The Efficacy of Family Intervention in Adolescent Mental Health.

By

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Abstract:

The term 'family therapy' is used to encompass a range of approaches that share a common view about the importance of family involvement in psychiatric disorders. This paper reviews the effectiveness of family interventions in adolescent mental health with a special emphasis on single session therapy. Research evidence shows that the family intervention in psychiatric disorders such as schizophrenia, depression, attention deficit hyperactive disorder, anxiety and anorexia not only provides better outcomes, but also increases client satisfaction with services. Among the family therapy approaches, single session therapy (SST) seems to be a flexible and very effective model for adolescent mental disorders, which seem to offer an efficient means of providing rapid access to services whilst removing some of the difficulties associated with other forms of family therapy approaches. A new service development model is also discussed by drawing together a number of ideas encountered in practice settings.

KEYWORDS: Adolescent - Family Intervention – Outcomes - Single session therapy.

Introduction:

The advent of evidence-based medicine has prompted adolescent psychiatry as well as other mental health professionals to present 'evidence' that their particular mode of practice has clinical significance for consumers. Clinical practice is now expected to produce measurable results that may be used as an integral part of resource allocation (Graham, 2000).

It is generally accepted that randomised control trials, systematic reviews and meta-analyses provide the best form of 'evidence' with regard to a particular treatment efficacy (Graham, 2000). This can be misleading as most randomized controlled trials focus on symptoms and diagnosis, and do not generally inherently take into account the structural difficulties encountered in families with children who are suffering emotional difficulties, behavioral problems, mental illnesses, educational schooling difficulties, financial hardship and the often attendant social problems (Graham, 2000).

This is further complicated by the degree of co-morbidity experienced in this age group. In Australia, among young males, 76% of those with conduct disorder met the criteria for another co-morbid disorder (Sawyer, Arney, Baghurst, Clark, Graetz, 2000). In part, or perhaps as a consequence of this, empirical evidence suggests that each child and their diagnostic/familial situation need to be dealt with differently, using clinical experience and expertise to identify the most effective treatment modality. Research on psychosocial interventions has provided evidence for the efficacy of a number of interventions for specific disorders. We need to look at what interventions work best in 'real world' settings and be able to differentiate for ourselves that which is efficacious and that which is effective.

This paper reviews the effectiveness of family intervention in adolescent mental health with a special emphasis on single session therapy. Research evidence shows that familial involvement in care not only provided better outcomes, but also increased client satisfaction with services (Estrada, 1995; Gaugler, 2005; Kazdin, 2000; Diamond, Serrano, Dickey & Sonis, 1996). These initial findings then formed a broad base for the development of an integrated treatment paradigm.

The review was conducted by identifying the most commonly presenting diagnostic criteria, then researching those treatment options that appeared to be not only effective, but also practicable for use within a child and adolescent mental health service, particularly taking resource allocation into consideration. The term 'family based therapy' is used throughout the discussion simply because it accommodates the notion of family, and any interaction with it.

Family Based Therapies:

Family based therapies are used to foster healthy child and adolescent development. Extensive developmental research indicates that healthy parent child relationships have a positive impact on child and adolescent development in the areas of attachment, ego development, self esteem and social adjustment (Berlin & Cassidy, 2001). In dealing with adolescent clients the impact of ill health reverberates throughout the family and their attendant support systems (Perkins, Winn, Murray, Murphy & Schmidt, 2001). It is often family members and /or friends who first notice untoward or 'out of character' behaviors and provide the impetus that sees the individual (and /or their families) seeking help from the service. Invariably it is the families and friends of the client (and others in the systemic milieu) who will support and encourage them throughout their 'treatment,' and who will remain in situ long after the service has ceased its involvement (Perkins, Winn, Murray, Murphy & Schmidt, 2001).

The emergence of family intervention in psychiatry may be traced back to early research into the families of people experiencing schizophrenia and the push for community based care (Lidz and Lidz 1949). Family based therapy has since developed outside of mainstream psychiatry and gained prominence in community settings, largely because of theoretical and organisational differences (Diamond, Serrano, Dickey and Sonis, 1996). As a consequence of this, the available evidence in support of family based therapies whilst initially scarce has grown in quality and quantity mostly over the last twenty years. Family based therapists now integrate a full range of clinical theories into their practice and it is not uncommon for a therapist to work with the individual, their families or extended families (Kalinyak & Jones, 1999).

Meta-analysis is a statistical procedure in which results from a number of studies are standardised, combined and 'cleaned up'. In a review of meta-analysis of family based treatment research it was found effect sizes ranged between .50 and .80. and concluded that "...findings demonstrate that, on average, families treated with family based treatments improved more than 67% of families treated with alternative treatments or no treatment." (Diamond, Serrano, Dickey and Sonis, 1996 p.7). In a comprehensive meta-analysis of 163 randomised trials, Shadish, Montgomery, Wilson, Bright and Okwumabua (1993) concluded that "Marital and family psychotherapy clients have a more improved outcome, that "the literature supporting this conclusion is at least as strong as it is for other forms of psychotherapy," ((Shadish, Wilson, Bright and Okwumabua, 1993 p.9, 99). Of the 71 studies that compared Mutisystemic Family Therapy (MFT) clients and untreated control clients, MFT clients did significantly better. (Effect size .51) (Shadish, Ragsdale and Glaser, 1995). A review of the research examining child and adolescent substance abuse programs concluded that family-based treatments produce more positive outcomes in terms of both the substance abuse itself and the related school, family and behavioral problems (Liddle, 1999).

Schizophrenia:

During the 1990s important advances were been made in understanding and treating families with a schizophrenic adolescent or young adult (Diamond, Serrano, Dickey & Sonis, 1996). A number of pycho-educational approaches to treating this disorder have been well studied and are very successful. (Falloon, Boyd & McGill, 1982; Leff, Kuipers, Berkowitz, Eberlien & Sturgeon, 1982; Hogarty, Anderson, Reiss, Komblith, Greenwald & Jaine, 1986; Goldstein, Rodnick, Evans, Phillip, May & Stienberg, 1978; Tarrier, Barrowclough & Porceddu, 1988). Five clinical trials of long term treatment programs demonstrated that medication and psychosocial intervention reduce relapse rates at a higher rate than medication alone. "These programs have proven so successful that current research no longer questions whether family-based treatments for this population are effective" (Diamond, Serrano, Dickey & Sonis, 1996, p.8).

Psycho-educational approaches have tended to focus on reducing expressed emotion by training family members in communication and problem solving skills in order to reduce guilt and blame, to create a structured and predictable domestic environment, and education in recognising early sign of relapse (Goldstein, Rodnick, Evans, Phillip, May & Stienberg, 1991). The outcomes of this research is supported by a meta-analysis of randomized controlled trials (RCT) by De Jesus (1996) which looked at outcomes with regard to relapse, levels of expressed emotion, compliance with drugs and hospital admission. Similarly Mari and Streiner (1996 p.121) conclude, "Family intervention reduces relapse rates, rehospitalisation and costs, and increases compliance with medication in the family member with schizophrenia".

A further development has been psychoeducation programes in multiple family groups. In a study involving 172 randomly assigned acutely psychotic patients, results indicated this to be as, if not more effective than individual family treatments ((McFarlane, Link, Dushay, Marchal and crilly, 1995)). They found that relapse rates at 2 years were 27% in the single family group and 16% in the multiple family group. However, difficulties were experienced in getting families to attend groups.

Depression:

The association between family factors, such as neglect and poor child-parent attachment, hostility between parent and child, parental psychopathology and ineffective parenting and the onset of a depressive illness have been well established (Asarnow, Goldstien and Thompson, 1993; Downey & Coyne, 1990). In Australia, up to 24% of adolescents will have had a major depression by the age of 18. (Sawyer, Arney, Baghurst, Clark, 2000). Given this statistic the available literature on the effectiveness of treatments for depression is surprisingly sparse. There are however a number of treatments that have been proven to be effective for depression.

In a systematic review of the literature on Cognitive Behavior Therapy (CBT), Harrington, Whittaker & Shoebridge, 1998a) reviewed 6 randomised trials of CBT. No study included inpatients and the CBT was compared with a set of comparison interventions that were designed to be inactive (waiting list) or an attention placebo (relaxation training, art exercises). The rate of remission from depressive disorder was higher in the therapy group (62%) compared to the comparison group (36%) (Harrington, Shoebridge & Campbell, 1998b).

Birmaher, Brent, Kolko, Baugher, Bridge, Holder, Lyengar and Ulloa (2000) in an effort to compare longer-term comparison outcomes for adolescents with a major depressive disorder, compared CBT, Systemic Behavioral Family Therapy (SBFT) and Non-Directive Supportive Therapy (NDST). The authors reported that although patients acutely treated with CBT obtained faster symptomatic relief with a higher rate of remission than SBFT and NDST, CBT did not confer any long term advantage over family or supportive therapy with regard to rates of remission, recovery, recurrence, or level of functioning. Moreover family conflict has been reported to relate to the onset of pediatric and adult mood disorders.

Diminution of family conflict may be an important component for promoting recovery and preventing recurrences" (Birmaher, Brent, Kolko, Baugher, Bridge, Holder, Lyengar & Ulloa, 2000 p.34). It may also be worth noting "the efficacy of CBT plummets in the face of maternal depressive symptoms" (Brent, Kolko, Birmaher, Baugher, Bridge, Roth and Holder, 1998, p.912).

Harrington, Whittaker and Shoebridge (1998a) in a review of the research on the psychological treatment of depression in adolescents, found only four randomised control trials involving family based therapy. Two of the studies involved the parental sessions given in parallel with CBT (did not appear to augment therapy). (Lewinsohn, Clarke & Hops, 1990; Lewinson, Clarke & Rhode, 1996).

One compared CBT, SBFT and NDST and one compared routine care to family based therapy in a sample that had taken an overdose, around half of whom had a major depression. No significant difference was found between the two approaches to treatment. (Harrington, Shoebridge & Campbell, 1998b). Tricyclic antidepressants (TCA's) were not found to be superior to placebo in treating adolescent major depressive disorder (Ambrosini, 2000; Hazell, O'Connell, Heathcote and Henry, 2001).

Attention Deficit Hyperactive Disorder (ADHD) Conduct Disorder:

Conduct problems are amongst the most frequently occurring child behavior disorders in both clinic referred and general populations (Estrada, 1995). In a review of the scientific evidence for the effectiveness of family-based approaches in the treatment of selected childhood behavioral disorders note that 'family interventions have consistently improved child, and in some cases, parent functioning in families with children presenting with Conduct Disorder (CD) and autism'. 'Long-term follow-ups indicate that CD and autistic children achieved lasting gains. Similarly, the research on Attention-Deficit/Hyperactivity Disorder (ADHD) indicates that parent training improves child non-compliance and aggression yet does not affect core symptoms of ADHD' (Estrada, 1995, p.403). In addition, addressing marital issues in discordant families (within this model) seems to facilitate better outcomes, greater treatment satisfaction and more enduring outcomes (Estrada, 1995).

Chamberlain, 1995) in a review of family based therapy treatment for conduct disorders in adolescents indicated that "family therapy interventions appear to decrease the adolescent conduct problems and delinquent behaviour when compared to individual therapy, treatment as usual, or no therapy" (Chamberlain, 1995 p.445).

A review that evaluated the effects of school based interventions for ADHD and included data from 63 studies over 24 years concluded that (non pharmacological) school based interventions for children with ADHD lead to significant behavioral benefits regardless of the study design (Jadad, Booker, Gauld, and Kakuma, 1999). Co-morbidity is an issue that needs to be addressed particularly that of Oppositional Defiant Disorder, Conduct Disorder and ADHD.

Anxiety / Obsessive Compulsive Disorder:

Anxiety disorders are amongst the most common psychological conditions in the pediatric population. (Labellarte, Ginsberg, Walkup and Riddle, 1999). Children and adolescents with excessive anxiety often meet diagnostic criteria for a number of disorders listed in the DSM IV (Labellarte, Ginsberg, Walkup and Riddle, 1999). Cognitive Behavioural Therapy (CBT) is a widely accepted treatment option for a number of anxiety disorders, phobias, panic disorder, post traumatic stress disorder (PTSD) and generalised anxiety disorder. (Enright, 1997).

A review of treatment outcome findings across CBT and various anxiolytic medications and their combination, suggests that these treatments do not operate in a complimentary fashion. (Westra & Stewart, 1998). A high potency benzodiazepine (Alprazolam) when compared to CBT alone demonstrates poorer short-term and long-term outcomes (Marks, Swinson, Basoglu, Kuch, Noshirvani, O'Sullivan, 1993). With milder benzodiazepines long term medication use has been linked to more severe withdrawal.

Several studies have examined CBT and antidepressant therapies such as Tricyclic Antidepressants (TCA's), Selective Seratonin Reuptake Inhibitors (SSRI's) and Mono Amine Oxidase Inhibitors (MAOI's). Collectively, these reviews observed superiority of CBT alone over TCA's and or MAOI's (Westra and Stewart, 1998). In one study comparing family-based and individual-based treatment for fears and anxiety, Barrett, Dadds, Rapee and Ryan, (1993) compared CBT to CBT plus a family intervention for the treatment of overanxious and avoidant disorders.

At treatment termination, 61% of children who received CBT alone, 88% who received a combined treatment, and 30% of those on a waiting list no longer met DSM III-R criteria for anxiety. The issue of co-morbidity has the potential to render problematic the translation of research findings in this area. Children with anxiety disorders commonly have co-morbid depression, (28% -47%) and approximately one third meet the criteria for two or more anxiety disorders (Bernstien & Show, 1997). Between 15% and 24% of children with separation anxiety disorder or overanxious disorder also meet the criteria for ADHD (Last, Perrin, Hersen and Kazdin, 1997).

Anorexia:

In 1978 the first study (open trial) of a family based treatment for anorexia nervosa using structural family therapy produced an 86% improvement rate (Minuchen, Rosman and Baker, 1978). Robin (1999) compared the effectiveness of Behavioral Family Systems Therapy (BFST) with that of Ego-Orientated Individual Therapy (EOIT). Those treated with BFST were seen conjointly with the family whilst the EOIT group was seen individually, each given a number of interventions. The BFST produced greater weight gain and higher rates of resumption of menstruation than EOIT. Both produced highly significant improvements in eating attitudes, depression, and eating related family conflict (reported independently by adolescents and parents). BFST produced a faster return to health with four fifths of the assigned patients reaching target weight by one year follow-up (Robin, 1999).

In a trial to determine whether psychological treatments gave rise to enduring benefits, a 5 year follow up study was conducted on patients (n=80) who had participated in a previous trial of family therapy for anorexia and bulimia nervosa (Eisler, Dare, Russell, Smukler, Grange and Dodge, 1997). Significant improvements were found in the group as a whole, due mainly to the natural outcome of the illness. However significant benefits attributable to previous psychological treatments were still evident, favoring family based therapy for patients with early onset and short history, and individual supportive therapy for those with late onset anorexia nervosa. More recently the same authors conducted a randomised treatment trial of 40 patients compared Conjoint Family Therapy (CFT) and Separated Family Therapy (SFT) (Eisler, Dare, Russell, Smukler, Grange and Dodge, 2000).

Considerable improvement in nutritional and psychological state occurred across both treatment groups. There were also significant changes in measures of expressed emotion. Critical comments between parents and patients were significantly reduced and warmth between parents increased. These findings complemented Eisler and his associates (1997) (as discussed above) in finding that parental involvement was essential to the success of their interventions, but that it was not necessary to conduct Conjoint Family Therapy in which the adolescent and the parents are in the room together for all sessions (Robin, 1999).

Single Session Therapy (SST):

One innovation that seems to address the issue of efficacy, effectiveness and efficiency is the idea of single session therapy. It is a flexible concept that has been implemented and evaluated over the last decade and seems to be very effective for depression. Talmon (1990) in a review of 100,000 outpatient contacts discovered that 30% of all clients chose to attend only once. When following up 200 of his own unplanned single session clients he found that more than 75% of these reported improvement and satisfaction with the single contact. (Talmon, 1990).

He then investigated by carrying out planned SST with 60 clients, 58% of these decided they did not require further session, and were satisfied that they could re-contact if necessary. 88% of the 60 clients reported improvement or much improvement when compared to similar clients receiving long term therapy (Young and Rycroft. 1997).

These findings challenge the long held idea that therapy is (or needs to be) a lengthy process. Clinicians are often resistant to the concept of SST and frequently overestimate the amount of assistance that clients feel they require (Hampson, O'Hanlon, Franklin, Pentony, Fridgant and Heins, 1999), and that to do brief therapy one requires specific skills and talents. Talmon (1990) argues that therapists should not view SST as failure rather to be aware of its potential and to maximise it.

In response to full caseloads and a six-month waiting list, the family therapy team at Dalmar Child and Family Therapy Care in New South Wales introduced the concept of 'Open Days' (Price, 1994). In an otherwise ordinary family therapy setting, one day a week was cleared by all therapists to offer families therapy on an immediate and single session basis. A consultant was available to offer support and assistance in crisis circumstances. In discussion with the clients a decision as to whether one visit is sufficient for now is made. These clients were advised that they could attend any open day at any time. Some needed more sessions but not urgently. These were placed back on the waiting list but were still able to access open day if needed. Sixty three percent of families reported their problems much better or a little better following the open day. Of the 90 families contacted 78% reported that the open day was very helpful or somewhat helpful (Price, 1994).

More recently at Mental Health Services for Kids and Youth (MHSKY) the effectiveness of SST was investigated (Perkins, 2001). Treatment was provided to children and adolescents (N=258) with a range of mental health problems. Outcomes determined from pre and post treatment measurements, compared against a randomly selected control group. The outcomes showed statistically significant improvement for all patient and clinician ratings. Over 95% of the MHSKY clients expressed satisfaction with the service. In short SST was shown to be an effective treatment approach in the treatment of children and adolescents with mental health problems (Perkins, 2001).

Single Session Therapy does not mean a client will only be seen once. The Bouverie Centre Melbourne found SST to be not so much a model in itself, so much as a framework or set of attitudes that incorporates client choice and participation (Young and Rycroft, 1997). As they demonstrate "that the possibility that the first session may be the last encourages the therapist to view each contact as complete in itself, with an increased need to clarify goals... Also that by tackling the presenting problem and eliciting and being persistently responsive to client direction a surprisingly intensive relationship is created" (Young and Rycroft, 1997, p.21).

In the development of a family based service one has to look at the issues of efficacy, effectiveness and efficiency. As discussed earlier in this article, family interventions in adolescent mental health are effective across a range of presentations. Given the high co-morbidity rate, it has the ability to address not just clinical phenomena, but also the systemic and structural issues that are attendant within mental health. Single session therapy as a model for first point of contact would seem to offer an efficient means of providing ready rapid access to services whilst at the same time removing some of the difficulties associated with ascertaining co-morbid diagnosis via a telephone screening assessment.

Further, single session therapy as a concept is flexible enough to be implemented in a wide variety of ways, daily appointment times for example, or many appointments in one day or spread over several days. These interviews are screening assessments in themselves, where diagnostic and therapeutic decisions are made. Integration of other specific efficacious interventions can be negotiated and implemented on acceptance of further treatment, giving staff and clients a clearly negotiated treatment path, (always of course amenable to re-negotiation.)

Those clients who it is felt need further input may be brought back to the team meeting for allocation, where treatment options could also be discussed prior to commencing treatment/therapy. In a team with a generic skills base, caseloads and skill levels become secondary issues. Shared knowledge becomes the norm, case management supervision done as a group, moral, professional and clinical assistance available from colleagues with shared knowledge, skills and experience.

Finally, there are more than 550 different child and adolescent therapy techniques currently in use, and more than 200 clinical disorders applicable to children and adolescents contained in the Diagnostic and Statistical Manual for the Classification of Mental Disorders (DSM-IV) without including co-morbidity. (Kazdin, 2000). The number of controlled outcome studies for adolescents is vast with an estimated total of 1500 studies (Kazdin, 2000). Despite this, client satisfaction, therapeutic effectiveness and efficiency of service can be measured, and it is possible to develop a service delivery model that gives us the opportunity to measure all three.

Towards a New Service Delivery Model:

In developing a service delivery model that may take into account some of the findings discussed above, it is vital to recognise that in a multi-disciplinary environment, experience and expertise differs from one professional group to another. It is in an effort to accommodate these differences that the psychosocial/bio-psychosocial models were so named, models that effectively allow us to consider a range of skills and knowledge bases that may be able to be used in the treatment arena.

The acknowledgment that more than biochemical forces may be at play, introduces the notion of the practical application of psychosocial therapy in the formal sense. The development of a systemic, holistic view becomes formalised as inherent in the development of the treatment/management plan. As Graham (2000) describes, "rather than making a distinction between scientific evidence (groups of similar cases) and clinical expertise (the individual case), it might be better to think of external evidence and then of case evidence." (p. 415). In developing this further it may be that disciplines within a team would need to develop a common understanding of the impact of social, systemic structures on the particular social, economic and cultural groups that make up their practice. So that each 'case' becomes conceptualised within the management/treatment paradigm. This would also allow us to place the family in a cultural context *externally* (social culture), and the case in a cultural context *internally* (the family culture).

Whilst in many cases a wide range of treatment and management options is available within a team, they are not necessarily those, which the evidence suggests as the most effective. Many psychosocial interventions are not (or need not be) discipline specific, it is therefore possible for a multidisciplinary team to develop a common or core set of skills, as an adjunct to that discipline specific professional skills already developed.

This of course already happens widely in many mental health services, but often on an ad-hoc basis. Individual members of a team taking an interest in and developing skills in Family Therapy (of various styles) Cognitive Behavioural Therapy, Stress and Anger Management etc. add a therapeutic richness to a team, but leaves the individuals themselves vulnerable to 'collecting' particular types of (diagnostic) clients, and those that respond well to that particular clinicians skills, leaving the clinician as the local 'expert' in a particular area. This also implies that other members of the team may not get to see that particular type of client and in the process become deskilled, not have the opportunity to develop new skills, or have to develop areas of interest other than their preferred choice.

The corollary becomes problematic of course when the clinician who has become the local expert decides to move on, leaving not just a professional position, but also a void in the teams clinical skill and knowledge base, specific to a particular diagnosis. It becomes apparent then that services organised in such a way will not only have a turnover of professional skills but also of specific individual skills and expert knowledge bases. Added to this is the difficulty commonly associated with teams around case management, that is, one of equitable distribution of the client base. If the therapist with 'enhanced' skills in CBT say has a full caseload (or is sick or on leave), someone else within the team would pick up the case, someone with perhaps fewer (or just developing) skills in the required area. In which case enhanced support and supervision would be required creating an added burden to an already depleted team.

The challenge is to develop a service delivery model that would allow a multidisciplinary professional group to develop a treatment paradigm along the bio-psychosocial model based upon best available evidence. A service delivery model in which it would be possible to monitor for effectiveness, and be sufficiently responsive to new 'evidence.' One that would be able to be readily accessed by the targeted client base and would be able to provide them with a clear negotiated working arrangement from day one. A model that would facilitate an equitable distribution of clients within the team. One that would allow each member of the team develop the core set of skills, (in addition to their professional qualifications), that would enable them all to manage a large number of the problems presented.

This would enable the team to function then from a common knowledge base in the first instance. It would reduce the impact of the loss of individual (given some are usually better than others at certain tasks) expert skills. It would also allow staff to develop specific interests without being exclusionary, provide a best evidence treatment paradigm, and a mutually inclusive working environment. It would be possible to develop a service that could offer:

- Provision of a service validated and based upon the scientist-practitioner model. (Evidence Based Practice.)
- The ability to have standardised specific treatment options for specific diagnostic criteria, following established clinical pathways.
- Quantifiable client outcomes including satisfaction with quality of service.
- The flexibility to change interventions in line with (our own and others') research findings.
- Inevitably a cost effective (and ultimately a cost measurable) service.

The development of this type of service delivery model would require, in the first instance:

- The ability to step aside from the current treatment paradigm and take stock of resources, both in human resources and available skill level.
- The recognition of a clearly defined and targeted client base, that is manageable within current resource allocation.
- Knowledge of what appears to be the best available evidence of effective treatment options.
- The development of a common skill base, based upon best available evidence.
- An acknowledgment and commitment from the management structure, that education and training based around a best evidence/practice model is valid and valuable, by providing funding for education and training.

It should be made clear that suggesting one should merely say 'this is what the evidence suggests do it this way' would not work. As mentioned earlier the 'evidence' that is available is not perfect, but it does offer up the suggestion that incorporating particular aspects of treatment for particular diagnostic criteria may provide better outcomes for clients. One of the consequences of developing this model of practice is that it would be possible to develop an effectiveness study. This would establish how well an intervention works under the typical treatment environment, thus allowing clinicians to modify their treatment/management protocol specifically as it applies to their own practice. This would negate some of the more obvious shortcomings of research conducted with key (contextual) characteristics that are impractical to replicate in the clinical setting.

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