



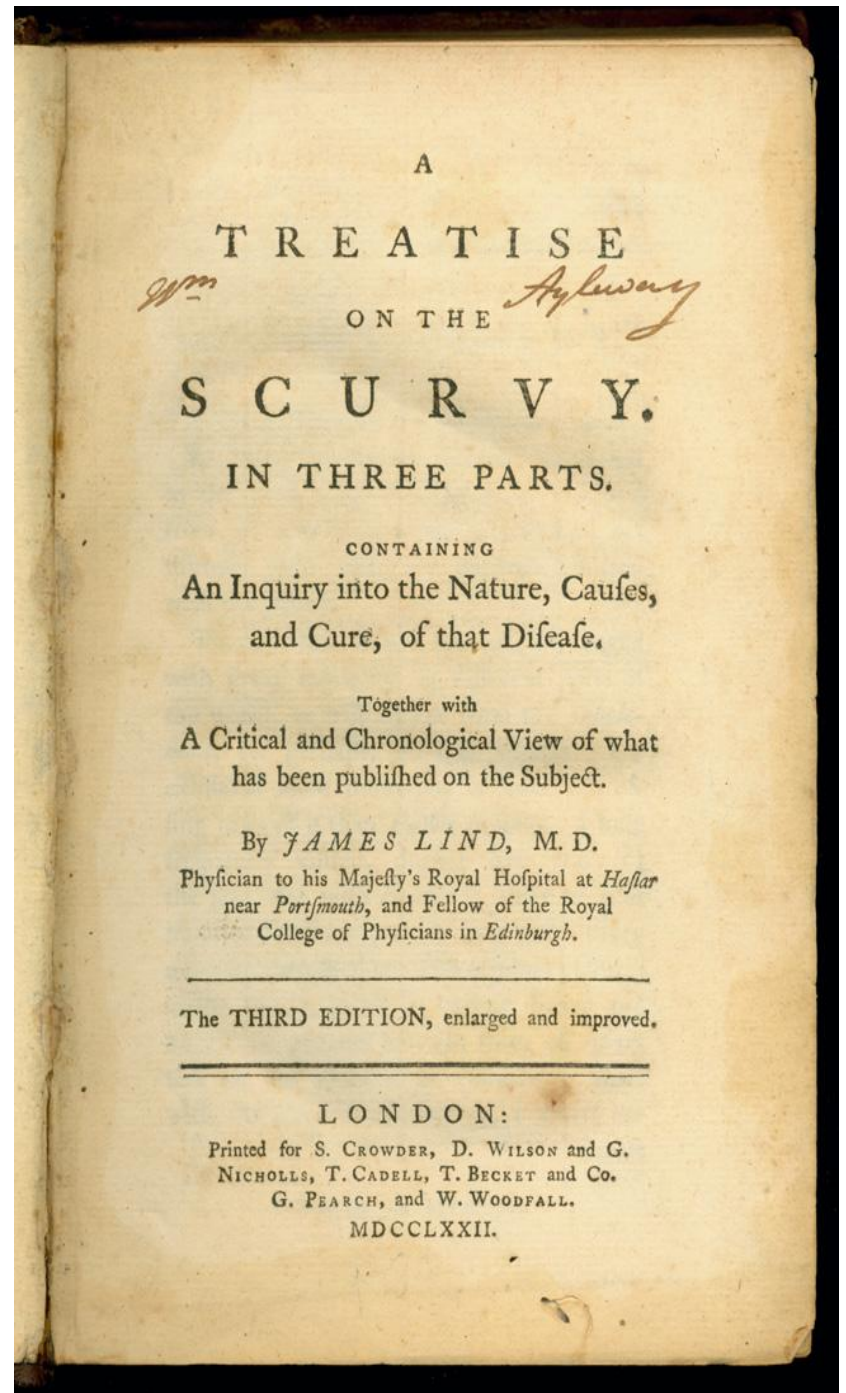
Researching MFT and documenting change

Ivan Eisler

Kings College
Institute of Psychiatry
London



James Lind (1716-1794)



Lind's first RCT for scurvy

Cider

Some improvement

Vitriol

No effect

Vinegar

No effect

Seawater

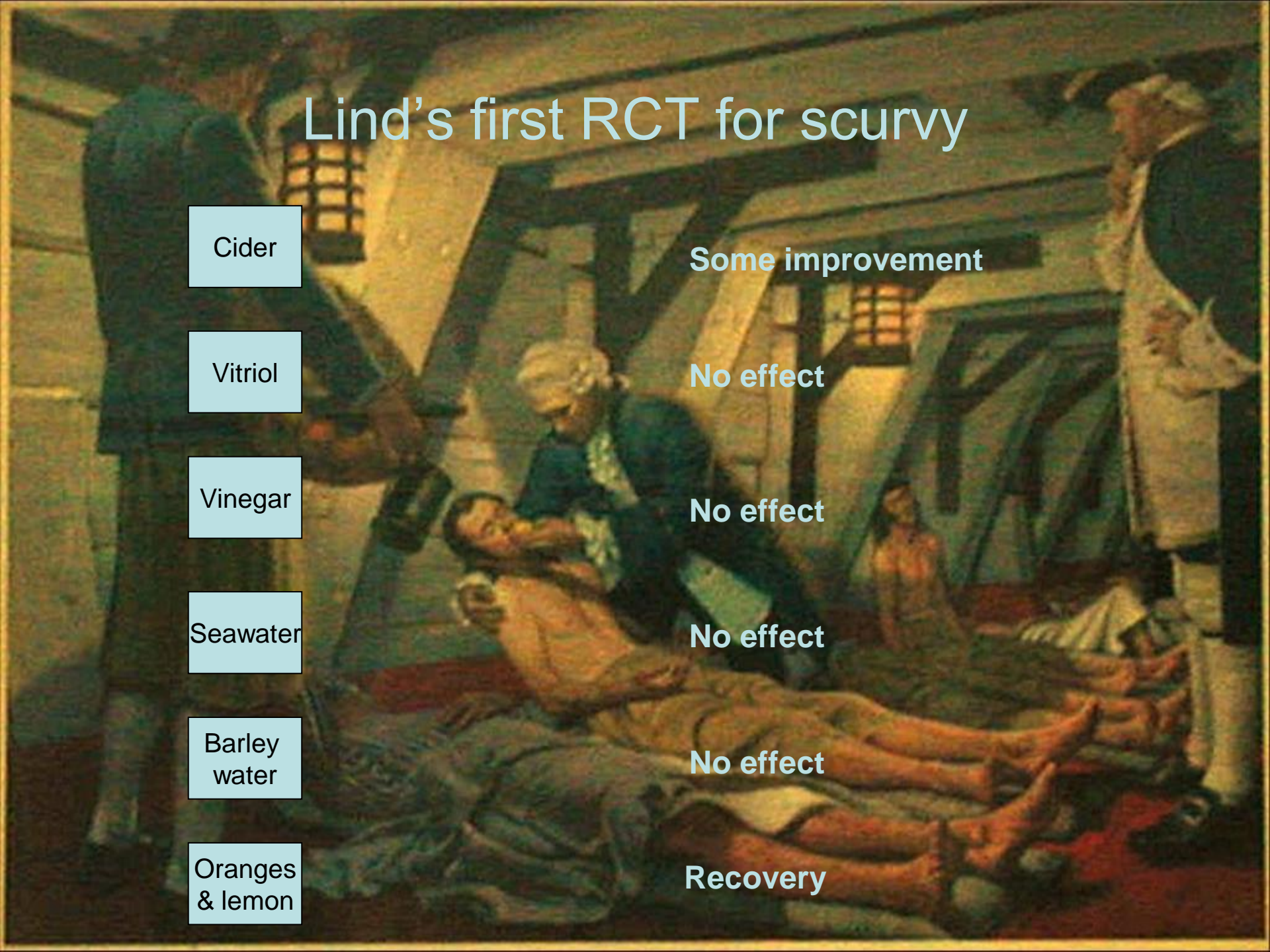
No effect

Barley
water

No effect

Oranges
& lemon

Recovery



Trauma, Violence, & Abuse

<http://tva.sagepub.com/>

Treating Perpetrators of Child Physical Abuse : A Review of Interventions

Jessica Oliver and Karla T. Washington

Trauma Violence Abuse 2009 10: 115

DOI: 10.1177/1524838009334132

The online version of this article can be found at:

<http://tva.sagepub.com/content/10/2/115>

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<i>Article</i>	<i>Design</i>
Bigelow and Lutzker (1998)	Case studies ($N = 2$)
Dombrowski, Timmer, Blacker, and Urquiza (2005)	Case study ($N = 1$)
Donohue and Van Hasselt (1999)	One group pretest, posttest ($N = 47$)
Fantuzzo, Stevenson, Kabir, and Perry (2007)	Randomized controlled trial ($N = 116$)
Gershater-Molko, Lutzker, and Wesch (2002)	One group pretest, posttest ($N = 2$)

<i>Article</i>	<i>Design</i>
Gershater-Molko, Lutzker, and Wesch (2003)	One group pretest, posttest ($N = 80$)
Mandel, Bigelow, and Lutzker (1998)	Case studies ($N = 2$)
Meezan and O'Keefe (1998)	Randomized controlled trial ($N = 81$)
Osofsky et al. (2007)	One group pretest, posttest ($N = 46$)
Taban and Lutzker (2001)	Postintervention evaluation ($N = 45$)
Timmer, Urquiza, Zebelle, and McGrath (2005)	Two-group, pretest, posttest (is this right? No random assignment; $N = 136$)

Adapted from Oliver and Washington 2009

Fantuzzo, Stevenson, Kabir, and Perry (2007)	Randomized controlled trial (N = 116)	Ten parent training group sessions as part of Head Start programme vs standard Head Start programme including monthly parent meetings and occasional workshops	Modified Uplifts Scale; Modified Hassles Scale; Sociometric measuring contact with other parents	Lower levels of perceived stressors and higher levels of support in intervention group compared to controls. No differences in levels of maltreatment
Gershater-Molko, Lutzker, and Wesch (2003)	One group pretest, posttest (N = 80)	In-home intervention (Project SafeCare) addressed health care skills, safety training, and parent-child interaction training	Researcher's qualitative observations; Home Accident Prevention Inventory-Revised; Trainer-rated performance on scenarios; 10-item checklist assessed parent use of Planned Activities Training	Positive outcomes were observed in all three targeted areas. Significant increases were observed in parenting skills and abilities of the families
Meezan and O'Keefe (1998)	Randomized controlled trial (N = 81)	Multifamily group therapy sessions were led by clinicians who used a variety of interventions depending on families' needs. The program lasted 6 weeks with a different theme explored during each session with a goal of reducing incidents of child abuse and neglect	Family Assessment Form; Child Behavior Checklist (CBCL); Children's Action Tendency Scale; Index of Peer Relations	The experimental group had a lower attrition rate than families in traditional therapy. Caregivers in experimental group reported that more support was available and other members were helpful
Timmer, Urquiza, Zebelle, and McGrath (2005)	Two-group, pretest, posttest (is this right? No random) One group, pre-test, post-test (N = 136)	This article evaluates parent-child interaction training as an intervention to alter interactions within the parent-child dyad in maltreating and nonmaltreating families	Child Abuse Potential Inventory; CBCL; ECBI; PSI; Symptom Checklist 90-R; Maltreatment history	There were improvements in child behavior and parent stress levels. Families with a maltreatment history reported fewer gains on some scales when compared with families with no maltreatment history

Adapted from Oliver and Washington 2009

A Model of Multi-Family Group Therapy for Abusive and Neglectful Parents and Their Children

William Meezan, Maura O'Keefe & Margrit Zariani
Social Work With Groups, 20:2,71-88

Evaluating the Effectiveness of Multifamily Group Therapy in Child Abuse and Neglect

William Meezan and Maura O'Keefe
Research on Social Work Practice 1998 8: 330

Family to family programme

- 6-8 families
- 4 counsellors
- Weekly meetings over 8 months (80 hours)
- Separate management sessions
- Exclusions:
 - Income 185% above poverty line
 - Sexual abuse
 - Psychosis
 - Severe substance misuse

Treatment goals

- *increasing social supports*
- *increasing the problem-solving abilities of participants*
- *increasing knowledge of child development*
- *establishing appropriate family structures*
- *Increasing parent to child nurturing behaviours*
- *increasing appropriate disciplining behaviours*
- *improving children's behaviour*
- *enhancing children's interpersonal behaviour*

Structure of sessions

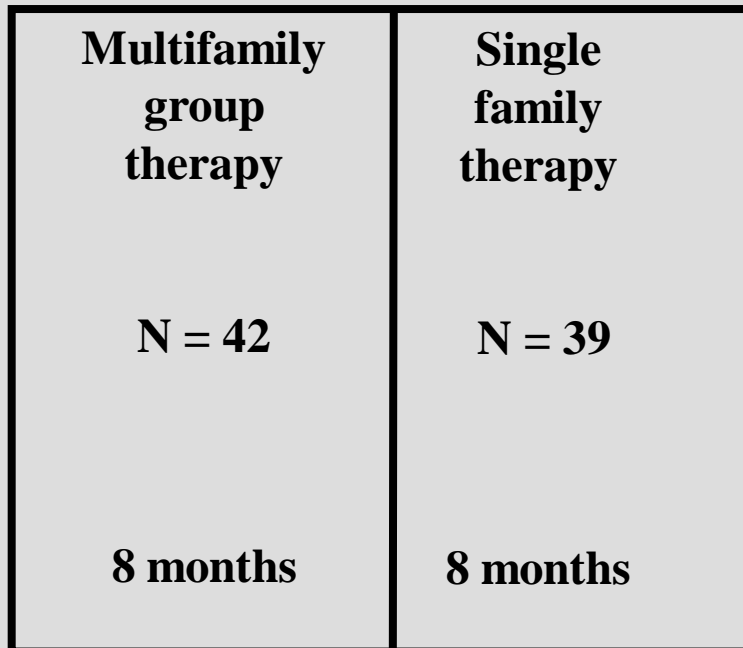
Informal Gathering Time	15 minutes
Opening–Coming Together	10 minutes
Structured Activity	20 minutes
Regrouping and Feedback	10 minutes
Living Skills	20 minutes
Regrouping and Feedback	10 minutes
Informal Break	10 minutes
Separate Parents' and Children's Group	40 minutes
Regrouping and Closing	15 minutes

Session themes

- *Physical. Emotional/Social, and Cognitive Development*
- *Discipline, Responsibility, and Self-Regulation*
- *Value, Character Building. and Self-Respect*
- *Focus on Feelings*
- *Person, Partner and Parents. . . Plus*
- *Productive Communication and Relationship Building*

Referral from County Department from Child and Family Services to Friends of the family service, van Nuys California

Agree to randomisation



Time 1 Assessment

Time 2 Assessment

Measures

- *Parenting Social Support Index (SSI)*
- *The Problem-Solving Inventory (PSI)*
- *Adult-Adolescent Parenting Inventory (AAPAI)*
- *Family Adaptability and Cohesion Evaluation Scale II (FACES II)*
- *Child Abuse Potential Inventory (CAP),*

	<i>Time 1 Mean</i>			<i>Adjusted Time 1 Mean</i>			<i>Time 2 Mean</i>		
	MFT	FT	p	MFT	FT	p	MFT	FT	p
Abuse	203.8 (112)	229.1 (99)	NS	193.0 (116)	232.7 (95)	NS	144.6 (81)	224.9 (82)	.001
Distress	126.0 (87)	148.7 (76)	NS	117.9 (91)	152.7 (72)	NS	92.5 (60)	141.9 (71)	.01
Ego strength	18.7 (11.1)	14.9 (11.3)	NS	19.6 (11)	14.3 (10.8)	NS	21.1 (10.2)	15.7 (10.3)	.06
Problems—family	15.3 (13.3)	18.7 (14.7)	NS	15.0 (13.5)	19.5 (14.7)	NS	8.3 (9.9)	14.5 (13.1)	.07
Problems—others	14.7 (8.4)	16.7 (6.9)	NS	13.9 (8.3)	16.2 (7.2)	NS	10.1 (7.3)	16.0 (7.0)	.004
Problems—self	6.4 (6.8)	6.6 (7.9)	NS	7.1 (7.2)	7.6 (8.2)	NS	4.1 (6.0)	7.2 (7.0)	.09
Loneliness	7.9 (4.7)	9.4 (4.1)	NS	7.4 (4.8)	9.4 (4.0)	.10	5.6 (3.7)	7.0 (3.8)	.009
Rigidity	18.3 (15.8)	16.6 (13.5)	NS	17.2 (15.7)	16.6 (13.5)	NS	11.6 (12.9)	16.1 (15.9)	NS
Unhappiness	23.0 (13.2)	21.8 (14.8)	NS	21.8 (14.0)	22.3 (15.4)	NS	14.9 (9.2)	22.3 (13.5)	.03

Adapted from Meezan & O'Keefe (1998) Evaluating the Effectiveness of Multifamily Group Therapy in Child Abuse and Neglect. *Research on Social Work Practice*, 8: 330-353

Psychosocial Interventions for maltreated and Violence-Exposed Children

**Judith A. Cohen, Anthony P. Mannarino,
Laura K. Murray, Robyn Igelman**

Journal of Social Issues, Vol. 62, No. 4, 2006, pp. 737--766

Trauma focussed CBT for sexual abuse

Study1: Cohen and Mannarino (1996a, 1997)

Trauma Focussed-CBT vs nondirective supportive therapy,

Sixty-nine sexually abused children (aged 3-7 years)

Children who received TF-CBT demonstrated significantly greater improvements ($p < .05$ to $p < .002$) in internalizing, externalizing and PTSD symptoms and sexualized behaviour problems

Study 2: (Cohen & Mannarino, 1998; Cohen, et al 2005)

Trauma Focussed-CBT vs nondirective supportive therapy

Eighty two sexually abused children (aged 8–14 years),

TF-CBT was superior in decreasing depression and increasing social competence ($p < .01$) and decreasing PTSD and dissociation at 12-month follow-up

Trauma focussed CBT for sexual abuse

Study 3: Deblinger, Lippmann, and Steer (1996)

TF-CBT (children only vs parents only vs children and parents) vs TAU (N=100)

TF-CBT in either child condition significantly superior to TAU in reducing PTSD

TF-CBT in either parent condition significantly superior to TAU in improving depressive and externalizing behavioural symptoms and improving parenting skills Differences maintained at a 2-year follow-up

Study 4: Deblinger, Stauffer, and Steer (2001)

Group TF-CBT (separate groups preschool children and non-offending mothers)

vs parallel child and parent nondirective supportive therapy groups

TF-CBT greater improvement in safety skills ($p < .05$); mothers greater reductions in intrusive thoughts and negative emotional reactions ($p < .01$ to $p < .001$).

Trauma focussed CBT for sexual abuse

Study 5: (Cohen et al 2004)

229 children and their non-offending parents,

individual TF-CBT or individual Child-Centred Therapy (CCT)

At 1-year follow-up children with multiple traumas or high levels of depressive symptoms at pre-treatment experienced particular benefit from TF-CBT as compared to CCT

Study 6: King et al. (2000)

36, 5–17 year old sexually abused children

TF-CBT with vs without a family component versus a wait-list control

TF-CBT experienced significantly greater improvement in PTSD, depression, and fear than those on wait-list ($p < .003$ to $p < .001$).

Family involvement improved children's involvement with lower levels of fear at the 3-month follow-up ($p < .05$).

Randomized trial of a statewide home visiting program to prevent child abuse: impact in reducing parental risk factors[☆]

Anne Duggan^{a,*}, Loretta Fuddy^b, Lori Burrell^a, Susan M. Higman^a,
Elizabeth McFarlane^a, Amy Windham^a, Calvin Sia^c

Child Abuse & Neglect 28 (2004) 623–643

Healthy Families New York (HFNY) randomized trial:
Effects on early child abuse and neglect^{☆,☆☆}

Kimberly DuMont^a, Susan Mitchell-Herzfeld^{a,*}, Rose Greene^b, Eunju Lee^b,
Ann Lowenfels^b, Monica Rodriguez^c, Vajeera Dorabawila^a

Child Abuse & Neglect 32 (2008) 295–315

Hawai & New York Healthy America Families (HFA) prevention studies

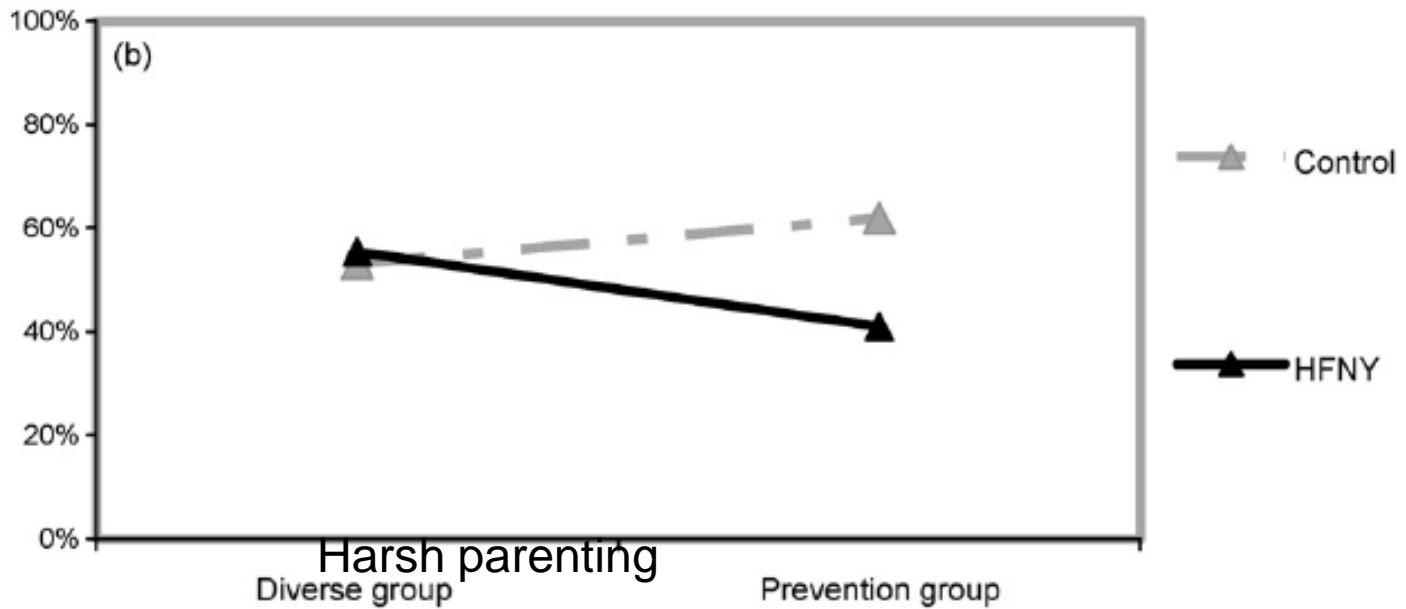
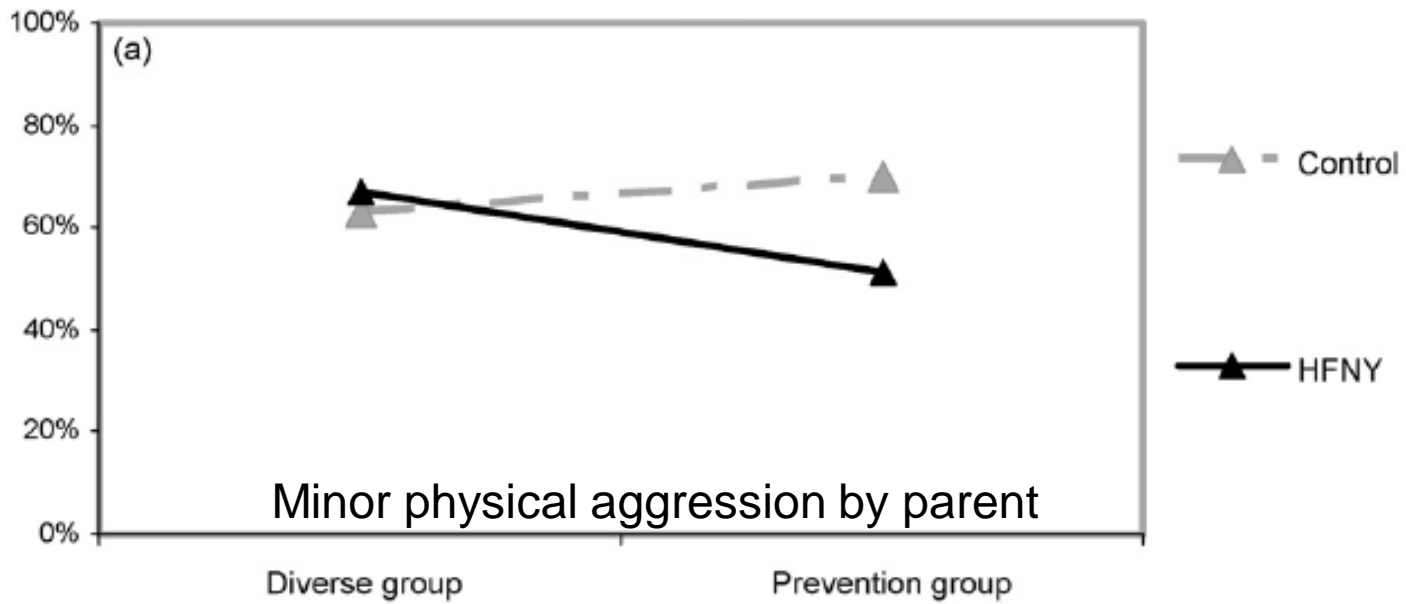
- Despite widespread use of home visiting preventive HFA programs in US only limited evidence of effectiveness in reducing abuse and neglect
- 2 large HFA RCTs (Hawai - N=634; New York – N=1173) demonstrate the importance of taking into account the context of interventions and population it is aimed at

Hawai Healthy Start Program (HSP) evaluation (Duggan et al 2004)

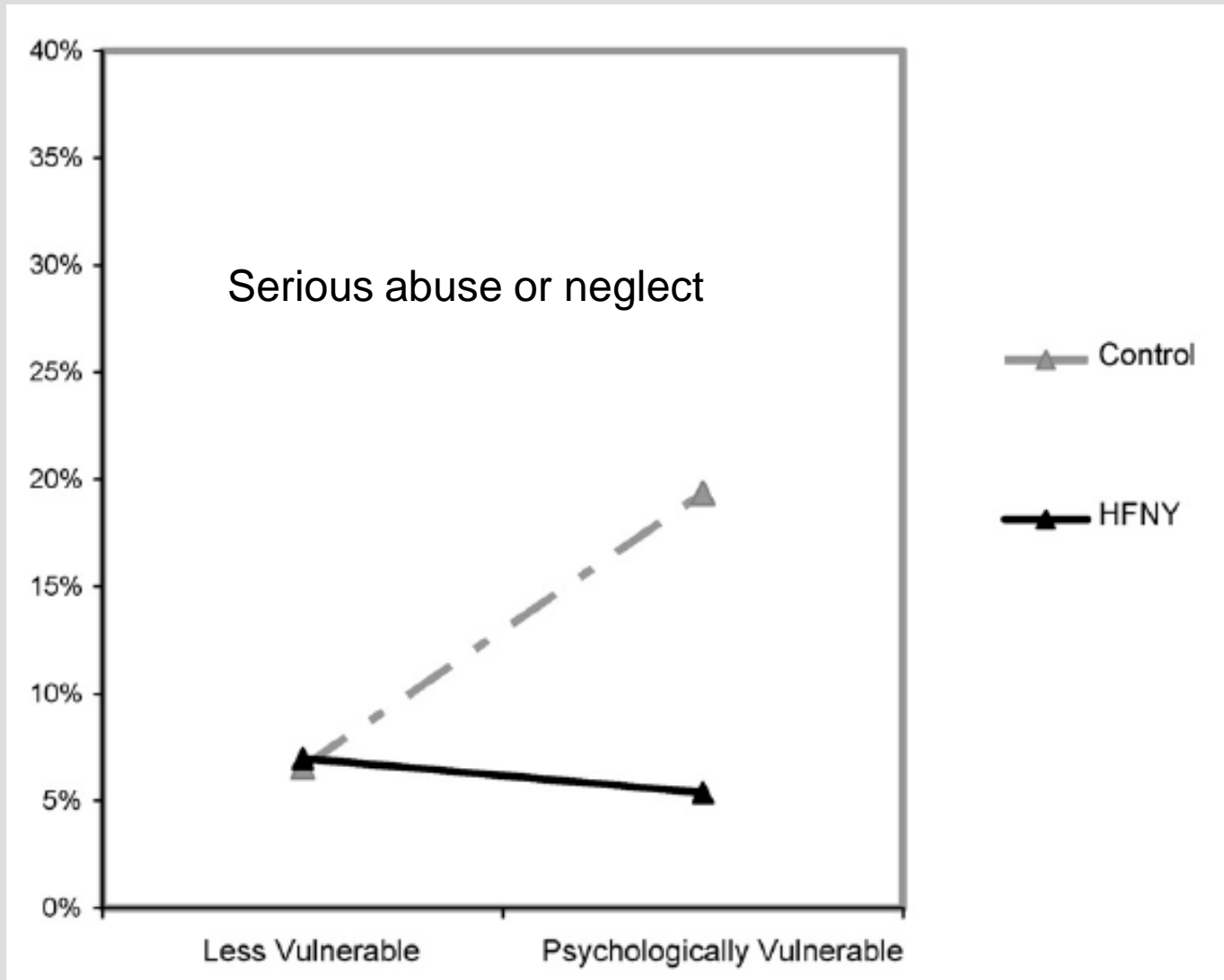
- Families recruited **after** birth of child and randomly allocated to HSP or control
- Home visits over 3-5 years, initially weekly, then bi-weekly, later monthly and eventually quarterly
- Small (but significant) differences in favour of HSP reported in use of physical/verbal punishment and neglectful behaviours
- No differences in reported maltreatment but generally low in both groups

Healthy Families New York (HFNY) evaluation (DuMont et al 2008)

- Proportion of families recruited **before** birth of child (15% of sample) defined as “prevention” group
- Mothers with high depression scores and low coping skills (10% of sample) defined as “vulnerable” group
- Home visits up to 5 years of age, biweekly during pregnancy, then weekly, and diminishing according to need thereafter



Adapted from DuMont et al 2008



Adapted from DuMont et al 2008

- **Case notes of 3393 patients with bloodstream infection treated in 1990-96**
- **Case notes randomly allocated to 2 groups in July 2000**
- **“Intervention” group had a a brief prayer said over the case notes for the retrospective well-being of the patient**

- **No differences in mortality**
- Intervention group had shorter stay in hospital ($p=0.01$)
- Intervention group had shorter duration of fever ($p=0.04$)

- Observational data can be biased because of
 - selection bias
 - reporting bias
- RCTs can largely control for such bias
- Clinical interventions can have negative effects and should be carefully scrutinized and compared to no intervention



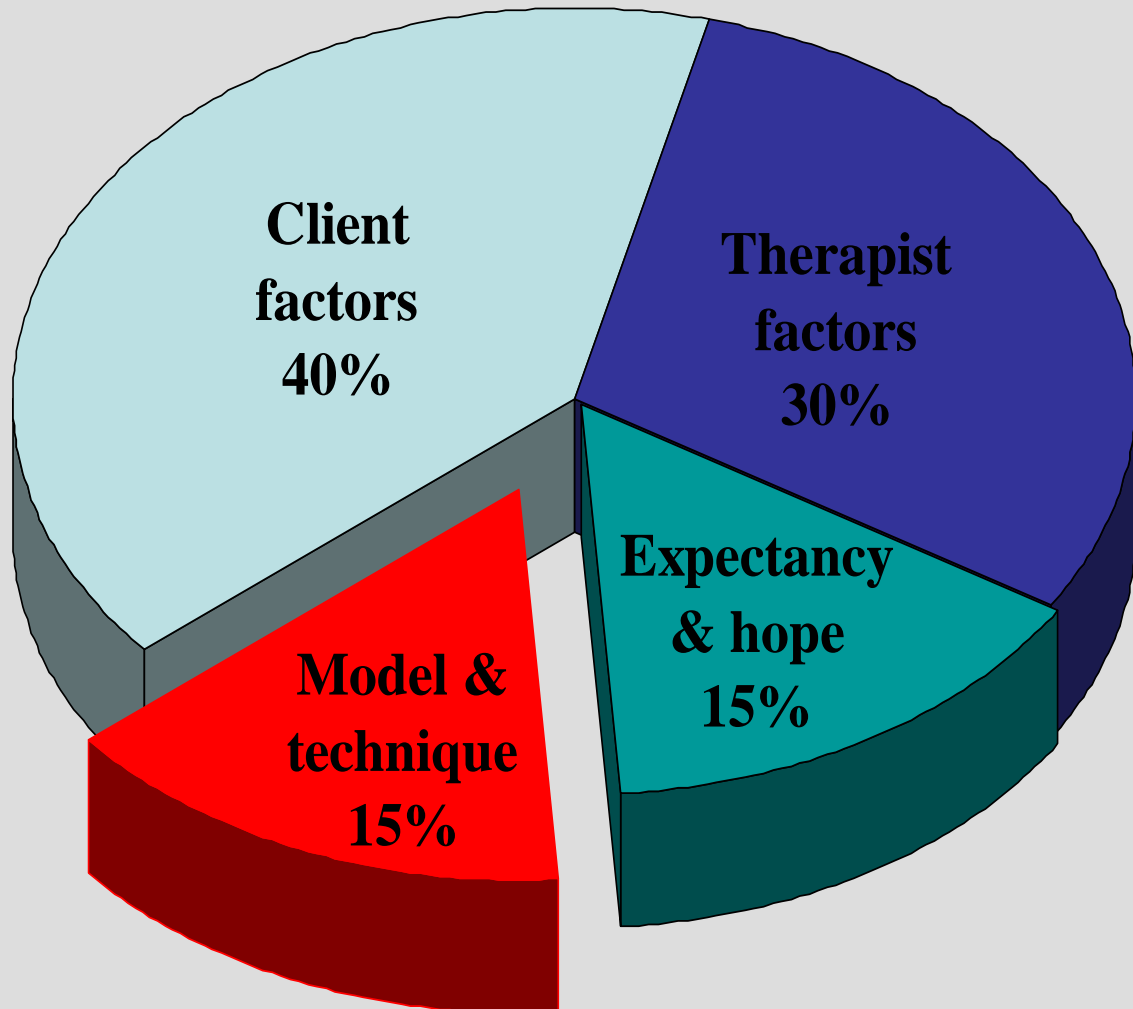
Parachutes reduce the risk of injury after gravitational challenge, but their effectiveness has not been proved with randomised controlled trials **(from Smith & Pell, 2003)**



Smith & Pell 2003 Parachute use to prevent death and major trauma related to gravitational challenge: systematic review of randomised controlled trials *BMJ*;327;1459-1461

- “The relevance to parachute use is that individuals jumping from aircraft without the help of a parachute are likely to have a high prevalence of pre-existing psychiatric morbidity.
- Individuals who use parachutes are likely to have less psychiatric morbidity and may also differ in key demographic factors, such as income and cigarette use.
- It follows, therefore, that the apparent protective effect of parachutes may be merely an example of the “healthy cohort” effect.”

Common factors in psychotherapy



Debriefing

“the experiences of 700 CISM teams in more than 40,000 debriefings cannot be ignored, especially so when the overwhelming majority of reports are extremely positive”

Mitchell & Everly, 2003

Debriefing

- Review of 15 RCTs of single session debriefing showed no short term difference between debriefing and control
- 2 RCTs with long term follow-up showed worse outcome following debriefing (particularly in those with worse initial trauma)

Researching MFT

Possible research designs – what they do and don't tell us

- Randomised controlled trial
 - Parallel group trials
 - Cluster trials
- Cohort studies (with follow-up)
- Service evaluation
- Mediator and moderator studies
- Experience of treatment studies
- Process studies
 - Observational studies
 - Self report studies (diaries, ratings)

Conclusions

- Research on treatment of child abuse and neglect limited by methodological limitations and small samples
- Prevention research of higher quality but not all studies give sufficient weight to context of intervention
- It is important to distinguish the role of evidence in making “categorical” decision and ongoing “process” decisions
- The RCT paradigm provides a useful but limited test of the efficacy of treatments
- RCTs (cumulatively) can have an important effect on professional consensus which influences the allocation of resources, training as well as clinical practice
- RCTs, by limiting clinical autonomy, will often lead to unexpected results which challenge beliefs about mechanisms of change and conceptualization of treatment
- Other research designs can be useful to explore the context of treatment, process of therapy and mechanisms of change