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Practice Based Evidence Based Practice. Navigating based on coordinated improvisation, collaborative learning and multi-methods research in Feedback Informed Systemic Therapy*

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In times when therapy is legitimized by transparency through control, standardization and benchmarking, the authors present a fluid manual of Feedback Informed Integrative Therapy within Systems (FITS) as a Practice Based Evidence Based Practice (PBEBP). The fluid manual FITS corresponds to the locality and complexity of social and cultural life and is substantiated by practice-based research. The FITS therapist navigates her reflected responses on the basis of coordinated improvisation, organized feedback, collaborative learning and multi-methods research. Accountability and transparency are offered through i) quantitative measurement of effects, developments and points of collaboration in therapy and ii) qualitative inquiry into navigational activities using improvisation and collaborative learning. FITS is a Practice Based Evidence Based Practice (PBEBP). The therapist is both practitioner and researcher and involves clients as co-researchers. Therapist and clients examine the effects of their collaboration. The output of research is input for therapy in the 'collaborative learning community' constituted together.

Practitioner points

- This article may inspire practitioners to manualize and research their own family therapy practice as a Practice Based Evidence Based Practice
- In FITS, a PBEBP therapist and family members constitute a 'collaborative learning community', learning together how they learn and evaluating their collaboration in therapy
- Practice Based Evidence Based Practice could be an alternative to standardized therapy models and manuals

Keywords: feedback; manualized practice; improvisation; collaborative learning; multi-methods research; family therapy research; systemic therapy.

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* The Journal of Family Therapy is delighted to announce that, from now on, abstracts will be translated into Spanish as well as Mandarin. We are grateful to Professor Valentin Escudero and his team for translation of the Spanish abstracts.

以基于实践的证据为本的实践：在反馈导向系统治疗中基于有组织的即兴发挥、合作学习和多方法研究的应对

在控制、标准化和基准测试所带来的透明度使治疗合法化的时代，作者提出了一种灵活的系统内反馈导向综合治疗（FITS）的手册，作为一种以基于实践的证据为本的实践（PBEBP）。该灵活手册FITS呼应社会和文化生活的地域和复杂性，并基于以实践为基础的研究。 FITS治疗师在有组织的即兴发挥、反馈、合作学习和多方法研究的基础上应对她所接收的反馈。通过1）对治疗中的效果、发展和合作点进行定量测量，以及2）使用即兴发挥和合作学习对引导活动进行定性调查，以提供责任制、保证透明度。 FITS是一种以基于实践的证据为本的实践（PBEBP）。治疗师既是从业者，也是研究人员，并将来访者看作共同研究人员。治疗师和来访者一起调查这种合作的效果。研究产出的结果成为共同构建的“合作学习团体”治疗投入。

对实务工作者的启示

- 本文或许会启发实务工作者将他们自己的家庭治疗实践作为以基于实践的证据为本的实践，来进行手册化和研究
- 在FITS中，PBEBP治疗师和家庭成员组成一个“合作学习团体”，一起弄清他们如何学习，并评估他们在治疗中的协作
- 以基于实践的证据为本的实践可以替代标准化治疗模型和手册

关键词：反馈；手册化实践；即兴；合作学习；多方法研究；家庭治疗研究；系统治疗

Práctica Basada en la Evidencia Basada en la Practica. Navegación basada en la improvisación coordinada, el aprendizaje colaborativo y la investigación multi-método en la Terapia Sistémica Informada por Retroalimentación

En estos tiempos en los que la terapia se legitima mediante la transparencia a través del control, la estandarización y el benchmarking, los autores presentan un manual de Terapia Integrativa Informada por Retroalimentación Intra-Sistemas (FITS, por sus siglas en inglés); dicho manual se concibe como una Práctica Basada en la Evidencia Basada en la Práctica (PBEBP). El manual FITS responde a las características de localidad y complejidad de la vida social y cultural y está sustanciado por la investigación basada en la práctica. El terapeuta FITS navega sus respuestas reflejadas sobre la base de

la improvisación coordinada, la retroalimentación organizada, el aprendizaje colaborativo y la investigación de múltiples métodos. Se ofrece transparencia y se da cuenta responsablemente a través de (i) medidas cuantitativas de efectividad, desarrollo y puntos de colaboración en la terapia y (ii) indagación cualitativa en las actividades que se recorren usando improvisación y aprendizaje colaborativo. FITS es una Práctica Basada en la Evidencia Basada en la Practica (PBEBP). El terapeuta es tanto profesional como investigador e involucra a los clientes como co-investigadores. El terapeuta y los clientes examinan los efectos de su colaboración. El resultado de la investigación es a su vez un input para la terapia en la "comunidad de aprendizaje colaborativo" constituida en conjunto.

Puntos de implicación práctica

- Este artículo puede inspirar a los terapeutas a manualizar e investigar su propia práctica de la terapia familiar como una Práctica Basada en la Evidencia Basada en la Práctica
- En FITS un terapeuta PBEBP y los miembros de la familia constituyen una "comunidad de aprendizaje colaborativo", aprendiendo juntos cómo aprenden y evaluando su colaboración en terapia
- La Práctica Basada en la Evidencia Basada en la Práctica puede ser una alternativa a los modelos y manuales de terapia estandarizados

Palabras clave: retroalimentación; práctica manualizada; improvisación; aprendizaje colaborativo; investigación multi-métodos; investigación en terapia familiar; terapia sistémica.

Introduction

This article is a response and hopefully a contribution to an ongoing conversation about bridging the gap between practice and research (Baldwin, 2012; Tilsen and McNamee, 2015) within the field of systemic family therapy. Traditionally evidence-based, empirical and postmodern orientations have been presented in opposition to one another. Recently, however, authors (Chenail, 2005; Sundet, 2012; Tilsen and McNamee, 2015) have proposed an integration of approaches. Quantitative and qualitative research are taken as compatible in multi-methods research designs (Chenail, 2005). Some authors (Escudero, 2012; Pote, Stratton *et al.*, 2003) promote the adoption and development of treatment manuals for research. Others (Tilsen and McNamee, 2015) unite evidence-based practice and

practice-based evidence but reject the use of manuals. Within this conversation we shaped our work and writing.

We, the authors, work as systemic therapists, teachers and supervisors in a mental healthcare institution in the Netherlands. Some time ago a company manager asked us to implement standardized systemic therapy. We asked ourselves whether we could commit to a singular model or treatment manual, decided not to, and developed, described and researched our own family therapy practice.

Psychotherapy, nowadays, is legitimized by its accountability, often with a focus on control. Policy-makers in healthcare organizations strongly believe that change is manageable, that competence and results can be maximized, by controlling processes of offering care in transparent ways. Here, accountability with a focus on control can be achieved through the large-scale introduction of evidence-based therapy standards and monitoring systems. This has led to the application of manualized treatments, systematic (routine) outcome measurement and benchmarking.

Yet our critique of the standardization of such treatment models and monitoring systems is that it decentres four main elements that we value in our therapeutic work. First, it overlooks the advantages of integrating multiple theories, practices and skills, gathered individually, over time. Lebow (2007) argues that each family situation demands a different configuration of theory and procedure to be emphasized. In an integrative family therapy approach, a therapist matches useful, evident concepts and techniques with the actual questions, needs and capabilities of clients (Lebow, 2007). Secondly, the standardization of treatment models ignores the importance of the therapeutic alliance, a partnership where both therapist and family members agree on the nature of the therapeutic process itself. Success in therapy is mostly the result of the following factors: the therapeutic alliance, the therapist's characteristics, allegiance and expectancy (Hubble, Duncan and Miller, 1999). Hubble, Duncan and Miller (1999) promote therapy informed by client feedback on outcomes, developments and collaboration.

Thirdly, improvisation, a crucial therapeutic skill, receives little attention in manuals and is often seen as an unwanted side effect. The family therapist has to improvise and respond in a 'fitting' matter to particular circumstances (Shotter, 2007). As these circumstances evolve spontaneously, one can never know what they will be, how they might arise or when they might occur (Andersen, 1991). Fourthly, standardization, in order to control, conflicts with a systemic perspective on

organizational learning (Beats, 2006; Blackmore, 2010). In complex non-linear systems, small changes can have dramatic effects and can generate much complex behaviour, because they may be amplified repeatedly by self-reinforcing feedback (Capra and Luisi, 2014). Control and structure are, therefore, counter-productive and have a paradoxical effect. As much as we control a symptom, the symptom will control us. Self-learning systems, however, allow for entropy, a tendency to move towards the edge of chaos (Beats, 2006).

We developed a 'fluid' manual of feedback-informed systemic therapy. We call our approach FITS (Feedback Informed Integrative Therapy within Systems). With FITS we seek to balance structure with spontaneity in a way that allows the methodical exploration of uncertain processes and outcomes. The therapist uses a manual and a time frame on the one hand and co-creates an appropriate configuration of theory and procedure in dialogue with family members on the other.

Could accountability be offered with a focus on relational ethics rather than control? Tilsen and McNamee (2015, p. 125) encourage the SCD (Systemic, Constructionist, Dialogic) therapist to maintain 'an ethical and relational orientation while simultaneously generating "evidence" that can inform effective practice'. Carr and Kemmis (1986) insist that, in order to promote democratic and dialogic validity, practitioner research must be done as collaborative inquiry. Gergen (1985) stated: 'truth is a local practice'. Validation and verification occur within particular communities and their 'language games', 'a validation from within'.

FITS is Practice Based Evidence Based Practice. Accountability will be offered by using a fluid manual, multi-methods research and collaborative inquiry. The outcomes of research are the inputs for collaborative learning in the system that the therapist and family members co-create together.

Practice Based Evidence Based practice

Practice Based Evidence Based Practice implies that no therapy is delivered without measuring its effects and no research is done outside the practice itself. The therapist and family members examine the effects of their cooperation in collaborative research. The output of research is input for therapy and for reconstruction of the fluid manual.

We develop FITS as PBEBP in five domains (Figure 1). (1) Manualization. We co-created a 'fluid' manual of feedback informed family

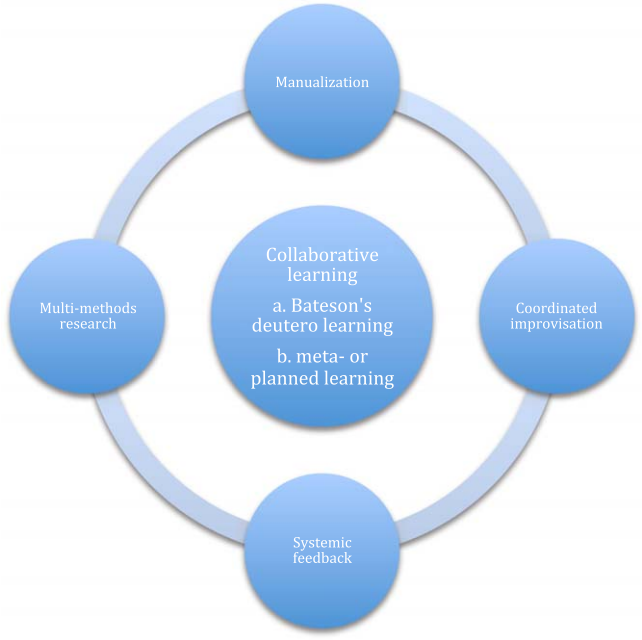

Figure 1. Practice Based Evidence Based Practice. [Colour figure can be viewed at wileyonlinelibrary.com]

therapy. (2) Coordinated improvisation. Therapists improvise in unpredictable situations within frames of meaning. We coordinate our improvisations when we are able to reflect on the connections and frames we make together. (3) Systemic feedback. We organize structured feedback, discuss developments and collaboration and learn how to improve collaboration. (4) Collaborative learning, central in this approach, is enhanced in the process of improvisation, feedback and research. By using feedback and doing collaborative inquiry we learn how we learn together. (5) Multi-methods research. With quantitative and qualitative data we inquire how a therapist navigates based on coordinated improvisation and collaborative learning in feedback-informed systemic therapy.

Manualization

With FITS we want to be accountable for unplanned organic processes as the main focus of our practice by co-creating a fluid manual

and doing multi-methods research. Co-creating a manual is not an obvious move, and it might even be considered controversial from a constructionist perspective. Tilsen and McNamee question the use of manuals: 'EBP often relies on manualized approaches, thus silencing creativity in the therapeutic practice, marginalizing relational inclinations, restricting therapists' capacity to respond to clients' unique circumstances' (Tilsen and McNamee, 2015, p. 125). They argue: 'When we view therapy as social construction, we are not particularly interested in predetermining what sort of interactions will produce transformation' (Tilsen and McNamee, 2015, p. 127).

Developing FITS as PBEBP we are interested to learn what sort of interactions produce transformation, but locally. 'What works for this therapist and these family members in their situated moment of collaborating?' Therapists improvise, but based on knowledge, skills and values. The former jazz musician and organizational adviser Frank Barrett (2012) connects the art of improvisation with training of skills and learning standards, in the way a jazz musician would. He quotes jazz legend Mingus: 'you can't improvise on nothing; you got to improvise on something (Barrett, 2012, p. 67). We improvise in therapy on knowledge and skills and cluster that in a coherent and flexible narrative, our 'fluid' manual.

Escudero (2012) promotes the use of treatment manuals for research in systemic family therapy, but calls it a heresy. A treatment manual, to be used for reliable outcome research and reproduction, should be the operationalization of the independent variable in research and, therefore, a precise description of the exact and time-framed steps a therapist takes. The therapist is only part of the procedure and the therapeutic relationship is a confounding variable (Escudero, 2012). This clashes with core values in systemic, constructionist family therapy. Relational communication between therapist and family members during therapy sessions is fundamental when explaining the therapeutic process, even though, Escudero argues, adopting manuals for research is the best way to answer questions like: 'How does family therapy work? What makes "good therapy" good? Do therapists do what they say they do?' He proposes the integration of empirically informed guidelines into practice and encourages process-outcome research, coherent with the systemic model and in a way that does not constrain the therapist's creativity. 'Such guidelines allow therapists to use manuals flexibly so that they deepen the understanding of the process of therapy' (Escudero, 2012, p. 106).

Our challenge, in co-creating FITS, was to develop a manual coherent with personal, systemic and constructionist values and useful for reliable research. We learned to see the manual differently, not as an operationalization of the independent variables but as a necessary myth, defined by Anderson *et al*., (2010, p. 157) as:

> *The complex interplay of a therapeutic orientation (myth), including its specific techniques (ritual), within the context of a healing setting and a relationship that provides the needed ingredients for successful psychotherapy.*

It provides a culturally acceptable rationale for change and fits with the idea of 'allegiance': a shared theory of change and agreed directions in therapy promote commitment towards collaboration. Both therapists and clients negotiate a collective frame of reference that permits them to undergo family therapy, to challenge dominant ideas, to break repetitive patterns and to do something unusual towards seeking beneficial change.

The focus on 'manualizing' as a verb indicates a process of describing, re-describing and adapting a fluid manual as a result of learning by feedback. Manualizing enables us to present FITS as a coherent and flexible narrative, open for exploration, critique and development. We do not want to generalize knowledge and establish a uniform approach. We rather constitute a 'learning community' and learn how therapist and family members learn together.

Coordinated improvisation

Learning, a transformation of living together, starts when the actual consequences of an action strategy do not correspond with the expected consequences (Visser, 2007). We learn in these unique moments of discrepancy, if we are able to reorganize ourselves and creatively respond in a 'fitting' manner to what spontaneously occurs. The FITS therapist improvises and invites family members to improvise in moments where they, previously, got stuck in repetitive patterns and fixations. We escape from these patterns and fixations if we co-create a 'zone for unforeseen connections' (Deleuze) and allow for some randomness and disorder in our interactions.

Improvisation is 'the art of adjusting, flexibly adapting, learning through trial and error initiatives, inventing ad hoc responses, discovering as you go on' (Barrett, 2012, p. 12), an embodied performance

of self-readiness (Goldmann, 2010) and risk-taking. Furthermore, Shotter (2007, p. 19) writes about readiness and risk-taking in therapy in his article 'Tom Andersen's way of being Tom Andersen'.

> *He had a composure that manifested a readiness – after a pause, after a moment of 'inner dialogue' – to respond in a 'fitting' manner to whatever might happen. But to live like that, to live in that moment of risk and uncertainty, to live with the fear of having to act, yet not knowing whether your action will be 'fitting' or not, being able to trust that if it wasn't, then others will help out, requires, I now think, a special kind of way … that I think we need constantly to remind ourselves of.*

The improvisational therapist is sensitive to whatever happens or comes to mind and 'reflects in action'. 'This *reflection-in-action* reveals itself in the thousands of small and ordinary questions the therapist asks herself in her inner conversation during her talks with clients: "What will I say? What will I ask? To whom? What do they expect from me? What will I do next?" and so on' (Rober, 2010, p. 159). The therapist is 'careful to monitor implicit invitations to join the family members in potentially destructive relational scenarios, reflect on the possible negative and perpetuating effects of her interactions with the family, and explore opportunities to proceed with the session in new and more constructive ways' (Rober, 2011, p. 233).

The FITS therapist senses, monitors invitations and reflects through inner dialogues, responding to self-reflexive questions such as: 'What invitation do I feel, how do I respond and can I make a difference?' A therapist's response, spontaneous or considered, can be reactive or reflexive. In a reactive pattern we sustain repetitive patterns. In reflexive patterns we open up space for new connections, reframing, something new to happen. Learning as a result of the therapist's improvisation widens our variety of possible future responses in undetermined interactions. Coordinated improvisation is learning through improvisation informed by systemic feedback.

Systemic feedback

FIT, Feedback Informed Therapy (Hubble, Duncan and Miller, 1999), often used in systemic family therapy, is an APA-registered evidence-based practice. In FIT the therapists take responsibility for creating a culture of feedback, using the outcome rating scale (ORS) and the session rating scale (SRS) (Miller and Duncan, 2000). The

conversation based on the ORS and SRS allows clients to tell us what is not working well, when we are not being helpful, and when we need to make changes in order to keep the conversation going in a meaningful way (Bargmann and Robinson, 2012).

As systemic therapists, we consider the focus in FIT as rather individualistic. The ORS/SRS scores represent individual perspectives. The 'identified patient' remains the central focus if only his or her wellbeing is rated in scales. Only the collaboration between the therapist and the family is evaluated in the SRS. It leaves out other collaborations. With FITS we add the 'S' of systemic therapy to the abbreviation. We consider the system that the therapist and family members constitute together. We developed and now use the FGS (Family Goals Scale) to negotiate personal and family goals (that can, and often will, change over time). Family members rate how they, as a group, collaborate to move closer to their goals.

Feedback in FITS is used as in FIT and also as in cybernetics (Von Foester, 1984). Cybernetic theory helps us to understand collaborative learning by feedback in the system we constitute together.

> *A community that maintains an active network of communication will learn from its mistakes, because the consequences of the mistake will spread through the network and return to the source along feedback loops. Thus the community can correct its mistakes, regulate itself, and organise itself* (Capra and Luisi, 2014, p. 96).

The system that the therapist and family constitute together could be seen as a 'self or social learning system' (Beats, 2006; Blackmore, 2010). Living systems, according to Maturana and Varela (1987), are self-organizing (auto-poietic). However, they are strictly dependent on their environment. System and environment transform together in mutual relationships. Learning is an expression of structural coupling. 'Organisms are structurally determined; reproduce themselves within the boundary of their own making. The environment permits the actualization of the organism' (Capra and Luisi, 2014, p. 134). Environmental influences trigger structural changes, but do not direct or specify them. A learning system co-evolves, renews its structure, expands its variety of behavioural modes and maintains compatibility with life's ever-changing dynamics.

> *As a living organism responds to environmental influences with structural changes, these changes will in turn alter its future response, because the organisation responds to a modification of behaviour on the basis of previous experience – is what we mean by learning* (Capra and Luisi, 2014, p. 255).

Epistemological approach	Systems	Learning	Learning how
Positivism	Closed systems	First order: Single loop learning	Adaption to external norms or expert knowledge.
Constructivism	Open systems	Second order: Double loop learning	Reflexivity. Triggering structural changes within the system that open up new possibilities to connect.
Complexity Theory	Complex systems	Third order: Deutero learning	Learning how to learn. (1) Coordinated improvisation. (2) Meta-learning
Constructionism	Belief systems	Collective meaning making	Co-construct a collective frame of reference that fits.

Figure 2. Perspectives on learning.

Collaborative learning

Collaborative learning means mutual reflective learning. Anderson (2012) speaks about a 'collaborative learning community' referring to training and supervision groups. Therapist and family members alike learn, through feedback, how to become an effective team, to be collaborative in ways that benefit all members as well as the group as a whole.

Collaborative learning is pursued by the question: how do we learn how we learn? We can understand learning from positivist, constructivist and constructionist perspectives on learning and change (Figure 2). From a positivist epistemological approach, knowledge exists independent of the learner. First-order learning is functional and informative education. The learner adapts behaviour to external norms and expert knowledge. From a constructivist epistemological approach, the learner constructs knowledge. Second-order learning, as the result of reflexive dialogues, occurs when assumptions and aspirations become

the subject of our learning. Third-order or deutero-learning means learning how we learn in unpredictable circumstances. This implies that we learn about the contexts in which experiences of repetitive interactions are formed, maintained, and altered (Visser, 2003). From a constructionist perspective, the learner constructs knowledge not as a reflection but as an artefact of communal interchange (Gergen, 1985). In the process of social constructionism we co-create a collective frame of reference, a cultural environment that allows our existence.

Learning how to learn, in cybernetic terms, is 'third-order learning'. Visser (2003, 2007) discerns different kinds of third-order learning. He uses Bateson's (1972) concept of deutero-learning to describe a learning that is a creative but implicit, often an unconscious adaptation in response to patterns of conditioning. Bateson's concept of 'deutero-learning' helps us to understand coordinated improvisation as a collaborative learning process. Visser describes meta- and planned learning as another kind of third-order learning. Meta- and planned learning are structured inquiries to processes in which single-loop and double- loop learning take place. We link Visser's concept of meta-learning and planned learning to manualizing and multi-methods research as a collaborative learning process (Figure 1).

FITS, a fluid manual

In our FITS manual (Figure 3) we divide the therapeutic process into six phases: (1) information and preparation; (2) alliance, creating a culture of feedback; (3) context and focus; (4) attunement, invitations to reflexivity; (5) actions, connections and improvisations; and (6) evaluation and learning how to learn. FITS therapy takes about 15 to 17 sessions. During sessions 3, 5, 8, 12 and 15 we evaluate the process. Evaluation is the pulse of FITS. We structurally organize feedback, using quantitative and qualitative information in evaluative dialogue. We gather quantitative information by using ROM (routine outcome measurement) before, during and after therapy. We use the outcome rating scale (ORS) and the session rating scale (SRS) in every therapy session. We use our own FGS (Family Goals Scale) during evaluations. Family members set personal and family goals and rate how they themselves and others have collaborated to achieve these goals. We gather qualitative information from the evaluations, asking: how do we cooperate more effectively in order to learn

Phases	**Practices**	**Inquiry**
Phase 1: Preparation	Intake and information	R.O.M.
Phase 2: Alliance	Creating a culture of feedback	ORS, SRS
	Evaluation in session 3	ORS, SRS, FGS
Phase 3: Context and focus	Discussing preferred directions in therapy	ORS, SRS
	Evaluation in session 5	ORS, SRS, FGS
Phase 4: Attunement and reflexivity	Invitations to reflexivity	ORS, SRS
	Evaluation in session 8	ORS, SRS, FGS, ROM Qualitative research - I: Select critical moments - II: Adding inner dialogues to the transcript. - III: Focus on patterns between therapist and family members. - IV: Contextualize patterns (contextual and implicative forces). - V: Learning how to learn.
Phase 5: Actions, connections, improvisations	Finding ways to go on based on improvisations and collaborative learning	ORS, SRS
	Evaluation in session 13	ORS, SRS, FGS
Phase 6: Learning how to learn	Evaluation in session 15	ORS, SRS, FGS, ROM Qualitative research - I: Select critical moments - II: Adding inner dialogues to the transcript. - III: Focus on patterns between therapist and family members. - IV: Contextualize patterns (contextual and implicative forces). - V: Learning how to learn.

Figure 3. A fluid manual of FITS practice and research.

collaboratively and get closer to the goals and directions the family have set? We analyse the transcripts of evaluative sessions and learn how the therapist navigates feedback-informed systemic therapy.

FITS as Practice Based Evidence Based Practice

In FITS as PBEBP we use a multi-methods design (Figure 3). We combine quantitative and qualitative methods in a complementary and preliminary sequence (Bishop and Morgan, 1998). Quantitative data/material is used as information in principal qualitative research. We cannot understand the quality of navigation, collaboration and developments by quantitative results alone, without having interpretive conversations with participants in the project (family members in family therapy). Quantitative outcomes are used here as 'conversational tools' (Sundett, 2012) in order to reflect on the process of collaborative learning in FITS therapy.

With quantitative research we produce reliable information about effects, developments and collaboration in therapy. To measure this we use as Routine Outcome Measurement the YSR (Youth Self Report; Achenbach, 1991), CBCL (Child Behaviour Checklist; Achenbach, 1991) and OBVL (Parenting Burden List; Vermulst *et al*., 2012). We use the ORS (Miller and Duncan, 2000) to measure the affected dimensions of a family member's life and the SRS (Miller and Duncan, 2000) to measure the quality of the therapeutic alliance. By these lists we measure primarily individual functioning, not family functioning. We use these outcomes as conversational input improving collective collaboration. The FGS (Family Goals Scale) is used to measure collaborative achievements in relation to personal, family and community valued directions.

With qualitative research we intend to understand unplanned organic change in FITS. We audio-record evaluative dialogue and analyse written transcripts according to five steps.

(i) Shortly after audio-recording the sessions the therapist/researcher selects two or three 'critical moments' out of every conversation. Critical moments are moments in which: 'if we act wisely, we can change the trajectory of the conversation and thus create a different "afterlife"' (Pearce, 2007, p. 3).
(ii) The therapist/researcher adds the inner dialogues to the transcript and responds to inner questions such as: what is the invitation in this experience, what pattern is (re-) produced, how can I make a difference?
(iii) The therapist/researcher focuses on patterns between family members and therapist. Patterns can be reactive or reflexive. Reactive patterns are self-reinforcing repetitive circles. There is a low level of reflexivity on intentions, effects and assumptions.

Reflexive patterns (a high-level reflexivity), on the contrary, open up space for new connections, reframing and for 'something new' to happen.

(iv) The therapist/researcher contextualizes patterns. We use Pearce's concept of 'logical (contextual and implicative) forces', or 'perceived oughtness' (Pearce, 1989) to inquire how patterns evolve within different layers of meaning. Contextual force describes how meaning, within a frame of reference, allows and affects interaction. Implicative force describes how interactions shape meaning, make a (re-) frame of reference.

(v) The therapist/researcher examines how family members and therapist learn how to learn, as a result of first- and second-order learning, coordinated improvisation and co-creating a collective frame of reference that allows existence in preferred ways.

The case of Jenny and her parents

Between August 2014 and August 2016 we worked with the first manualized version of FITS. We offered FITS family therapy to twenty families. Among those families was the case of Jenny and her parents. We illustrate FITS as PBEBP by using transcripts of two audiotaped evaluative sessions (8 and 15) from Jenny's case.

> *Jenny, 12 years old, is referred for therapy because of truancy, self-harm and thoughts about suicide. Her parents panic and respond with fear and anger. This has an escalating effect. Jenny feels guilty about the effect her behaviour has on her parents. She says she doesn't deserve to live because of this. In therapy we try to understand this pattern in context. Mother is the primary caregiver and has a close protective relationship with Jenny. Father takes a more distant position. Mother talks about violence in her family of origin. Five years ago mother had a burn-out and father experienced a depression. Jenny supported her mother, emotionally and by doing the housework, during those months. After her parents had made their recovery, Jenny began to refuse to go to school.*

During session 8 we evaluated developments and collaboration in therapy. Jenny had returned to school with the help of an interagency collaboration agreement between family, therapists and school, but later she relapsed. Mother told me that Jenny harmed herself badly and cycled along the railway during school time. The ROM and ORS

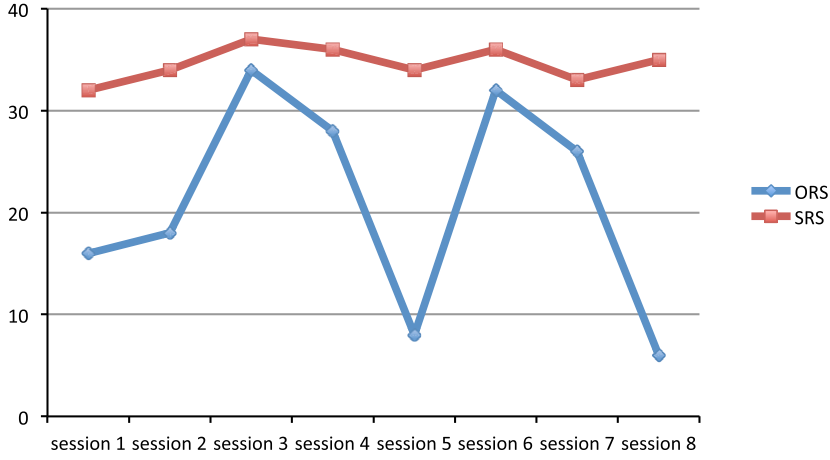

Figure 4. Diagram ORS/SRS Jenny. [Colour figure can be viewed at wileyonlinelibrary.com]

scores went down. I showed the results in graphics to the family (Figure 4).

I (Robert) audio-record the evaluation session, select critical moments and write transcripts (i).

Critical moment 1

Therapist: How do you do Jenny?

Jenny: (giggles) I am fine.

Therapist: This is the diagram of the lists you fill in every session.

Jenny: What is a good result?

Therapist: The higher, the better (with a smile). See It starts with score 16 and after that up to 34 and then. . .. Down, bam to 8.

Jenny is laughing

Therapist: Than back up high (points at the diagram) and now back downhill to 6.

Jenny: Bam.

Jenny: I didn't go to school from here (points at session 5 at the diagram).

Mother: We don't know what to do, we are all going down now, we need more help I think. We can't take it any longer.

Father: We put trust in this therapy and in you, Robert. But there is more to be done.

Critical moment 2

Mother: She covers up her feelings.

Mother to Jenny: Tell us what you really feel Jenny, not what you think we would like you to say.

Mother to therapist: She acts in a socially desirable way. She bakes cakes for us if she thinks we are angry with her.

Father to Jenny: We aren't angry with you.

Mother to Jenny: No we are not.

Jenny looks away.

After writing the transcript I add my inner dialogue to the text (ii).

Jenny ignores parents' panic and giggles. Family members reinforce each other's responses in unwanted repetitive patterns. Parents express despair and I feel a strong invitation to calm them down or to take over responsibilities. Do I feel what Jenny feels? I'll engage in these repetitive patterns if I take these invitations. We will allow too much dependency in the therapeutic alliance, which confirms their inability to act. How can I make a difference? Parents get stuck in a problem-saturated story. An emphasis on failure overshadows positive contributions and resilience. I feel an invitation to ask the parents about their strengths, but if I do they convince me how serious their problems are. And if I ask parents about their feelings of anger, they emphasize their caring involvements. Suddenly I feel worried, alone and, strangely, a bit cold. After a hesitation I decide to share this feeling at that moment.

Critical moment 3

Therapist to parents: It feels like we are getting not any further in this conversation. I am worried and for a moment I felt a bit cold and alone trying to find a way out. I am curious about your feelings and thoughts at this moment.

Father: I feel dazed. I really don't know how to support my wife who suffers most, right now, I think.

Mother (after silence): Jenny has to learn to value herself. I can't do this alone. I can push and talk, but 'it takes two to tango'. I often feel alone and cold. I can't carry her fear.

Jenny sings a Dutch song: 'Give me your fear'.

I look for patterns in the transcripts (iii). I ask myself the questions: what is the invitation I feel, what are the patterns we (re-)produce, are those patterns reactive or reflexive and how do I make a difference? In

this critical moment I sustain a reactive pattern (of panic, dependency and ignorance) if I, in response to the invitation, calm down, ask about strengths and anger, or take over responsibilities. Sharing my inner dialogue with the family members opened up space for new connections, reframing and 'something new to happen'.

One week after our evaluation (session 8) father phoned me. He told me that his wife had gone on holiday, deciding that she needed time for herself. Father and Jenny had to take care of themselves during this time. While mother was gone, Jenny went back to school. But after two days she relapsed by quitting school and cutting herself. Father decided not to ask for support from his wife, as he usually would. He phoned me for an extra appointment. Something unexpected happened during session 9. Instead of talking about the relapse, father wanted to make a bet.

> *Father turns his face to Jenny and says very seriously: 'Listen I am going to make you a proposal. If you go back to school and stay there for the next four weeks, I'll buy you an Ajax [soccer team] training-suit and you know this is difficult for me.' (Father and daughter supported rival soccer teams.)*

Jenny was surprised. I was even more surprised, because it worked. Jenny returned to school and has kept going since then. And I kept wondering. Could sharing an inner sensation (feeling cold) and making a bet (father's bet) make such a difference?

Analysing the transcript I try to understand patterns in their context of meaning (iv). Contextual forces and a low level of reflexivity sustain reactive patterns. Implicative forces and a high level of reflexivity enables us to challenge and change assumptions. Both mother and father missed out on support from their fathers in their families of origin. Mother had to take care of her father who suffered from addiction. Assumptions about fatherhood permitted an unequal division of parental tasks at home. Unexpected initiatives, mother taking a holiday and father making a bet, enables revision of assumptions about self-care, collaboration and fatherhood.

In session 15 we evaluate the developments and collaboration in FITS with Jenny and her mother. Father is not present this time. I show graphics (Figure 5), read back parts of transcripts, enhance collaborative learning (v) asking: 'how do we learn how we learn?'

Critical moment 4

> *Therapist to Jenny: The line (on the diagram) looks like an accordion, it goes up and down.*

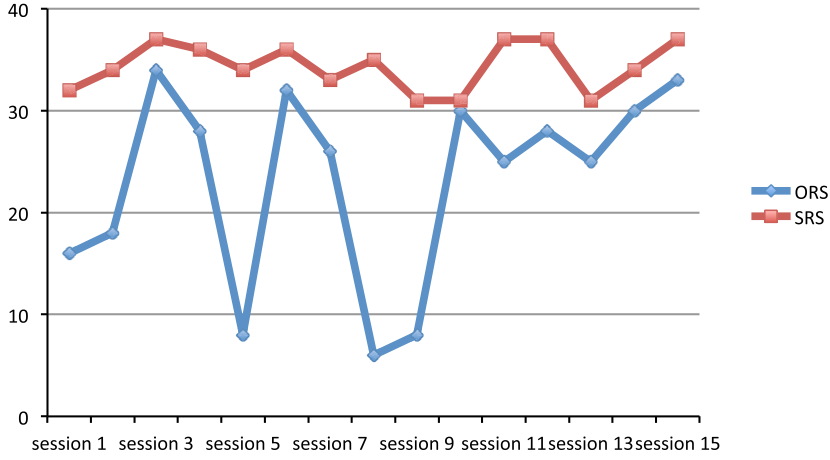

Figure 5. Diagram ORS/SRS Jenny. [Colour figure can be viewed at wileyonlinelibrary.com]

Jenny laughs.

Mother: The dips become less deep.

Jenny: I didn't miss a day at school last week.

Mother: I see a different kind of child.

Therapist: The line goes up. Do you think it will stay that way?

Mother: I think it probably will go down one more time, but I do strongly believe we can get out of the dips.

Jenny: No it won't go down because I won and I deserved my soccer-training suit.

Critical moment 5

Mother: If you are unhappy as a parent you can't help your child to become happy herself. I was 42 years old before I learned to take care of myself.

Jenny: We talk about you all the time, but what about daddy?

Mother: Your father always followed my lead.

Jenny to therapist: I was glad daddy made an appointment with you (during mother's holiday)

Mother: This was important for me too.

Therapist: This initiative seemed a bit new.

Mother: This was new and helpful. I learned to let go. That is not easy for me. I am a bit of a control freak.

Jenny: My father gets involved more often. He asks if I have enough call credits on my phone.

Mother: Yes, your father speaks up, I'm letting go and you are growing up, dear Jenny.

Therapist: At a certain point I told you about my feelings, 'a bit alone and cold'.

Mother: First I was disappointed. You should know how to deal with this, I thought. Later on, I connected. It is most important to be honest, not to take over, not to give up and to work together. Together we were able to make creative plans about going back to school, dealing with fear and keeping trust.

Therapist: And making a bet about soccer training suits.

Jenny and mother laugh.

How, in the case of Jenny and her parents, did the therapist navigate based on coordinated improvisation and collaborative learning? The 'interagency collaboration agreement' between family, therapists and school had only a short-term effect. It promoted first-order learning, change by adaptation to external norms. Second-order learning occurred after the therapist revealed his feelings and mother resonated with the expression and decided to 'let go' more often. During mother's holiday, father took an unexpected initiative, helping Jenny in crisis. Father made an unusual gesture that was accepted and that worked well. Third-order change occurs when we learn how we learn. Mother talks about the importance of self-care, collaboration and confidence in their capacity to be creative in crisis. Also the therapist learns to trust bodily responses (feeling cold) and how small, unexpected differences (like making a bet) can lead to big changes. At last we were able to discuss social, cultural and familiar scripts about the roles and responsibilities of being a parent and thus co-create a new frame of reference out of rich and lived experience.

Conclusion

With FITS we account for unplanned organic processes as the main focus in our practice by co-creating a fluid manual and doing multi-methods research. Family therapist and family members constitute a 'collaborative learning community'. Together they learn how they

learn, evaluating effects, developments and collaboration in therapy. Learning how to learn occurs as a result of improvisation and research. With multi-methods research we offer reliable information about interactions that produce transformation, always locally and culturally situated. We offer transparency about what works for this therapist and these family members in their situated moment of collaborating.

FITS as Practice Based Evidence Based Practice could be an alternative to standardized therapy models and manuals. There are no 'one size fits all' solutions and there is no independent variable available for complex social issues. We believe validation should be the result of evaluation, performed in dialogue between therapist and family members within professional and personal communities: a validation from within.

At this time we look back on an exciting and successful project. We are impressed how change 'that matters' occurs in the process of becoming a 'collaborative learning community'. In the near future we will present the results of our multi-methods research. Right now we are broadening our FITS practice, training therapists in FITS and encouraging therapists to co-create personalized Practice Based Evidence Based Practices. The world in which we live arises in the interplay of our living together. Collaborative learning is co-creating a world in which we would like to work and live.

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