changes, as the questions about treatments become more complex. The need to know which treatment model is more efficacious is often replaced by the need to know “how it works?” or “For whom does it work?” In this model, we proposed four categories of additional evidence that give additional confidence that the treatment models work, and provide specific evidence of the depth and breadth of those outcomes (evidence regarding comparisons over other models, evidence verifying change mechanisms, and evidence demonstrating the range of contexts in which it works, and evidence regarding transportability). In time, new and different aspects of clinical research are likely to be added to this group.

These recommendations for evaluating evidence-based treatment in family psychology are intended to build upon the strengths of previous efforts, address some of the relevant concerns raised about those efforts, and create a process that captures the unique nature of family and couple therapy interventions. In addition, this system of evaluation creates a levels of evidence based approach to evaluating the available research in a manner that it can efficiently be used to guide practice decisions, while at the same time providing researchers with a way to identify clinically relevant and timely research about new or existing clinical approaches.

The categories and levels of the Practice Guidelines also represent the different domains of evidence needed in long-term research programs investigating various treatment models. Thus, the guidelines are intended to serve a method to quickly identify the areas of research knowledge that exist and those that are missing, directing the researcher to the appropriate level
of evidence that may answer the question at hand. For example, early in the creation of a
systematic research program focusing on basic studies to show effectiveness, in the best
conditions, compared to no treatment alternatives is appropriate. However, once a treatment
program is systematically described, tested, and found to be effective (absolute efficacy)
continuing to do clinical trial research demonstrating outcomes over no treatment controls may
not be as relevant. Instead, it may be important to shift the focus of research to look at change
mechanisms, broaden the areas of demonstrated use, and gain more reliability in outcomes
through comparing the model to others in the same area (relative, contextual efficacy).
Subsequent research may be driven by clinical need (“What works in this setting?’) or the need
for theoretical advancement (“What are the change mechanisms in the early stage of X
therapy?’”). Research into the mechanisms of action of a model is likely to require a series of
studies over time. Other research ought to focus on contextual efficacy and testing the model
with varying clients, clinical problems, and service delivery contexts. The evidence offers
guidance regarding matching of clients to interventions and programs. Furthermore, it should
again be noted that the kind of research used will differ according to the clinical question of
interest, not every study needs to be a clinical trial to determine effectiveness; for example, to
answer the questions about potential change mechanisms, smaller process-to-change studies, if
done with high rigor, might be sufficient.

Caveats, Ruminations, and Future Directions

We remain aware that this proposed system, which accentuates treatments as the core
entities for evaluation, can take on a number of meanings, some of which could be mistaken
and/or ultimately limit our understanding and the advancement of practice (Westen, Novotny, &
Thompson-Brenner, 2004). Like any attempts to distinguish between the complexity of clinical
practice, these guidelines are complex and it will likely be difficult to clearly determine the appropriate placement for some interventions or treatment programs. Even with the best of systems, it is not easy to sort and organize the vast research in Couple and Family Therapy. This is not the fault of a system but rather a reflection of the complexity of clinical practice. We believe that with use and refinement these guidelines can come to meet the goals of identifying, evaluating, and providing a research path for the development of new treatments for couples and families. Classification systems of this kind can be enormously helpful in pointing to effective treatments, but, if not carefully understood, can also unwittingly promote problems.

One potential source of difficulty is that these types of lists can unintentionally serve to reify treatments rather than help to refine them. The history of family treatments is a history of evolving methods of intervention (Lebow & Gurman, 1995). Today, there are few prominently practiced methods of couple and family therapy that were practiced in the same ways with the same labels a generation ago. We expect that couple and family therapies will continue to evolve. Therefore, we are concerned that lists of the kind described here should not serve to limit the generation of improvements in these treatments because these treatments have already “made the list.” We must come to terms with a way of incorporating the best standards for evidence (which must emphasize a core consistency in treatments across studies for a treatment to qualify as a member of a class) and the natural tendency for treatments to evolve and improve. In this regard, the question might be asked, e.g., whether a treatment such as the Integrative Behavioral Couple Therapy (IBCT) of Jacobson and Christenson (Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000) might not be sufficiently similar to Behavioral Marital Therapy to fall within the same grouping in this type of classification. Of course, an alternative position can also be taken (that IBCT differs in substantial ways from BMT), but the conversation about what
constitutes variations of a “treatment” rather than new treatments is essential. Such consideration is necessary if the field is not to be doomed to replicate its history of appearing to create new treatments with each new generation rather than building a catalog of effective treatments, and thus ultimately having few studies of any given treatment.

We also are hopeful that this system of classification is likely in the future to lead to the identification of core ingredients of effective intervention. For example, future research may demonstrate the emergence of core principles of intervention that transcend the treatment methods that are available today for classification, similar to those overarching principles of treatment that are proposed in other areas of psychology (e.g., Beutler, 2003). For example, it is possible that some of the evidence-based family therapy programs for intervening with adolescent substance use disorders share core characteristics that eventually may evolve into a set of core principles for effective treatment of these disorders.

We also should add that we are not unsympathetic to the many criticisms frequently made of evidence-based treatments (e.g., Westen et al., 2004). Such systems are only as good as the ratings of treatments are objective and solidly based in data. Moreover, far too many psychotherapeutic treatments claiming a solid evidence base are actually supported by data derived from arbitrary metrics, such as measures of change that have tenuous relationships to real-life experience (Kazdin, 2006). Such systems can only address and classify the treatments and problems for which there is research. In the couple and family field, there are numerous widely practiced treatments that have not been subject to empirical evaluation (Alexander, Holtzworth-Munroe, & Jameson, 1994; Lebow & Gurman, 1995; Sexton & Alexander, 2002). We want to remind the reader that an absence of evidence for an approach does not mean that that approach is ineffective. It does mean that there is no present evidence for such an approach,
and until such evidence emerges, *caveat emptor*. However, the lack of research does not imply that the treatment/intervention is ineffective. Research as described here provides the consumer with the relative degree of confidence that treatments might provide the outcomes they promise. It is our hope that this classification system will motivate those associated with treatments they believe to be effective to research further the impact and outcomes of those treatments. It also is our hope that this system of classification can help sort out the non-specific and somewhat random research process into a relevant useful knowledge base.

Additionally, few treatments have been applied across multiple cultures and populations despite the best efforts of those doing treatment research. Specifically, almost no couple therapy and only a few family therapies have been studied in the context of diverse populations. As we note, treatments and interventions should be studied in their context and evaluated within this context. We again hope for more research on more problems in more populations.

In addition, this set of guidelines should not be taken to trivialize the role of the therapist in delivering treatment (Gurman & Kniskern, 1978b). Therapies are only delivered through therapists, and psychotherapy research has shown considerable differences in outcomes related to the skillfulness of the therapist (Orlinsky, Grawe, & Parks, 1994). Moreover, if evidence-based assessment schemas such as the one proposed here are to positively influence clinical practice, they can do so only via the therapist. It is likely that the role of the therapist would impact positive outcomes both as a general main effect as well as within specific treatment protocols. Yet the track record to date of the influence of psychotherapy research on clinicians has long been recognized to be modest at best (Barlow, 1982). Indeed, even a recent survey of the members of the Society for Psychotherapy Research found that psychotherapy research has a
good deal less impact on members’ practices than many other factors such as reading theoretical articles, receiving supervision, and, of course, direct contact with patients. It has long been clear that psychotherapists generally do not advocate or practice different approaches on the basis of their relative or comparative scientific status. Such a self-evidential observation may have important implications for the creation and refinement of evidence-based treatment classification systems such as that proposed here. If the typical practitioner of couple and family therapy is to listen to our collective research, it may well only happen when “our research touches the therapist where he or she lives experientially in everyday practice” (Gurman, 1983). That is, in our effort to understand the mechanisms of change in couple and family therapy, it may be that clinicians will be at least as influenced by research that identifies such mechanisms within given schools or methods as by research from comparative outcome studies or trans-method process studies. We hope that by embracing diverse research methods as was done in this system, these comparative analyses can be facilitated.

On a closing note, we remind the reader that the efficacy and effectiveness of treatments must be combined with attention to client values and clinical expertise (Levant, 2004). These guidelines must be viewed in a dialectic relationship to other critical sources of information including clinical experience and client needs. Indeed, clinical care often calls for a balance between two different sorts and sources of data: the evidence base regarding relevant EBP’s, on the one hand, and client preferences and values, on the other. This balance can only be achieved when the guidance of research matches the unique values of the client. It may be that different sources of data should carry different weights in different types of clinical situations. For example, treatment planning decisions should carry a heavier EBP-influenced weighting in clinical situations in which there is a focus more on “symptom problems” for which there are
demonstrably efficacious “treatments” (Barlow, 2005) (e.g., “How can we change our child’s poor compliance with parental requests?”). Conversely, client preferences and values and therapist clinical expertise might have more influence in “meaning-focused” therapeutic situations for which people often seek our help (e.g., “Should we stay in this painful marriage for the sake of our kids?”). It may be that research evidence will help establish the broad procedures of a practice while the specific content of clinical change is determined by the specific values of the client(s). Across various contexts and problems, it is crucial for clinicians to practice what Stricker & Trierweiler (1995) calls “the local clinical scientist” approach and to incorporate the best evidence available to inform practice. It is in the context of such a balanced view of evidence-based approaches that we present these guidelines.
References


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Figure 3: Levels of Evidence in Couple and Family Psychology Research

Category 3: Change Mechanisms (core model-specific clinical change mechanisms)

Category 4: Contextual Efficacy (studies of specific clients, clinical problems, and service delivery systems)

Category 2: Relative Efficacy (efficacy and effectiveness compared to reasonable alternative treatments)

Level III: Evidence-Based Treatments

Level II: Promising Interventions/Treatments

Level I: Evidence-informed Interventions/Treatments

Pre-Evidence Informed Intervention/Treatments/common practices/ non-specific theoretical approaches
Models with No effect
Approaches with iatrogenic effects