A Q-Sort Study of Conceptual Adherence to Brief Strategic Family Therapy

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Abstract

For a multi-site clinical trial testing the efficacy of Szapocznik et al.'s Brief Strategic Family Therapy (BSFT) in community settings, we developed a Views of Adolescent Drug Abuse Q-sort (VADA-Q) to study therapists' theoretical orientation. Q-methodology helps define how the BSFT model differs from other views of adolescent drug abuse and provides a useful tool for research and therapist training.

Background

This study uses Q-methodology (Stephenson, 1953; Brown, 1980) to examine therapists' views of adolescent drug abuse and to operationalize correspondence between their views and a particular theoretical orientation – Brief Strategic Family Therapy (BSFT; Szapocznik and Williams, 2000). A similar approach has been taken to understanding relationships among family therapy theories (Rohrbaugh, 1986) and conceptual adherence to alcoholism treatment (Rohrbaugh et al., 1995)

Respondents perform Q-sorts by ranking statements of opinion about some topic, usually in a forced distribution. The statistical correlation between any two Q-sorts provides a convenient index of their similarity (or dissimilarity), and when correlations among multiple Q-sorts are factor analyzed, the emergent Q factors serve to define an emergent typology of views. Factor loadings in this framework reflect the affiliation of Q-sorts with factor-viewpoints, and factor scores indicate which items contribute most and least to each factor. (This is in contrast to more familiar R-factor analysis, where items or tests are correlated across people.)

In preparation for a multi-site clinical trial testing the efficacy of BSFT in community settings, we developed a "Views of Adolescent Drug Abuse Q-Sort" (VADA-Q) to assess community therapists' theoretical orientation before they receive specialized training in BSFT. An immediate objective was to better understand similarities and differences between the BSFT perspective on drug abuse and other views likely to be held by community clinicians. We also plan to use the VADA-Q in research and training.

Method

Based on interviews with community treatment professionals and reviews of relevant literature, we assembled a set of statements representing diverse opinions about the nature and treatment of adolescent drug abuse. Some items concerned theoretical ideas regarding the nature of the drug problems, some concerned intervention aspects, and others concerned more general issues such as the importance of research in the treatment of drug abuse. To maximize sensitivity to BSFT conceptual adherence, the final sample of 56 items included more statements with potential relevance to BSFT compared to other (e.g., cognitive-behavioral, humanistic, 12-Step) viewpoints.

Q-sorts were done by 5 BSFT experts from the University of Miami (including Szapocznik), 5 other family therapy trainers familiar with BSFT, and a convenience sample of 22 addiction and mental health professionals from a variety of drug treatment programs in Tucson AZ. Each respondent sorted the 56 statements into 8 categories along a continuum ranging from "least agree" (category 1) to "most agree" (category 8), placing 7 statements in each category.

The VADA-Q was later administered to 6 clinical psychology graduate students studying family therapy in order to pilot test its utility as a training tool.

Results

Factor analysis of the 32 Q-sorts (correlating raters over items) revealed a primary factor accounting for 27% of

the common variance. All 5 of the BSFT experts and 3 of the family therapy trainers loaded very highly on this factor, indicating that it represents a BSFT view of adolescent drug abuse. The 22 addiction specialists had their highest (primary) loading on other factors, with only 3 showing a secondary affiliation (loading > .3) with BSFT. Together, factors 2 and 3 explained an additional 22% of the variance.

To interpret the Q factors, we created idealized Q-sorts by rank-ordering items according to their standardized factor scores and then assigning each item a factor-score category corresponding to the categories of the original Q-sort. Thus, for each factor, the 7 highest-ranked items received a category score 8, the next 7 received a score of 7, and so on. From this it became apparent that factors 2 and 3 represent essentially eclectic or integrative viewpoints that localize drug problems in the individual user. They seem to differ primarily in approaches to change – for example, one tends to emphasize individual skill development, while the other attaches more importance to 12-Step/recovery ideas.

Of particular interest is what distinguishes the BSFT factor from other viewpoints. Table 1 lists the items receiving the highest (category 8) and lowest (category 1) rankings on the BSFT factor, and Table 2 shows statements that discriminated between the BSFT factor and the other two factors (i.e., ranked 3 or more categories higher and lower for the BSFT factor than for factors 2 and 3).

Table 1: Items Defining the BSFT View

Items ranked highest	*Score*
07. The adolescent drug user is an "identified patient;" the real patient is the entire family.	8
25. Drug problems are linked to behaviors among family members that become habitual and repeat over time (e.g., adolescent misbehaves to distract adult from fighting).	8
23. Therapy should aim to change the pattern or sequence of interaction in which a problem is embedded.	8
09. A therapist must assess/diagnose family structure and interaction patterns in order to design effective interventions.	8
51. It is better to treat drug users and their family members conjointly (together) rather than individually or in separate groups.	8
40. Successful treatment of a drug problem usually requires realignment of family relationships.	8
42. Adolescent drug use often reflects the inability of parental figures to negotiate and agree on rules and consequences and to present a consistent, united front.	8
Items ranked lowest	
01. Long-term recovery from substance abuse requires a process of spiritual renewal.	1
26. Counselors should help adolescent drug users find something bigger than themselves to invest or believe in.	1
11. Complete detoxification is necessary before a substance abuse treatment can be effective.	1
06. Accepting and surrendering to a higher power is an important step towards recovery.	1
03. Residential treatment for substance abuse is usually essential for successful recovery.	1
52. Group treatments for adolescent drug users are usually more effective than individual therapies.	1
50. Family therapy for drug abuse is ill advised when the family is extremely dysfunctional or abusive.	1

Table 2: Items Distinguishing the BSFT View from Two Other Views

Item	*BSFT*	*Fac 2*	*Fac 3*
42. Adolescence drug use often reflects the inability of parental figures to negotiate and agree on rules and consequences and to present a consistent, united front.	8	2	3
51. It is better to treat drug users and their family members conjointly (together) rather than individually or in separate groups.	8	4	4
21. Adolescent drug abusers often find themselves at the center of a conflict between two other more powerful persons.	7	1	2
31. Drug abuse treatments should be based on solid research findings and employ only well-validated principles and techniques.	7	1	2
49. The way adolescents and their family members talk about problems is more important than the content of what they say.	7	3	3
28. Adolescent drug abuse often occurs when family members are too close or too distant, or when coalitions cross generation lines.	7	1	4
05. If a drug problem can be resolved without clients knowing how or why, that is satisfactory.	6	1	1
36. A counselor must first be accepted as a special temporary member of the drug user's family in order for treatment to be effective.	5	1	2

15. Effective treatments help clients identify and resist cues or “triggers” for drug use.	5	8	8
20. Effective treatment helps drug users learn new skills such as anger and stress management and other more effective ways of coping.	5	8	8
30. Adolescent drug abuse is symptomatic of other needs and deeper unresolved conflicts.	3	7	7
17. Drug users can only be helped if they want to change.	2	5	8
52. Group treatments for adolescent drug users are usually more effective than individual therapies.	1	8	6
26. Counselors should help adolescent drug users find something bigger than themselves to invest or believe in.	1	6	6
01. Long-term recovery from substance abuse requires a process of spiritual renewal.	1	6	5

Tables 1 and 2 make clear BSFT's commitment to viewing drug problems in context and treating them conjointly. Compared to other clinicians, for example, BSFT therapists pay close attention to parental unity and monitoring (42), clarity of generation boundaries (28), and triangulation of children into adult conflicts (21). They also consider a family's interaction style more important than the content of what family members say (49), and attach less importance than other therapists to individual motivation (17), skill acquisition (20), spirituality (26), or the notion that insight and awareness are necessary for behavior change (5).

Applications

In addition to defining basic assumptions of the BSFT model and how these differ from other perspectives, the VADA-Q offers an approach to assessing therapists' "conceptual adherence" to BSFT, which can then be applied in training and research.

When the clinical trial begins, BSFT trainers will use the VADA-Q to provide individualized feedback about how a particular therapist’s initial views converge with and diverge from the BSFT model. In this way it may be possible to enhance conceptual adherence while making trainees’ idiosyncratic or incompatible views more explicit. A template for providing such individualized feedback (which we have used with psychology graduate students) is illustrated in Appendix 1.

A research application will be to examine therapists' pre-training theoretical orientation (operationalized with the VADA-Q) as a predictor of later BSFT skill acquisition, as rated from therapy tapes, and of case outcomes in the clinical trial. We expect about 800 families to be randomly assigned to either BSFT or TAU (treatment as usual), and at least 30 BSFT and 30 control therapists to be randomly assigned to provide either therapy.

A limitation is that the VADA-Q oversamples statements relevant to BSFT, thus restricting the depth and precision with which other viewpoints can be represented.

References

Brown, S.R. (1980). *Political subjectivity: Applications of Q-methodology in political science*. New Haven: Yale University Press.

Rohrbaugh, M. (1986). Q-sort comparisons of the structural, strategic, and systemic family therapies. *American Journal of Family Therapy, 14*, 40-48.

Rohrbaugh, M., Shoham, V., Spungen, C., & Steinglass, P. (1995). Family systems therapy in practice: A systemic couples therapy for problem drinking. In B. Bongar & L. Beutler (Eds.), *Comprehensive textbook of psychotherapy: Theory and practice* (pp. 228-253). New York: Oxford University Press.

Stephenson, W. (1953). T*he study of behavior: Q-technique and its methodology*. Chicago: University of Chicago Press.

Szapocznik, J., & Williams, R. A. (2000). Brief strategic family therapy: Twenty-five years of interplay among theory, research and practice in adolescent behavior problems and drug abuse. *Clinical Child and Family Psychology Review, 3,* 117-135.

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