FAMILY-BASED PSYCHIATRIC INPATIENT SERVICES
AVANT GARDE PRACTICES IN SEARCH OF EVIDENCE-BASED VALIDATION[1]

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There are a number of advanced psychiatric in-patient services in Europe (there are few if any in the United States due to the tight restriction on services forced by managed care corporations) that integrate a systemic perspective into their practices. They constitute, in fact, an extraordinary bastion of "thinking systems" in a type of services that is frequently characterized by a staunch biological perspective. This extraordinary asset of European mental health is marred, however, by the paucity of efforts at evaluating the efficacy and effectiveness of their services. This gap needs to be filled urgently if we want these services to survive and even to flourish, especially in this era of diminishing resources and increasing expectations for evidence-based practices.

The philosophy of practice of these avant-garde systems-oriented inpatient services can be described as follows:

- Patients and families are part of the therapeutic system from the start and, in many aspects, "in charge" of the design of objectives, guided by the assumption that both patient and his/her social network are capable of change. Therefore, families are involved in the process from the start. Therefore, the very intake includes not only the patient and the staff of the institution, but the patient's family and, if available, friends, as well as prior treating professionals and agencies

- Therefore, patients' and family's ideas/views are as important guidance toward healthy changes as that of the professionals that are also part of the therapeutic team

- Most of the conversations with patients are focused on, or based on the assumption of, their strengths, and treatment plans are formulated using a positive, strength-based, optimistic language

- At the same time, respect is show for problems, worries, and fears, being progressive externalized throughout the organization of progressive narratives

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- Change is not considered a long term goal product of a complex process, but is also assumed to be able to be achieved in brief time

- Diagnosis labels are considered sticky and difficult to peal off once applied. Therefore, in most cases the "diagnostic" component is descriptive and not clinical, and, if clinical, it is provided with careful caveats.

- Within these services, operational restrictions, rules and procedures to be followed by staff and by patients are defined as the product of the institutions' limitations (rather than "for the good of the patient.")

- Success (including discharge from inpatient settings as well as reduction of utilization of external helping resources --professional or not): All good news and merits for improvement are spread, including patient, family, your staff, friends, whomever interacted w/pt

- Therapeutic practices, beyond containment if the patient is in danger of harm to self or others, and a paucity on the consensual use of psychotropic medications, are centered in the individual and collective construction of new ("better formed") stories about the problem, patient, contexts:

In the daily interaction with patients, staff, families, and all involved, one of the key processes aim at the creation of new stories. Characteristic of those practices include

- *Looking for unique outcomes or "exceptions" that will document the patients' and families, and all) skills & resilience--in the direction traced by "solution-oriented approaches"*

- *Separating the person from the problem --following practices of "externalization" s)*

- *Exploring content and context through circular questions which are framed by assumptions of positive intent*

- *Enhancing descriptions of self that showing its capacity for reflective (rather than impulsive) action, for reflection, for competency, and for responsibility (as demonstrated in prior vicissitudes witnessed by the staff, the patient him/herself, the family, and/or friends)*

- *Introducing temporality, with indications of evolution, changed future, progress and hope*

- *Establishing connections between individual and context, including life vicissitudes as well as potential resources from their personal social network*

- *Highlighting explicit or implicit ethic/moral standards, including respect for self and others, avoidance of oppression, capacity for reciprocal support, and sense of collective responsibility*

The search of validation but confont us with Dodos. What has been described above constitutes a coherent body of practices sustained by a progressive, systems oriented, narrative-based conceptual model. Both the elegance and the risk of these practices are that, within that guiding philosophy, they are self-evident. However, how do WE know that our method is the most efficient and effective way to provide steady, lasting improvement in our patients? How do OTHERS know that our methods are the most efficient and effective, or, at least, as effective much as practices? These questions are crucial not only for our own professional/ethical integrity, but, in the long run, to sustain those practices when we compare their results with those of other models and practices (or to change them if proven comparably weak), even more when resources if not survival are tided to proof of effectiveness and efficiency of methods. In order to answer those questions it is essential to evaluate outcomes. In fact, until we do so, we will remain caught in the comfortable but untenable trap of any close, un-falsifiable cosmogony, based on arguments of "self evidence": "our method is obviously the better –in addition to be the one we like the most," statements that crumbles in solipsism.

The welcomed but challenging new dominance of 'evidence based" therapies in the field of health and of mental health will know of no exceptions, and forces us to braze ourselves to undertake the harsh discipline of evaluation research: we must prove that our practices (and the theory of practices on which they are based) work, and work better.[3]

In evaluating outcomes, we may find butterflies. The definition of independent, intervening and dependent variables in the field of outcome research is extremely challenging, and that is even more so for a discipline with a systemic epistemology as is the case of family oriented approaches and its socio-epidemiological variants. The impact of a therapy or even of a single intervention in a complex system such as a family may have no discernible effects at all, or

[3] To do so entails being ready for surprises. Already in1936 Rosenzweig, discussing that common rather than model-based factors may be responsible for the positive effects of psychotherapy. He is the one who reminded us of what the Dodo pronounced at the end of a zero-sum game in Alice in Wonderland (Carroll, 1865): "Everybody has won, and all must have prizes." (p.412 of 1962 edition.) Luborsky, Singer and Luborsky (1975) confirmed this view in their review of psychotherapies outcome, and baptized it "Dodo bird effect." And a more recent meta-analysis of outcome studies (Wampold et al., 1997) affirms, in the very title of their article, that "Empirically, 'all (bona fide psychotherapies) must have prizes'." *Mutatis mutandis*, we may need to be ready to tolerate a possible collective narcissistic blow inflicted by evidence that may show that, whether we like it or not, perhaps different therapies may be roughly similarly (hopefully positive) effective when compared one another, or even that, horror of horrors, family therapy may show similar beneficial effects than other forms of therapy. I don't believe so, but don't tell me that I didn't warn you!

it may result in changes in unsuspected and unpredictable places in the system, in a sort of "butterfly effect"[4] *–an improvement in a child's asthma may result in the parental divorce of his or her parents, a couple whose relationship was sustained by that symptom; or it may lead to a joyful re-discovery of each other in the parental pair, until then overinvolved in the drama of a symptom that made the child demanding and central. It may, of course, have detectable effects in the symptomatic patient –an increase or decrease of the symptom, or a reduction of its centrality and dominance, or an overall improvement in wellbeing, or a different description of their past, perhaps traumatic, experiences, or a shift in interest or plans or vocation. It may have similar positive or negative effects on meaningful others with whom the patient and the staff interact.* Therefore, a thorough tracking of the systemic changes that may follow a single intervention or of a whole treatment may require tracking the presence or absence of symptoms or positive or negative behaviors in other family members, the engaging in or finishing of an individual or collective mourning process, shifts in relations between subsystems –parents-offspring, males-females--, opening up or reduction of exchanges with surrounding social milieu, consolidation or changes in routines, jobs, and habits. And changes in each of these variables may, alas, be the result not of therapy but of the natural evolutionary processes that unavoidably accompany the passage of time (and of roles, maturity, decay, deaths) in each system, as well as of macro socio-economic variables such as economic bonanza or crisis, political conflicts or wars in the region where the individual or the family lives, no to mention genes with timing of their own.

Chaos theory –the model that gave birth to the metaphor of the "butterfly effect"—is both a basic tenet of systemic thinking. However, it has been argued more than once as a pretext to bypass efforts at evaluating systemic therapies, posing that it would overwhelm inpatient services with impossibly complex research designs and practices, and overwhelm at the same time computer programs with too complex operations of correlation. Indeed, it may be necessary to reduce our set of intervening variables, and humbly minimize the tracking "reason for the consultation" –symptoms, conflicts, pains--- of as key outcome variable.

Research designs: An introduction. A number of research strategies can be proposed to evaluate the efficacy of systemic/family-oriented services. A first, unavoidable step will consist in operationally definite what do we do when we practice a systemic-oriented approach in our

[4] The "butterfly effect", refers to the possibility that a flap of a butterfly' wing in Hong Kong may, through a long chain of atmospheric and multiple other variables, lead to the unleashing of a hurricane in the Caribbean. This metaphor epitomizes a central tenet of Chaos Theory, namely, the sensitive dependence on initial conditions of any complex dynamic system (Lorenz 1963; see also Gleick, 1987, especially chapter 1; and Hillborn 2004)

institutions, followed by testing the reliability of these definitions within and across practitioners. In the meanwhile, we have to establish procedures that will preserve the patient/family confidentiality and anonymity.

Interestingly, the preliminary process toward operationally define what we do[5] in our institutions is not only cumbersome but frequently triggers a revision of our practices as well as an institutional revision of the theories underlying those practices, as well as a reduction of ad hoc practices. We may find ourselves fascinated by that self-reflective exercise, which may lead in it to major restructuring of the institutional practices. But this is only a prologue to the next step, namely, a long-term, multi-variable *follow-up study* of our own patients.

However, this does not truly evaluate success comparatively, unless we have a control sample with whom who to contrast our data. Alternative options include:

- To develop and implement short and long term outcome research designs comparing two approaches in different sections *within our unit* (very difficult to do due to "milieu contagion" as well as an a-priori sense by staff that one may be better than the other)

- To develop and implement short and long term outcome research comparing units that are *similar* in terms of catchment area and cost (if possible within our own hospital) but *different* in terms of treatment philosophy

- To develop and implement short and long term outcome research designs that evaluate *rate of re-hospitalization* of patients previously discharged from two units with different philosophy in same territory (if there are such units) or between units in equivalent demographic areas

And to close, a harangue. It is <u>imperative</u> that we prove that a systemic orientated inpatient service is a more effective and efficient treatment approach for psychiatric severe crisis (in addition to more humane, and all that) so as to learn from our failures as well as tout our successes. And it is <u>urgent that we do it now</u> in order not to risk disappearing because of the lack of proof of our solidity as a therapeutic practice.

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[5] Without even dealing with outcomes proper, services may develop evaluation tools of interest. For instance, the International Quality Indicator Project (Kazandjian, Wood, Lawthers, 1995; Kazandjian, Matthes, Wicker 2003; Thomson, Taber, Lally, Kazandjian, 2004) utilizes a number of variables for the evaluation of mental health services all of which readily available on record –even without patient follow-up, that is, entailing some parameters that may evaluate the effectiveness of services rather than specific long-term outcome. They include, for in-patient services, unplanned readmissions, injurious behavior and deliberate self harm, unplanned departures resulting in discharge, use of involuntary restraint, use of seclusion, transfer to a more restricted unit, and, for outpatients, unscheduled appointments within 72 hours (unless that is policy within the agency), and registered patients who abandon treatment before completion. Many other indexes could be added to this list as needed.

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