



The Evidence Base of Family Therapy and Systemic Practice

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About the cover: Outcome research can be thought of as a journey on a path towards an unpredictable but hopefully worthwhile destination. The path can be rough, but the travel along it is likely to offer experiences of interest and even enjoyment. In the end it might be the travel, as much as the destination, which makes the journey worthwhile.

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1. Overview

Family Therapy and Systemic Practice (FTSP) has evolved into a variety of forms to meet the needs of the people who come for therapy. Our clients bring the full range of psychological and relationship difficulties while living their lives in a variety of family structures and relationships. They also occupy the full life span and the great range of ethnic and other cultural variation that communities now contain. This review starts with an account of the basis of systemic therapy and explains why it offers a particular kind of resource.

This report draws on a substantial number of recent meta-analyses and systematic reviews that consistently point to a strong positive conclusion about the general effectiveness of the approach. We draw on the detail of all the research surveyed to identify the extensive range of conditions, for children and adults, for which FTSP can be evaluated. These reviews demonstrate successful application in the conditions for which significant amounts of comparative research data have been published. 72 conditions (as defined by the research) found family therapy to meet established criteria. FTSP is also shown to have benefits beyond diagnosable conditions providing a useful adjunct therapy or alternative when an initial approach has not worked.

Six major programmes for well-developed and documented forms of family therapy are reported. They demonstrate high levels of effectiveness and cost-effectiveness. Many involve therapies for adolescent substance abuse and conduct disorder. Funding, and thereby generation of evidence, follows political priorities and neglects other areas of need in the population. People whose suffering has been neglected by research funding risk being deprived of the services they need.

The research review demonstrates that systemic therapies are effective, acceptable to clients, and cost effective for a sufficient range of conditions to give confidence that the wide application in current practice is justified and could usefully be extended.

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2. Background of the Report

2.1 Scale of the problem

“One in four adults experiences at least one diagnosable mental health problem in any given year. People in all walks of life can be affected and at any point in their lives, including new mothers, children, teenagers, adults and older people. Mental health problems represent the largest single cause of disability in the UK. The cost to the economy is estimated at £105 billion a year – roughly the cost of the entire NHS.” (Mental Health Taskforce to the NHS in England, 2016, p. 4).

These estimates are based on the person diagnosed as ill. But when one person has a mental illness all members of their family are impacted, so even these figures are likely to be seriously underestimated. There is a reciprocal tendency in that the person’s relationships are at least a potential source of support but the tragedy is that the current mental health system makes too little provision for helping families work effectively to help a member who is suffering. As evidenced in this report, many cases of psychological difficulty benefit from being treated in collaboration with the person in the context of their supportive relationships.

But *“despite the existence of cost-effective treatments, it receives only 13% of NHS health expenditure. The under-treatment of people with crippling mental illnesses is the most glaring case of health inequality in our country”* (LSE, 2012, p. 2).

A particular concern in the UK is the underfunding of mental health services for children which receives only a small proportion of this 13% mental health budget:

“Half of all mental health problems have been established by the age of 14, rising to 75 per cent by age 24. One in ten children aged 5–16 has a diagnosable problem such as conduct disorder (6 per cent), anxiety disorder (3 per cent), attention deficit hyperactivity disorder (ADHD) (2 per cent) or depression (2 per cent). Children from low income families are at highest risk, three times that of those from the highest. Those with conduct disorder – persistent, disobedient, disruptive and aggressive behaviour – are twice as likely to leave school without any qualifications, three times more likely to become a teenage parent, four times more likely to become dependent on drugs and 20 times more likely to end up in prison. Yet most children and young people get no support” (Mental Health Taskforce to the NHS in England, 2016, p.5).

There is good evidence, reviewed in this report, that FTSP has a number of benefits beyond its effectiveness with referred conditions, including greater acceptability to clients and families, continued improvement after discharge, cost-effectiveness, and reduced use of health and social services resources.

2.2 Systemic therapy breaks the mould

Therapies designed to treat individual people have a remarkable record of achievement. Estimates of the number of people helped by individual therapies such as cognitive behaviour therapy (CBT) range from 23% (Elkin, 1994; Dreissen, 2013) through 50% (LSE, 2012) up to 75% in some smaller studies.

“A half of all patients with anxiety conditions will recover, mostly permanently, after ten sessions of treatment on average. And a half of those with depression will recover, with a much diminished risk of relapse” (p. 1, LSE, 2012).

However, with at least 25% of people in need not being helped and large numbers either not accessing treatment or dropping out before treatment it is completed, we have no reason for complacency. Rather, we should build on the current moves to foster a variety of approaches, and support practitioners to incorporate an ever increasing range of possibilities into their practice. Systemic family and couples therapy offers something unique. It was not developed by taking people out of the central context within which they live their lives, treating a ‘mental illness’ or some other dysfunction inside them and then returning them to that context. Instead the therapy takes place within their system of close relationships: The family context that both challenges and supports each one of us.

The advantages of working with the couple or family are becoming recognised and individualist therapies, particularly the cognitive, the behavioural and the psychoanalytic have recently started working with couples and even whole families. But they are extending a model of ‘cure’ that was developed for treating individuals. Even when they are drawing on techniques that have been developed within systemic therapy, this is not the same as a coherent approach that was developed specifically to work through relationships. We can therefore expect that it is research using recognised systemic forms of therapy that is most relevant to this review.

As this review demonstrates, Systemic Family and Couples Therapies (SFCT) provide effective help for people with an extraordinarily wide range of difficulties. In section 3.4.3 we list 72 conditions for which there is evidence of the value of SFCT. The range covers childhood conditions such as conduct and mood disorders, eating disorders, and substance misuse; and in adults, couple difficulties and severe psychiatric conditions such as schizophrenia. Throughout the life span, it is shown to be effective in the treatment and management of depression and chronic physical illness, and the problems that can arise as families change their constitution or their way of life.

While the range is remarkable, the effectiveness of FTSP is perhaps not so extraordinary. After all, the great majority of families cope adequately with a range of difficulties. Families that include a child with serious mental health difficulties, for example, have been shown to come to therapy with substantial strengths and resilience (Allison *et al.*, 2003). So we should expect that a determined effort by people trained and experienced in mobilising the resources of families that have reached an impasse would be effective.

This review of the existing evidence base finds substantial evidence for the efficacy and the effectiveness of family interventions². Where economic analyses have been carried out, family therapy is found to be no more costly, and sometimes significantly cheaper, than alternative treatments with equivalent efficacy.

In the light of such a strong evidence base for the effectiveness of Family Therapy, we conclude that trained

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family therapists need to be employed not just to provide Family Therapy services but also:

- to support training of future family therapists through education and supervision;
- to provide training and support for professionals applying specific family interventions, such as Systemic Practitioners.
- to provide supervision and, where appropriate, training of other professionals working with families;
- to develop the research base of their practice by participating in research, perhaps most usefully through practitioner research networks.

2. Efficacy studies investigate the outcomes of well-defined therapies for clear diagnostic conditions using standardised measure under controlled conditions. For example a randomised clinical trial, with clients randomly allocated between two kinds of treatment. They allow comparison of therapies when applied under optimal conditions and are oriented to statistical significance.

Effectiveness studies are more naturalistic outcome studies, reflecting everyday practice. They cannot usually follow rigorous procedures but are likely to be especially informative about how well a therapy will work under normal clinic conditions. They are oriented to whether changes are clinically significant.

3. Review of the Research Evidence

3.1 What is systemic therapy?

When reviewing research we encounter many different criteria of what to include as systemic therapy or family therapy. The implications of findings about the effectiveness of therapy, from specific studies or reviews that combine the results of selected studies, depends on the definition of therapy that is being applied. So an essential preliminary is to attempt a description of the fundamental assumptions and ways of working in the many formats of family therapy and systemic practice.

Some answers to this question are available on the website of the Association for Family Therapy, UK (www.aft.org.uk). A very useful resource is their leaflet *What is Family Therapy?* at <http://bit.ly/2cw1I1D>. Alternative sources are current handbooks (Carr, 2012; Sexton & Lebow, 2015) that provide detailed coverage of different forms and aspects of FTSP.

Systemic family therapy is an approach to helping people with psychological difficulties which is radically different from other therapies. It sees its work as being to help people to mobilise the strengths of their relationships so as to make disturbing symptoms unnecessary or less problematic.

3.1.1 The Systemic Family Therapy Perspective

We live our lives through our relationships. Research into what matters most to people consistently finds that close relationships, especially family relationships, rank higher than anything else. *"In every study, family relationships (and our close private life) are more important than any other single factor in affecting our happiness"* (Layard, 2005, p. 63).

Our sense of who we are and our sense of wellbeing are intimately associated with our relationships – both to other people and to the contexts in which we live. When relationships do not give us what we need, we lose our sense of comfort and confidence about the person that we are.

When relationships go seriously wrong, powerful psychological processes come to operate. Often not in full awareness, and while they may offer some protection they often bring unwanted consequences.

Much psychological distress is a result of these processes. Conditions that get given labels such as depression, anxiety, and conduct disorder, are very often effects of relationship problems. Conversely, when systemic family therapists see someone in psychological distress they look first for ways that existing relationships could be adapted to better help that person. Even when conditions have a clear biological basis, psychological and relationship problems have a real impact on the levels of distress and likelihood of relapse.

Relationship problems are usually best treated by meeting with those in the relationships. Often that means working with the couple / all members of the family or the household together. The advantages are many:

- Problems are being treated in the context in which they arose
- The other people in the family or group with close relationships are a powerful (and nearly always willing) resource for change.
- Therapeutic gains that have been achieved in collaboration with

the family and other relational systems are most likely to continue as the person moves forward in their context of everyday living.

In fact, we find that therapy carried out within relational systems is so effective that it is often not necessary to understand where a problem such as depression came from. More often we need to understand what is preventing the problem from being resolved, and to find out what resources the relational system has to bring to bear. But, resolving it within the web of relationships is particularly effective. The research described in this review supports a claim that working in this way has been shown to have benefits for all family members both at the time and for how they handle future difficulties.

We also find that systemic family therapy is effective with chronic and intractable conditions where it does not make sense to talk of a cure. Here we are about establishing a quality of life through the system of relationships and in a way that recognises and incorporates the condition.

Systemic therapists will often prefer to work with as many as practicable of the people in the close network of relationships, whether a couple, the family members living together or a wider network, for example to include grandparents. Several practical advantages have been demonstrated: Gurman and Burton (2014) offer reasons why conjoint couples therapy is likely to avoid problems that arise when seeing individuals: *"structural constraints on change; therapist side-taking and the therapeutic alliance; inaccurate assessments based on individual client reports; therapeutic focus; and ethical issues relevant to both attending and nonattending partners"* (p. 470). Similarly Baucom *et al.* (2014) state:

"Several investigations indicate that relationship distress and psychopathology are associated and reciprocally influence each other, such that the existence of relationship distress predicts the development of subsequent psychopathology and vice versa. Furthermore, findings indicate that for several disorders, individual psychotherapy is less effective if the client is in a distressed relationship. Finally, even within happy relationships, partners often inadvertently behave in ways that maintain or exacerbate symptoms for the other individual. Thus, within both satisfied and distressed relationships, including the partner in a couple-based intervention provides an opportunity to use the partner and the relationship as a resource rather than a stressor for an individual experiencing some form of psychological distress" (p. 445).

3.1.2 How Systemic Family Therapy Works

60 years ago an inspired group realised that in some cases, apparently irrational behaviour of an individual made complete sense when seen in the context of that person's close relationships. From that point they started to work directly on relationships with a particular attention to patterns of (mis)-communication. For a brilliant example of the understanding of problems arising from the forms that communication takes in family relationships, see Watzlawick *et al.*, (1967).

Systemic family therapy has developed over some 60 years to the point at which we have a varied repertoire of highly effective methods that a family therapist can call on to meet the needs of specific clients and families. These include:

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- An awareness of how family processes operate and ability to make these apparent to the family.
- An ability to work with children in relation to their parents and vice-versa.
- Working with families to understand and productively use the influence of their family history and traditions.
- Through both conversation and action, helping family members to recognise options they have not been making use of.
- Collaborative exploration of strengths and resources of family members that they can bring to bear to support each other.

As an effective overview of what this review is trying to achieve, Carr (2016) brings together his substantial body of literature reviews to answer four questions:

Question 1 – Does systemic therapy work?

Question 2 – What sort of systemic therapy works for specific problems?

Question 3 – What processes occur in effective systemic therapy?

Question 4 – Is systemic therapy cost-effective?

A systemic therapist will create a highly adapted and flexible combination of approaches for each unique client. From this perspective, we should ask ‘what are the conditions that optimise the tailoring of therapy – what therapeutic situation opens up the best opportunities for effective work? There will be cases in which having several of the people who are important in the relationships present creates opportunities that are very difficult to achieve working with an individual. The work often proceeds by bringing difference in assumptions and beliefs into the open for discussion and accommodation.

The systemic perspective is to always take account of the full range of systems that can be seen as nesting inside each other. It is this orientation that has led the field to place a high priority on working with all aspects of diversity and to be concerned with issues of power and difference such as the impact of migration, economic hardship and racism. Systemic practice may be with an individual, a couple, a family, a group of families, professional systems and other wider contexts. It is most often offered to couples or families but always with the larger and smaller systems in mind, and with an awareness that change at any level of the systems is likely to impact on the other systems. A counterbalance is provided by an increasing willingness in systemic therapy to incorporate understandings of internal processes as they have been understood by psychodynamic and cognitive therapies.

A typical family therapy clinic helps families deal with a great variety of physical and psychological difficulties. The families will vary widely in terms of family structure, ethnicity and culture. Even so, treatment very often consists of about seven sessions. Carr (2016) suggests that on the basis of the evidence “*We can say (to clients), ‘Family therapy helps about two out of three families with problems like yours. You will know after about six to 10 sessions if family therapy is likely to help you. You may wish to give therapy a trial for six to 10 sessions and review progress at that stage.’*” (p. 39).

Within the broad orientation described here, systemic therapy has developed many different approaches, methods and techniques (Burnham, 1992). So FTSP is not one single approach and although there is a commonality in the focus on the relational system and wider context as resource and constraint, and an understanding of the connections between behaviour, beliefs, relationship and emotions, different approaches may focus on different aspects of interaction. This is in large part a clinical

judgement about what area requires intervention. For example the focus may be on interrupting repetitive and unhelpful patterns of behaviour in families or it may focus on helping a couple to view their relationship in a different way. At other times it will be to overcome or to deal better with symptoms, illnesses and their consequences. Systemic therapies also help people to change redundant patterns and restrictive narratives which limit their lives, in such a way as to overcome suffering and symptomatology.

A summary description for the public from the AFT website:

“Family Therapy helps people in close relationship help each other. It enables family members, couples and others who care about each other to express and explore thoughts and emotions safely, to understand each other’s experiences and views, appreciate each other’s needs, build on strengths and make useful changes in their relationships and their lives. Individuals also can find Family Therapy helpful, as an opportunity to reflect and strengthen important relationships.

Family and systemic psychotherapists also work with the ‘systems’ or teams of people based in the caring professions and in a variety of settings such as in social care, schools, hospitals, hospices, substance misuse services, older adults services, youth offending projects, community outreach projects, and also in a wide range of organisational consultancies.”

Finally, a concise statement of systemic therapist orientation comes from a qualitative metasynthesis by Chenail *et al.* (2012) of 49 studies of clients’ experiences of their conjoint couple and family therapy: “*Regardless of the clinical orientation, the investigators did not find significant differences in family members’ experiences across the 49 studies examined. These common factors across couple and family therapy suggest that irrespective of their models, couple and family therapists embrace curiosity for, and attention to, what family members find helpful and unhelpful in therapy*” (pp. 258-259).

3.2 Overviews and meta-analyses of efficacy and effectiveness

This report has been compiled to answer the (deceptively) simple question ‘does systemic family and couple therapy work?’ After reviewing the published evidence from this broad orientation, it will be possible to unpack different issues that refine the question (see section 3.5). We are fortunate to have several careful reviews available which combine specific studies to draw general conclusions. While some individual research studies are included for specific reasons, this report primarily draws on these reviews.

There is a form of therapy outcome research that is widely assumed to be the most compelling, the Randomised Control Trial (RCT). Two examples of specific RCTs are described in order to be familiar with their methodology and to clarify the kinds of implications that can be drawn from them. Then we will be in a position to evaluate the studies that have combined collections of RCTs in meta-analyses and systematic reviews. These two are also useful studies in their own right with a broad definition of the problem, as is common in meta-analyses, and are indicative of the significant number of outcome studies that are too recent to have been included in current meta-analyses or systematic reviews.

Dakof *et al.* (2015) compared multidimensional family therapy (MDFT, Liddle, in press) with a standard group-based treatment of adolescent group therapy. A sample of 112 youth who were referred

by a US juvenile court for offending and substance use. They were randomly assigned to one of the two treatments and extensively tested at baseline and at 6 monthly intervals up to 24 months. During treatment itself both groups achieved similar reductions in delinquency, externalizing symptoms, rearrests, and substance use. But at follow-up, extending to 24 months, only the MDFT treatment group maintained their gains in externalizing symptoms ($d = 0.39$), commission of serious crimes ($d = .38$), and felony arrests ($d = .96$). There were no differences in substance use or arrests for minor misdemeanours, but the authors point out that it is reduction in criminal behaviour that is the major objective of the courts. Strengths of this study are the comparison of a well-defined model of systemic therapy with a realistic standard treatment, and measurement of the real life effects that matter to the youths, their families, and the justice system.

Perrino *et al.* (2016) compared treatments for youth identified through delinquency but their main focus was the internalising which relates to later major depression (Wesselhoeft, 2013) and risk of conduct disorder and delinquent behaviour. 242 youths were randomised into either standard community practice or 'Familias Unidas' which is an intervention of multiparent group sessions drawing on Ecodevelopmental Theory. The intervention was developed for reducing sexual and other risk taking e.g. an RCT study of reducing HIV risk (Prado *et al.*, 2012) but was tested here because it works to strengthen parenting and family factors relevant to internalizing symptoms. The main finding was of superiority of the Familias Unidas group with a medium effect size of $d=0.48$. They also examined the relationship of this improvement to aspects of parent-adolescent communication and found that those who started off with the poorest communication benefitted most from the Familias Unidas intervention. Here we have an RCT which reports not on a diagnosable symptom but on important aspects of family life with well-established future risks. The team analysed not just the comparison of the two treatments but also for whom and how the intervention works. Another impressive aspect is that they achieved 95% participation at the 12 month follow-up as a result of substantial efforts which included keeping assessors blind to the form of intervention.

These two examples may already indicate that trying to draw reliable conclusions by combining a significant number of such studies is a complex task. One route is to identify all of the RCTs that meet rigorous standards and use statistical methods to combine the data. Each RCT is given a weighting according to criteria such as the size of the sample and overall statistical conclusions are drawn. This is a meta-analysis and can give a much more reliable indication of the efficacy of a therapeutic approach than any individual RCT. But it does depend on there being a sufficient number of good quality RCTs and they have to fit the model of a well-defined therapy applied to clients with a clear diagnosis. For a variety of reasons discussed in this report, there may not be enough of such studies in FTSP to be a basis for a meta-analysis. The option then is to conduct a rigorous systematic review and such reviews are included with meta-analyses in the next section. Clear criteria for the quality of evidence-based treatments in couple and family have been proposed by Sexton *et al.* (2011). This paper is a useful guide to understanding why certain aspects of RCTs are necessary. They should use treatment manuals, apply measures of adherence to the treatment, clearly identify client problems, describe service delivery contexts, and use valid measures of clinical outcome. Sexton and

Datchi (2014) offers a useful overview of the outcome evidence up to 2013:

"Science has always been a central part of family therapy. Research by early pioneers focused on the efficacy of both couple and family interventions from a systemic perspective (Pinsof & Wynne, 1995). This early work established family therapy as an effective and clinically useful approach to treatment. In the ensuing decades, the research agenda broadened from answering initial questions of outcome (i.e., establishing whether it works in general) to assessing more specific applications of family therapy with specific clinical problems in specific settings. The result of these decades of research is a strong, scientific evidence base for the effectiveness of family therapies (Sexton et al., 2004; Sexton et al., 2013; Sprenkle, 2002, 2012; von Sydow et al., 2010, 2013). Outcome research for couple and family therapy has drawn from meta-analyses that combine results across large client groups and individual outcome studies conducted in local communities with diverse clients in realistic clinical settings. In addition to these outcome research efforts, process research studies have identified the change mechanisms that underlie positive clinical outcomes that are both common across methods and specific to certain approaches" (p. 417).

Four major approaches to treatment have been widely applied and researched in a variety of contexts and have become called the "big four": Brief strategic family therapy (BSFT/SET); Multisystemic therapy systemic family therapy (MSFT); MultiDimensional Family Therapy (MDFT) and Functional Family Therapy (FFT). All four meet the requirements for evidence-based treatments as specified by the Sexton *et al.* (2011) guidelines. They are considered specifically in Section 3.3.

In this compilation, and in the overview of support for CFT for specific conditions in Section 3.4 there is inevitable overlap in the material used for different reviews. Each meta-analysis and systematic review operates its own criteria for both the definition of therapy and the range of conditions considered. They will each include some of the research that has been included in other reviews, so the appearance of similar conclusions of effectiveness from different authors does not mean there are this many independent research studies that came to the same result. But it is worthwhile to consider all of them because they each use different criteria by which specific studies are evaluated and combined.

3.2.1 Meta-Analyses and systematic studies combining findings on general efficacy

The earlier meta-analyses were reviewed in the previous editions of this report (Stratton, 2005, 2011). They are now of limited value because most of the therapies on which the original research was based predate current practice. Also the standards of RCTs and of systematic reviews have progressively developed. However, one report which gives a good overview and is relatively recent is unique in combining existing meta-analyses. Shadish and Baldwin (2003) identified 140 meta-analyses in psychotherapy and the authors undertook a meta-analysis of 20 meta-analyses of couple and family therapy. It is thus a meta- meta-analysis and is a useful summary of the earlier reviews. The average effect size across all meta-analyses was $d = .65$ after family therapy, and $d = .52$ at six to twelve months' follow-up³. These results show that, overall, the average treated family fared better after therapy

and at follow-up than more than 71% of families in comparison groups. They conclude that ‘marriage and family therapy is now an empirically supported therapy in the plain English sense of the phrase – it clearly works, both in general and for a variety of specific problems’ (p. 567).

More specifically, they conclude: “Marriage and family interventions are clearly efficacious compared to no treatment. Those interventions are at least as efficacious as other modalities such as individual therapy, and may be more effective in at least some cases”. And (in that period) “There is little evidence for differential efficacy among the various approaches within marriage and family interventions, particularly if mediating and moderating variables are controlled” (p. 566).

Sydow *et al.* (2010), analysed 38 RCTs of adult patients diagnosed as suffering from mental disorders, published up to 2008. They state: “A meta-analysis could not be performed due to the high variability of the methodology of the trials we identified. Therefore, we conducted a meta-content analysis”. A unique feature of this and their subsequent reviews is that research was selected if investigating therapy that was explicitly systemic, whether with family, couple, individual, group, or multifamily group therapy. As the authors point out, all other reviews have defined their sample in terms of the context of the therapy (child, couple, family etc.). Another exceptional aspect is that as far as possible, all languages of publication were included. For example 8 RCTs from China were considered although after investigation only one met the criteria and was translated for the report.

Sydow *et al.* (2010) conclude that 34 of the 38 studies show systemic therapy to be efficacious. Results were stable across follow-up periods of up to 5 years. They drew a variety of conclusions:

1. In 34 of 38 RCT, systemic therapy is either significantly more efficacious than control groups without a psychosocial intervention or systemic therapy is equally or more efficacious than other evidence based interventions (e.g., CBT, family psychoeducation, GT, or antidepressant/neuroleptic medication).
2. Systemic therapy is particularly efficacious (defined by more than three independent RCT with positive outcomes) with adult patients in the treatment of affective disorders, eating disorders, substance use disorders, psychosocial factors related to medical conditions, and schizophrenia.
3. Research on the efficacy of systemic therapy for adult disorders focuses on certain diagnostic groups, while other important disorders are neglected in research (e.g., personality or sexual disorders).
4. We found no indication for adverse effects of systemic therapy.
5. Systemic therapy alone is not always sufficient. In certain severe disorders, a combination with other psychotherapeutic and/or pharmacological interventions is most helpful (e.g.,: schizophrenia; heroin dependence; severe depression).
6. The drop-out rate of systemic therapy is lower than that of any other form of psychotherapy
7. Highly efficacious interventions that evolved in the context of systemic (and Ericksonian) therapy are resource/strengths orientation and positive reframing” (p. 477).

“Results of this meta-content analysis show that systemic therapy in its different settings (family, couples, group, multifamily group,

*IT) is an efficacious approach for the treatment of disorders in adults, particularly for mood disorders, substance disorders, eating disorders, schizophrenia, and psychological factors in physical illness” (Sydow *et al.*, 2010, p. 478).*

In 2012 the *Journal of Marital and Family Therapy* published its third research review of couple and family therapy. Sprenkle (2012) reviewed each of the 12 papers and groups the findings under broad headings of the issues covered. First he rated the quality of the research out of a maximum score of 12. The conditions reported in order of strength of the research: Conduct disorders 12; Drug abuse 11; Psycho-education for major mental illness 11; Couple distress 10; Alcoholism 9; Relationship education 6; Childhood and adolescent disorders (other) 5; Chronic illness 4; Depression 3; Interpersonal violence 3. This list is one of many examples suggesting that the allocation of research funding is less based on the amount of distress the problem causes for the person and much more on how much it creates problems for society. After reviewing the areas he lists 17 issues for which there is strong evidence of the efficacy of CFT. These issues are considered in section 3.4. His review included the RCT by Baldwin *et al.* (2012) which examined the differential efficacy of major approaches and did not find strong evidence of superiority of any particular form of systemic couple and family therapy over any other. “While we may be able to speak with some confidence about a modality effect (systemic treatment is often better than non-systemic treatment), we cannot have the same confidence about the advantages of specific systemic interventions/ models” (Sprenkle, 2012, p. 24).

Sprenkle’s overall conclusion is that:

“Reading the 12 papers in this issue should leave little doubt that CFT has established itself as a scientific discipline. Couple and family therapy began with a belief in the ‘Big Idea’ – namely, that ‘relationships matter’. During the early decades of the discipline, this belief was more akin to religious dogma than to an assertion rooted in evidence that could pass muster with skeptical outsiders. During the past three decades, the number of CFT evidence based investigations with good methodology has grown exponentially. We can now assert with considerable confidence that many CFT interventions frequently add value and that relationships do indeed matter when it comes to many interventions” (p. 24).

In 2013 the ‘Hamburg-Heidelberg Group’ who had examined adult conditions (Sydow *et al.*, 2010 above) published two reviews of RCTs of therapies for children and adolescents. Sydow *et al.* (2013) offer a ‘systematic review’ of 47 RCTs which as before, were specifically systemic therapies and published across the world. The RCTs were of treatment of childhood and adolescent externalizing disorders.

This review specifically considers the “big four” therapies, BSFT, FFT, MDFT, and MST which provided the great majority of RCTs in this area. Pointing to different strengths of each one, their specific conclusions are:

1. We found no indication for adverse effects of systemic (family) therapy.
2. Engagement and retention rates of systemic (family) therapy are superior to other therapy approaches for externalizing disorders (Hamilton, Moore, Crane & Payne, 2011; Ozechowski & Liddle, 2000).

3. Cohen’s *d* is a widely accepted measure for interpreting the effect of an intervention and is based on the difference in a chosen measure found between two samples. Mathematically it is the difference between two means divided by a standard deviation for the data. For practical purposes a *d* = 0.2 is regarded as small; *d* = 0.5 as medium; and *d* = 0.8 as a large effect (Cohen, 1988).

3. *Systemic (family) therapy is an efficacious treatment approach for externalizing and juvenile delinquency: In 42 of 47 RCT, systemic therapy was either significantly more efficacious than control groups without a psychosocial intervention, or systemic therapy was equally as or more efficacious than other evidence-based interventions (e.g., individual and group CBT, family psychoeducation).*
4. *Systemic therapy is efficacious in multiple domains of functioning (primary and secondary mental symptoms, family outcomes, problems with the justice system, and school performance).*
5. *The positive effects of systemic (family) therapy are long lasting and can be demonstrated not only 6-12 months posttreatment termination but also for longer follow-up intervals – up to 23 years posttreatment (Sawyer & Borduin, 2011).*
6. *Some of the latest European trials have less positive results than older U.S. trials.*
7. *Engagement and retention rates of patients from minority groups are lower than those of majority groups (e.g., Robbins et al., 2011).*
8. *Treatment programs are adapted more to the needs of boys and men, which are the majority of patients with externalizing disorders, and more efficacious for male index patients (Baldwin et al., 2012).*
9. *Results on cost effectiveness of ST are promising, but, to some extent, inconclusive at this point (see also Crane & Christenson, 2012)” (p. 608).*

“A total of 42 of the 47 trials reviewed showed systemic therapy to be efficacious for the treatment of attention deficit hyperactivity disorders, conduct disorders, and substance use disorders. Results were stable across follow-up periods of up to 14 years. There is a sound evidence base for the efficacy of systemic therapy for children and adolescents (and their families) diagnosed with externalizing disorders” (p. 576).

Retzlaff et al. (2013). This article presents findings for internalizing and mixed disorders using the same methodology as Sydow et al. (2010, 2013). They included articles from 1970 onwards and warn that some of these studies may not meet current standards. Research on the efficacy of ST for children and adolescents has focused on certain diagnostic groups, while other important disorders like anxiety and adjustment disorders have been neglected (Retzlaff, Beher, Rotthaus, Schweitzer & Sydow, 2009). The pattern fits the comment by Sprenkle (2012):

“Presumably, there is less money available for research on internalizing problems because they are generally less disruptive to society than the externalizing disorders” (Sprenkle, 2012, p. 14).

Retzlaff et al (2013) report that *“Thirty-eight trials were identified, with 33 showing ST to be efficacious for the treatment of internalizing disorders (including mood disorders, eating disorders, and psychological factors in somatic illness). There is some evidence for ST being also efficacious in mixed disorders, anxiety disorders, Asperger disorder, and in cases of child neglect. Results were stable across follow-up periods of up to 5 years” (p. 619).*

“Results of this systematic review show that ST in its different settings (family, group, multi-family group, individual therapy) is an efficacious approach for the treatment of children and adolescents suffering from internalizing psychological disorders, such as mood and eating disorders and psychological factors affecting physical illness” (p. 644).

Their overall conclusion is that there is a sound evidence base for the efficacy of Systemic Therapy as a treatment for internalizing disorders of child and adolescent patients.

Stratton et al. (2015) collated CFT outcome studies published in English in the decade 2000-2009. The 225 research studies were extensively coded for analysis, one objective being to identify the patterns in publication. The 225 research studies were rated according to seven criteria of quality of methodology. Grouped into broad diagnostic categories the number of studies ranged from 29 to 2 publications. In descending order they were:

Adult substance misuse
 Child/Adolescent behavioural problems
 Adult psychosis (schizophrenia)
 Adult mood disorders (depression, bipolar)
 Child/Adolescent substance misuse
 Child/Adolescent physical illness (cancer, obesity, epilepsy, HIV, asthma, diabetes)
 Child/Adolescent eating disorders
 Adult other mental health (post-traumatic stress disorder, child sexual abuse, dementia)
 Child/Adolescent anxiety disorders (separation anxiety, obsessive compulsive disorder, post-traumatic stress disorder)
 Adult relationship problems
 Child/Adolescent mood disorders (depression, bipolar)
 Adult physical health (cancer, pain, HIV)
 Child/Adolescent other or mixed presentations
 Adult eating disorders (anorexia, bulimia)
 Child/Adolescent learning disability
 (from Table 2, p. 6).

From this pattern the authors concluded that: *“research is disproportionately available in areas of societal concern such as substance misuse, Child/Adolescent behavioural problems, and adult psychosis. This concentration leaves other areas of good and effective practice without research support and vulnerable to being denied to clients in systems of managed care or state provision” (p. 9).*

In terms of claims of effectiveness, *“No study reported that the clients deteriorated during therapy, 8% did not make a clear claim; 16% reported no significant difference with the comparison treatment; and the majority (75%) claimed that the therapy was effective. Only 18% claimed clear superiority over the comparison treatment” (Stratton et al., 2015, p. 5)*

The paper concludes that: *“Within the limits of accepted standards of publication, the research supports the belief in the field that many different forms of CFT can be effectively applied in varied contexts for the benefit of people (though not evidencing the full range of diversity of people) struggling with a great variety of difficulties”.*

But *“The published studies do not give confidence that ineffective therapy would be identified” (p. 10).*

Darwiche et al. (2015) conducted a detailed analyses of a small sample of RCTs defined by the treatment package. They used the Sexton et al. (2011) criteria to report on 9 treatment approaches at three levels. They allocated approaches to Level I *“evidence-informed treatments”*; level II *“evidence-informed treatments with promising preliminary evidence-based results”*; and the strongest: level III *“evidence-based treatments”*. Three approaches are shown to have several RCTs of high quality that demonstrated strong levels of efficacy: BSFT, FFT, MDFT. These are reviewed specifically in Section 3.3. Family Focused Grief Therapy (FFGT, Kissane & Bloch, 2002) was found to have a satisfactory level. Level II consisted of just one approach, Systemic Couple Therapy (Jones & Asen, 2000) having only one RCT. This still relevant study is considered in section 3.3.6. Level I contained four studies judged to be promising but not yet

able to claim clear evidence of effectiveness: Structural-Strategic Family Therapy (Stanton & Todd, 1982), Milan Systemic Therapy (Bertrando *et al.*, 2006), Leeds Systemic Family Therapy (Pote, Stratton, Cottrell, Shapiro & Boston, 2003), and Family Systems Therapy (Rohrbaugh, Shoham, Spungen & Steinglass, 1995).

Pinquart *et al.* (2016) report a meta-analysis of 45 RCTs which met stringent criteria similar to those of the Sydow group in terms of a clear theoretical systemic basis for the therapies. This analysis was offered as an advance on these reviews by selecting only RCTs that measured changes in symptoms of adult mental disorders, so that statistical aggregation was possible and the overall efficacy could be calculated. They adjusted the reported Cohen *d* scores to give a slightly reduced *g* score to compensate for lower sample sizes.

"The d-scores were adjusted for bias due to small sample sizes and transformed to Hedges's g. Fourth, weighted mean effect sizes and 95% confidence intervals (CI) were calculated. For interpreting the practical significance of the results, Cohen's (1988) criteria were used, which characterize effect sizes of g = .2 as small, g = .5 as medium, and g = .8 as large. The observed mean efficacy of systemic therapy at posttest when compared against no-treatment control condition of g = .51 tends to be smaller than the average efficacy of psychotherapy reported by Wampold (2001). Nonetheless, comparisons of systemic therapy against alternative bona fide treatments (g = .12 at posttest and g = .00 at follow-up) support the conclusion that systemic therapy and other psychotherapies are similarly efficacious. Our overall effect size of g = .51 is similar to the mean effect size of d = .65 reported in meta-analysis of couple and family therapy in general" (Shadish & Baldwin, 2003).

"The average efficacy did not differ according to whether patients received pure systemic therapy or a combination of systemic therapy with another intervention (e.g., medication or psychoeducation about the disorder" (p. 248).

"The present meta-analysis found empirical support for the assumption that dropout rates would be lower in systemic therapy than in other forms of psychotherapy" (p. 251).

They conclude: *"systemic therapy is an efficacious treatment approach for eating disorders, mood disorders, obsessive-compulsive disorders, and schizophrenia, and there is initial evidence of positive effects on somatoform disorders. Nonetheless, comparisons with other meta-analyses indicate that systemic therapy may not be the most efficacious treatment for depression and obsessive-compulsive disorders, but RCTs have to compare these treatments directly. In addition, evidence is insufficient for the efficacy of systemic therapy on anxiety disorders and substance use disorders/addiction in adulthood" (p. 252).*

The seven careful and thorough analyses reported in this section and the considered conclusions of the authors' amount to a powerful indication that SCFT is consistently effective and superior to a variety of alternatives made available to people who come for treatment. It is notable that the more recent reviews have started to apply quantifiable criteria by which the quality of the reported research can be taken into account.

3.2.2 Some alternative approaches focused on core issues for therapists

The reviews of the previous section are based on well-established outcome measures that enable CFT to be compared with other treatments. However, many clients, couples and families

attend for treatment for serious problems that do not fit the medically oriented diagnostic definitions of the DSM. Also SFCT, like some other therapies, has objectives that are not specified in terms of measurable problems. It is important therefore to take account of research which has tracked other effects of therapy, and which have had other objectives than evaluating the implications of high quality RCTs.

Russell Crane and his colleagues have conducted extensive analyses of the effectiveness of different types of therapy in the USA health care insurance system. Many of these studies concern cost-effectiveness and having first established in each case that marital and family therapy (MFT) is effective, their work consistently concludes that MFT is a cost-effective option (See section 3.5.2 'Cost Effectiveness' of this report). For example, Moore *et al.* (2011) *"Provider types compared included medical doctors (MDs), nurses, psychologists, social workers, professional counsellors, and marriage and family therapists. MFTs had the lowest dropout rates and recidivism and were more cost effective than psychologists, MDs, and nurses" (p. 2).*

Crane and Payne (2011) report data from 490000 individuals. Using the simple measure of whether clients returned for further treatment they found that compared with individual or "mixed" psychotherapy, family therapists had the highest rates of success. Only 13% requested further treatment of any kind.

Bachler *et al.* (2016) report a substantial pre-post naturalistic study in which 379 families received a home-based therapy designed for multi-problem families. It was an *"integrative form of family therapy and integrates structural, family therapy interventions (Minuchin & Fishmann, 1983), psychoanalytic elements of mentalization-based psychotherapy (Fonagy et al., 2006) and structural psychotherapy (Rudolf, 2006)" (p. 126).* An extensive battery of tests gave information on a range of outcomes including treatment goals, patient-therapist collaboration, and psycho-social outcome measures. They reported a medium to large effect size for all parameters (range of *d*: .35-1.49) with about two-thirds of the sample improving by two standard deviations on individually set treatment goals. So it was the change over treatment for this sample of families with long-standing and complex problems that was measured, not a difference from a control group. The improvements are not only on possibly diagnosable treatment goals but features of the therapeutic collaboration. Improvements in goal-directed collaboration and treatment expectancy were found to be related to clinical improvement. The authors point to their findings as support for individualisation of treatment and setting of goals by clients in improving self-efficacy and problem solving.

Keiley *et al.* (2015) Report on a multi-family group intervention for 115 male adolescents who sexually offend and their families. Data from the adolescents and their male and female caregivers collected at pre-, post-, and 1-year follow-up and found that *"problem behaviors (internalizing, externalizing) decreased over pre- and posttest and the significant decreases in maladaptive emotion regulation predicted those changes. Adolescent-reported anxiety over abandonment and attachment dependence on parents increased significantly; these changes were predicted by decreases in maladaptive emotion regulation. Linear growth models were also fit over the 3 time points and indicate decreases in adolescent problem behavior and maladaptive emotion regulation" (p. 324).* They conclude that the multiple-family group intervention is an effective, yet affordable, 8-week treatment.

Such studies are interesting because they focus on effects that are likely to be judged important by therapists, being relevant to the relationships between wellbeing and mental health. The ways such effects have been shown to relate coherently to symptoms can be taken as an indication that such changes could be taken seriously when evaluating systemic approaches. For example Guo *et al.* (2016) report on 179 runaway adolescents who were randomly assigned to one of three treatments: to Ecologically-Based Family Therapy (EBFT), the Community Reinforcement Approach (CRA), or brief Motivational Enhancement Therapy (MET) with the primary focus on substance abuse. All of the treatments significantly increased perceived family cohesion and reduced family conflict from baseline to the 24-month follow-up. *“Adolescents who received EBFT demonstrated more improvement in family cohesion after treatment than those who received CRA or MET, and more reduction in family conflict during treatment than those who received MET”* (p. 299). These authors also report reductions in depressive symptoms among substance abusing runaways, with a positive impact on other family member’s mental health (Guo *et al.*, 2014). Guo *et al.* (2013) examined effects on discrepancies in perception between adolescents and their parents: *“Previous research indicates that lower levels of discrepant perceptions are associated with better individual and relationship functioning. Therefore, this study’s findings support family therapy as superior to individual therapy for addressing parent-child discrepancies – possibly through its focus on improving family communication, perspective taking, and understanding”* (p. 182). Most recently they conclude that *“The greater impact of family therapy on family outcomes suggests that family systems therapies should be offered to families who seek services through runaway shelters”* (Guo *et al.*, 2016, p. 309).

Hunger *et al.* (2014) Report an RCT of 208 participants half of whom received Family Constellation Seminars (FCS), using a variety of measures to examine the ways personal social systems were experienced. *“The average person in the intervention group showed improved experience in personal social systems, as compared with approximately 73% of the wait-list group after 2 weeks (total score: Cohen’s $d = .61, p = .000$) and 69% of the wait-list group after 4 months (total score: $d = .53, p = .000$). No adverse events were reported”* (p. 288).

This particular focus was part of a larger study which also demonstrated improvement of psychological functioning and goal attainment at 2 weeks and 4 months after FCSs while a quasi-experimental, controlled trial had demonstrated improvement of physical and psychological health, self-esteem, and self-acceptance 4 months after a family constellation and another showed increased emotional connectedness and relational autonomy 4 weeks and 4 months after a family constellation. This collection of studies indicates just some of the wide range of outcomes that can usefully and practicably be measured.

At the start of this section the question posed was ‘does systemic family and couple therapy work?’ The combined weight of the systematic reviews leave no doubt that there is a well-founded positive answer to this question and between them constitute the basis for making progress on the six specific issues raised by the ‘simple’ question (Section 3.5).

3.3 Established forms of SFCT that have been examined in extensive RCTs and other research

Randomised control trials are difficult to operate rigorously in the common contexts of the practice of systemic family and couples

therapy. They therefore require involvement of a substantial research team and are expensive. As a result, relatively few high quality RCTs are reported as compared to therapies such as CBT which are sometimes referred to as ‘the evidence based therapies’. Many of the well funded RCTs that we do have concern adolescents: delinquency, conduct disorder and drug addiction/ substance abuse. As Stratton *et al.* (2015) point out there is substantially more research on externalizing disorders (i.e. conduct disorder, attention deficit hyperactivity disorder, oppositional defiant disorder) than internalizing disorders, depression and anxiety disorders. Perhaps this is an example of research funding being restricted to areas of current societal concern but also, well funded RCTs are most likely to be conducted in the USA. The concentration on adolescence can leave an impression that therapies for other client groups are less effective where in fact they have simply failed to obtain funding. The availability of funding in the USA could leave an impression that therapies that have been developed specifically to meet the needs of patients in other countries, such as the UK, are inferior. Indeed, the UK government has been much more willing to implement therapies such as Multisystemic Therapy and Functional Family Therapy that have been developed and proven only in the USA than to support local forms of SFCT.

As frequently stated in NICE reports, lack of evidence of effectiveness is not evidence of ineffectiveness. But a consideration of intensive research of well planned and manualised therapies is bound to be instructive.

3.3.1 Multi-Dimensional Family Therapy (MDFT)

One of the most comprehensive research programmes has been carried out by Howard Liddle and associates (Liddle *et al.*, 2009; Liddle, 2015). This series of studies is worth considering in some detail because it shows the range of information that can be provided by properly funded and rigorous research. The studies are especially impressive because the therapy was provided for a difficult group of clients (adolescents, mostly living in poverty, and in disrupted family constellations) with problems that are difficult to treat (drug misuse and a high level of co-morbidity). The authors have developed a comprehensive treatment drawing on a wide range of achievements in Family Therapy, called Multi-Dimensional Family Therapy (MDFT).

“MDFT is a structured (e.g., “core session” protocols) and flexible treatment delivery system. Depending on youth and family needs and session goals, sessions occur in the home, clinic, or at convenient locales ranging from one to three times per week over the course of 3–6 months. Therapists work simultaneously in four treatment domains—the adolescent, parent, family, and extra-familial. Each of these is addressed in three Stages: Stage 1: Building a Foundation for Change, Stage 2: Facilitating Individual and Family Change, and Stage 3: Solidifying Changes. Interventions in each domain are interdependent and linked to interventions and the proximal mini-outcomes in other domains (Liddle & Rigter, 2013). Throughout treatment, therapists meet individually with the adolescent as well as the parent(s), and together with the youth and parent(s), depending on the specific problem being addressed, and most of all, on the immediate therapeutic objectives”. (Liddle, 2015, p 6-7).

A recent review by Greenbaum *et al.* (2015) pooled results from five RCTs to create a sample of 646 adolescents receiving treatment for drug use. The main focus of the study was to remediate the lack of data on gender and ethnic differences. In the process they were

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also able to draw general conclusions about the effectiveness of MDFT:

“MDFT reduced drug use involvement ($p < .05$) for all participant groups. Pooled comparison groups reduced drug use involvement only for females and Hispanics ($ps < .05$). MDFT was more effective than comparisons for males, African Americans, and European Americans ($ps < .05$; Cohen’s $d = 1.17, 1.95, \text{ and } 1.75$, respectively). For females and Hispanics, there were no significant differences between MDFT and pooled comparison treatments, Cohen’s $d = 0.63 \text{ and } 0.19$, respectively. MDFT is an effective treatment for drug use among adolescents of both genders and varied ethnicity with males, African American, and European American non-Hispanic adolescents benefitting most from MDFT” (p. 919).

Two related articles succeed in providing a good overview of the operation and objectives of MDFT. Danzer (2013) offers a valuable independent synthesis of MDFT designed to help psychiatrists to use the method while understanding its limitations:

“Multidimensional Family Therapy (MDFT) is reviewed, both in theory and as an evidence-based approach to treating adolescent substance abuse and related risk factors. The primary objectives of MDFT are to improve functioning in the four domains that centrally influence the course of adolescent development—the adolescent himself or herself, the parents, family interactions, and extrafamilial relationships. In MDFT, functioning in each domain is conceptualized as a risk or protective factor for problematic adolescent behavior and overall development; adolescent substance abuse is thus understood as a deviation from healthy, adaptive development and as indicative of impaired family systemic functioning. Improved functioning in the four domains is expected to place adolescents on healthier developmental trajectories, which decreases risk for substance abuse. Previous reviews of treatment approaches for adolescent substance abuse have surveyed multiple models. Previous articles specifically on MDFT have addressed a defined range of issues—whether theory, technique, or research. This review comprehensively synthesizes MDFT in theory, research, and practice, and suggests directions for future research” (Danzer, 2013, p. 175).

Liddle & Rigter (2013) responded to this article with an argument that the objectives and potential of MDFT are rather wider:

“The processes involved in MDFT will result, it is to be hoped, in renewed, day-to-day motivation. But they also include the articulation and discussion of the “big picture” that encompasses each individual and the family as a whole. Focusing on and using emotion is one way of bringing conscious attention to the desired processes. When we watch a film, read a novel, or view a work of art, the experience can stimulate emotion, create certain experiences, and affect us in various ways or at different levels. Likewise, therapy can have a multiplicity of effects on our experience, emotions, and understanding. MDFT develops and uses what individuals consider larger life themes, weaving these together with behaviorally oriented work in skills training and problem solving. Youth, parents, and even outsiders become engaged at both broader, thematic levels. That is, they join together to stop the youth’s slide toward more drug use and delinquency, and they listen to the youth’s experiences and reflections on their lives and circumstances” (p. 201).

Rowe *et al.* (2014) review treatment fidelity as MDFT is applied away from its original base into other countries as part of the International Cannabis Need for Treatment (INCANT) multi-national randomized clinical trial. They conclude that: *“These findings paint a promising picture of the feasibility of implementing*

*MDFT internationally. Indeed, MDFT implementation efforts in the Netherlands have been underway for several years now and the demand continues to grow for more training. Other INCANT countries are also responding to the enthusiasm over MDFT from providers and its apparent success in preliminary reports of effectiveness. As of this writing, MDFT teams have been trained and are operational in 43 sites in the U.S. and Canada (45 supervisors and 190 therapists), as well as 50 MDFT programs across Europe (53 supervisors and 200 therapists), for a total of 93 MDFT programs, 98 supervisors, and 390 clinicians worldwide. Positive outcome data from the INCANT trial may further increase the potential of MDFT international implementation” (p. 398). Darwiche *et al.* (2015) applying Sexton’s (2011) criteria to nine approaches concluded that *“MDFT was backed by studies with generally high methodological scores in several areas, in addition to having numerous RCTs and strong outcomes. However, assessing the quality in detail can also highlight potential areas for improvement in future research; According to our coding, long-term follow-up and sample size calculations are still lacking and could be included in future research” (p. 151).**

Most recently, Liddle (2016) provides a comprehensive overview of the evidence base of MDFT. His abstract states:

“This article summarizes the 30+ year evidence base of Multidimensional Family Therapy (MDFT), a comprehensive treatment for youth substance abuse and antisocial behaviors. Findings from four types of MDFT studies are discussed: hybrid efficacy/effectiveness randomized controlled trials, therapy process studies, cost analyses, and implementation trials. This research has evaluated various versions of MDFT. These studies have systematically tested adaptations of MDFT for diverse treatment settings in different care sectors (mental health, substance abuse, juvenile justice, child welfare), as well as adaptations according to treatment delivery features and client impairment level, including adolescents presenting with multiple psychiatric diagnoses. Many published scientific reviews, including meta-analyses, national and international government publications and evidence-based treatment registries offer consistent conclusions about the clinical effectiveness of MDFT compared to standard services as well as active treatments. The diverse and continuing MDFT research, the favorable, multi-source independent evaluations, combined with the documented receptivity of youth, parents, community-based clinicians and administrators, and national and international MDFT training programs all support the potential for continued transfer of MDFT to real world clinical settings.”

MDFT has been considered in some detail because its extensive application shows that a well formulated systemic therapy, applied to a challenging client population, can be exported to a variety of national contexts and still maintain its standards of application while in general, being equally effective. It may be that over time it will show us how a therapy can avoid the common phenomenon of becoming less effective the further it moves away from its originators.

3.3.2 Multisystemic therapy (MST)

MST originated within the tradition of systemic family therapy but added a significant component of skills training for the adolescent and substantial interventions involving schools and other agencies. Stouwe *et al.* (2014) say it is also *“one of few interventions targeting externalizing behavior problems that intensively monitors treatment integrity” (p. 469).* The early studies in the US generated very positive

results. Henggeler and Lee (2003) reported on 8 studies showing significant improvement in individual and family adjustments. In a meta-analysis of 11 studies, Curtis *et al.* (2004) found comparable improvements in family functioning but smaller effects on individual adjustment of the adolescents. Positive effects were maintained for up to 4 years post-treatment.

There is a pattern of stronger results achieved by the originators of MST, and of greater effectiveness with family functioning than with drug use by the adolescents which appears to continue in more recent reviews.

Henggeler (2004) pointed out that “Effect sizes for evidence-based treatments will most likely decrease along the continuum from efficacy studies to effectiveness studies to studies conducted in field settings that are independent of the treatment developers.”

Henggeler’s evaluation probably applies to all forms of treatment as they move from rarefied RCTs in specialist units to adoption in everyday practice. But there seem to be specific factors at play in relation to MST. Sundell and colleagues (Sundell *et al.*, 2008; Loftholm *et al.*, 2009) report that MST did not show a difference from treatment as usual (TAU) in Sweden whereas it did in Norway (Ogden & Amlund Hagen, 2006). This findings are characteristic of a longstanding debate about the transportability of MST and in this case the research team suggest the main differences are that TAU in Sweden is superior while the level of problems of youth are not as severe as in the US.

Stouwe *et al.* (2014) conducted an extensive meta-analysis of MST: “Multisystemic Therapy (MST) is a well-established intervention for juvenile delinquents and/or adolescents showing social, emotional and behavioral problems. A multilevel meta-analysis of $k = 22$ studies, containing 332 effect sizes, consisting of $N = 4066$ juveniles, was conducted to examine the effectiveness of MST. Small but significant treatment effects were found on delinquency (primary outcome) and psychopathology, substance use, family factors, out-of-home placement and peer factors, whereas no significant treatment effect was found for skills and cognitions. Moderator analyses showed that study characteristics (country where the research was conducted, efficacy versus effectiveness, and study quality), treatment characteristics (single versus multiple control treatments and duration of MST treatment), sample characteristics (target population, age, gender and ethnicity) and outcome characteristics (non-specific versus violent/non-violent offending, correction for pretreatment differences, and informant type) moderated the effectiveness of MST. MST seems most effective with juveniles under the age of 15, with severe starting conditions. Furthermore, the effectiveness of MST may be improved when treatment for older juveniles is focused more on peer relationships and risks and protective factors in the school domain” (p. 268).

Sexton and Datchi (2014) state: “*Multisystemic Therapy (MST) has been tested for more than 30 years in 23 randomized trials, 17 independent evaluations, and many other studies of severe conduct problems, substance abuse, emotional disorders, sexual offenses, family maltreatment, and chronic health problems*” (p. 416). For a full overview see Multisystemic Therapy (2014). The most recent overview, by Henggeler and Schaeffer (2016), states: “*With more than 100 peer-reviewed outcome and implementation journal articles published as of January 2016, the majority by independent investigators, MST is one of the most extensively evaluated family based treatments. Outcome research has yielded almost uniformly*

favorable results for youths and families, and implementation research has demonstrated the importance of treatment and program fidelity in achieving such outcomes.”

MST is a fully described approach with clear achievements in certain areas. Its application is being extended beyond the original focus on adolescent drug use. For example Wagner *et al.* (2014) describe an adaptation for behaviour problems in youths with autistic spectrum disorders.

3.3.3 Functional family therapy (FFT)

FFT was developed by James Alexander and Tom Sexton. As with MST it started with a strong base in systemic therapy, with an emphasis on the therapeutic alliance with family members with special attention to family problem solving and competence. It offers weekly session for up to 6 months. The goal of FFT is to alter dysfunctional family patterns that cause or maintain substance abuse and problem behaviors. The first phase of FFT involves engaging families in treatment, boosting their motivation to change, and introducing the themes to be worked on during treatment (Sexton & Alexander, 2003). The second phase is dedicated to creating new patterns of family interaction and encouraging behavioural change using a wide range of communication skills training, behavioural and cognitive techniques, and working with extrafamilial systems such as the juvenile justice system to extend the improvements beyond the therapy context and the home. This treatment model is supported by seven RCTs. (Darwiche & de Roten, 2015, p. 146).

Sexton and Datchi (2014) point to the effectiveness of both FFT and MST but also draw attention to the narrow focus of this research: “*Family therapy studies have supported the effectiveness of a few systematic family intervention programs (e.g., MST, FFT) for youth externalizing behaviors, drug abuse, schizophrenia, bipolar disorders, in a variety of clinical settings, including residential and outpatient facilities; it has identified the specific distal outcomes of these systematic interventions on comorbid populations, using multiple dependent variables and perspectives to measure the impact of treatment on various areas of individual and relational functioning; it has established the link between therapists’ model adherence and treatment outcomes, yet produced limited knowledge about the change mechanisms of successful intervention programs*” (p. 420).

FFT is being successfully applied beyond the origins for example in Ireland. When implemented with high levels of model adherence, FFT was found to reduce recidivism among juvenile offenders in community-based settings in the United States and Ireland. (Graham *et al.*, 2014).

3.3.4 Brief strategic family therapy (BSFT)

BSFT was developed to work with adolescent substance abuse in minority, particularly Hispanic, families and combines structural and strategic approaches. It works to engage families, working on maladaptive interactions and cultivating family strengths. It is flexible in working with whoever in the family is motivated to attend while attempting to draw other family members into the therapy (Szapocznik *et al.*, 2012).

In an early review, Santisteban *et al.* (2006) concluded that it was effective at engaging adolescents and their families in treatment, reducing drug abuse and recidivism, and improving family

relationships. There was support for the efficacy of its strategic engagement techniques for inducting resistant family members into treatment, and for one-person family therapy, where parents resist treatment engagement.

"BSFT focuses on four areas: joining with the family, assessing problematic interactions, creating a context for change, and restructuring family interactions (Robbins, Horigian & Szapocznik, 2008; Szapocznik et al., 2012)" (Darwiche, 2015, p. 147-148). Darwiche (2015) reviews 7 outcome studies of BSFT with positive results. In the study with the highest quality rating, "(for) 480 drug-using adolescents, BSFT was more effective than treatment-as-usual for engagement in treatment and at improving family functioning (Robbins, Feaster, Horigian, Rohrbaugh, et al., 2011). In addition, greater therapist adherence was associated with better engagement and retention and better outcomes in terms of family functioning and reduced drug use (Robbins, Feaster, Horigian, Puccinelli, et al., 2011)" (Darwiche, 2015, p. 148).

3.3.5 Emotion Focused Therapy (EFT)

EFT has a developing and positive evidence base (Greenman & Johnson, 2013). Characteristically for EFT, this article has a clear focus on the mechanisms of change, and the therapeutic processes by which EFT is effective. They say it is *"an approach to couple therapy with substantial empirical support, evidence of lasting treatment effects (Cloutier, Manion, Gordon Walker & Johnson, 2002; Halchuk, Makinen & Johnson, 2010), and a growing body of process Research"* (p. 47). In this article the authors provide a detailed account of the underpinnings of EFT from client-centered therapy, systems theory, attachment theory and research on couple dynamics. They conclude: *"EFT for couples is one of the only approaches for which there is both empirical support of its effectiveness and evidence of links between therapy processes and client outcomes. Thus, we know not only that EFT works, but we are starting to have a clear idea of how it works"* (p. 59).

Burgess-Moser et al. (2016) extended the research on EFT with an intensive study of 32 couples and found that they significantly decreased their in relationship-specific attachment avoidance, which was associated with increases in relationship satisfaction.

3.3.6 Systemic couples therapy

The London depression trial (Leff et al., 2000) used a manualised systemic couples therapy (Jones and Asen, 2000) for a randomised control trial. The manual from this study is still used as a valued resource in couples therapy. Unfortunately 73% of participants in the CBT comparison dropped out of treatment at an early stage of the study and this arm of treatment was discontinued, so no comparison was possible. 44% of the drug comparison group completed 12 months of treatment (a 56% dropout from drug treatment is well within normal standards). The systemic couples therapy was highly effective with average Beck Depression Inventory scores reduced from 25 (high clinical level) to 11 (within the normal range) maintained over 2 years. So systemic couples therapy had higher compliance than CBT or medication and proven effectiveness. The authors conclude that *"For this group couple therapy is much more acceptable than antidepressant drugs and is at least as efficacious, if not more so, both in the treatment and maintenance phases. It is no more expensive overall"* (Leff et al., 2000, p. 95).

More recently Janet Reibstein and Hannah Sherbersky have developed a manualised couples therapy known as the "Exeter Model". It has been approved by the Association for Family Therapy (AFT) as a Specialist Training in Evidence-Based Practice with Couples for Depression. Current information at: <http://cedar.exeter.ac.uk/cpd/coupletherapyworkshop/>

As a summary for this section, Liddle and Rigter (2013) state: *"Overall, comprehensive, multifaceted, multi-target treatments show feasibility and promise in clinical outcomes. Likewise, implementation research promises to unlock some of the mysteries in understanding the systemic influences on the growth and change in services in regular care settings"* (Liddle & Rigter, 2013, p. 203).

We can conclude that SFCT has the benefit of a number of major, carefully developed approaches which originated in systemic therapy and have created quite different programmes of implementation. All of them have good evidence of effectiveness within their area of application and are fully manualised. We can therefore call on several different examples to demonstrate that when a well-defined approach receives adequate funding for its research, SFCT emerges with proven effectiveness.

3.4 Reviews of the effectiveness of Family Therapy for specified conditions

There have been several recent, careful reviews that assess the range of evidence available in relation to specific conditions. The reviews consistently identify certain conditions of children, adolescents and adults as effectively treated by SFCT. They are of particular interest because they give a direct indication of the range of conditions that have been researched and within each review the therapies have been evaluated according to the same criteria. As these reviews are readily available, in this section we identify recent reviews that list the conditions for which Family Therapy is indicated as a treatment, with additional information where this is likely to be useful. Finally is an alphabetical listing that extracts from the reviews all the conditions for which positive evidence has been reported.

Many conditions were identified in the meta-analyses and other reviews discussed in section 3.2. and the conditions they identified are listed below in date order. First it is worth considering the list compiled by Sprenkle (2012) in his overview of the 12 research articles in the special issue of the *Journal of Marital and Family Therapy*. Sprenkle concluded that the 12 articles provided evidence of a strong Couple and Family Therapy (CFT) Modality Effect for the following issues:

- Adolescent Conduct disorder/delinquency
- Getting adolescent substance abusers into treatment
- Adolescent substance abuse
- Getting adult substance abusers into treatment
- Adult substance abuse
- Childhood and adolescent anxiety disorders
- Childhood oppositional defiant disorder
- Adolescent anorexia nervosa
- Family management of adult schizophrenia
- Coping for family members of alcoholics unwilling to seek help
- Getting adult alcoholics into treatment
- Adult alcoholism
- Moderate and severe couple discord
- Adult depression when combined with couple discord
- Couple violence associated with alcoholism and drug abuse

- *Situational (not characterological) couple violence*
- *Type 1 diabetes for adolescents and children*

(From Table 2, p. 25).

This is an impressive list to have derived entirely from the articles contained in one issue of *The Journal of Marital and Family Therapy* (Vol. 38, No. 1).

3.4.1 Family and couple therapy with children and adolescents

Retzlaff *et al.* (2013) report child internalizing systemic therapy (ST) to be efficacious for the treatment of internalizing disorders (including mood disorders, eating disorders, and psychological factors in somatic illness). There is some evidence for ST being also efficacious in mixed disorders, anxiety disorders, Asperger disorder, and in cases of child neglect.

Sydow *et al.* (2013) list child externalising: attention deficit hyperactivity disorders, conduct disorders, and substance use disorders from their systematic review.

Guo *et al.* (2013) for adolescents and their parents: perceived family cohesion and reduced family conflict, and depressive symptoms.

Dakof *et al.* (2015) at the end of therapy found positive changes in delinquency, externalizing symptoms, rearrests, and substance use. But at follow-up, extending to 24 months, only the MDFT treatment group maintained their gains in externalizing symptoms, commission of serious crimes, and felony arrests.

Keiley *et al.* (2015) found adolescent-reported anxiety over abandonment and attachment dependence on parents increased. *“Significantly; these changes were predicted by decreases in maladaptive emotion regulation. Linear growth models were also fit over the 3 time points and indicate decreases in adolescent problem behavior and maladaptive emotion regulation”* (p. 324).

Stratton *et al.* (2015) collated CFT outcome studies published in English in the decade 2000-2009. The frequency of articles in which therapy was rated as effective for the most commonly researched conditions were:

- Child behavioural problems 25 articles out of a total of 29
- Child eating disorder 13 articles out of a total of 16
- Child anxiety and mood 6 articles out of a total of 23
- Adolescent substance misuse 6 articles out of a total of 20.

Carr (2014a) In a review of reviews using a broad definition of systemic practices. In this context, systemic interventions include both family therapy and other family-based approaches such as parent training. The evidence supports the effectiveness of systemic interventions either alone or as part of multi-modal programmes for:

- sleep, feeding and attachment problems in infancy
- child abuse and neglect
- conduct problems (including childhood behavioural difficulties, attention deficit hyperactivity disorder, delinquency and drug misuse)
- emotional problems
- (including anxiety, depression, grief, bipolar disorder and self-harm)
- eating disorders (including anorexia, bulimia and obesity)
- somatic problems (including enuresis, encopresis, medically unexplained symptoms and poorly controlled asthma and diabetes) and
- first episode psychosis.

3.4.2 Family and couple therapy with adults

Sydow *et al.* (2010) ST is particularly efficacious (defined by more than three independent RCT with positive outcomes) with adult patients in the treatment of affective disorders, eating disorders, substance use disorders, psychosocial factors related to medical conditions, and schizophrenia. In certain severe disorders, a combination with other psychotherapeutic and/or pharmacological interventions is most helpful (e.g. schizophrenia; heroin dependence; severe depression).

Carr (2014b). A review of reviews with a broad definition of systemic practices. The evidence supports the effectiveness of systemic interventions either alone or as part of multi-modal programmes for:

- relationship distress
- psychosexual problems
- intimate partner violence
- anxiety disorders
- mood disorders
- alcohol problems
- schizophrenia
- and adjustment to chronic physical illness.

Hunger *et al.* (2014) report personal social systems, improvement of psychological functioning and goal attainment improvement of physical and psychological health, self-esteem, and self-acceptance, increased emotional connectedness and relational autonomy.

In their review of a decade of outcome studies, Stratton *et al.*, (2015) reported that the frequency of articles in which therapy was rated as effective for the most commonly researched conditions were:

- Adult substance abuse 28 out of a total of 29
- Adult schizophrenia and psychosis 18 out of a total of 23
- Adult – other psychiatric 10 out of a total of 13
- Adult mood (depression) 7 out of a total of 20.

Pinquart *et al.* (2016) *“Adult Illness-specific analyses showed positive short-term efficacy of systemic therapy on eating disorders, mood disorders, obsessive-compulsive disorders, schizophrenia, and somatoform disorders. At follow-up, efficacy of systemic therapy was only found on eating disorders, mood disorders, and schizophrenia”* (p. 241).

It may be helpful to have a comprehensive listing of all of the conditions described above as having evidence of efficacy or effectiveness.

3.4.3 A Final alphabetical Listing of all conditions with evidence for efficacy or effectiveness

This compilation derives only from the research and reviews considered in this report. It is not therefore offered as a comprehensive listing of all conditions for which SFCT research has demonstrated positive outcomes. Another limitation is that conditions are listed in the nomenclature used by the authors, so there is likely to be some overlap or duplication between categories and different levels of generality of the category as stated. All of the items have positive evidence for the effectiveness of some version of systemic, family, or couples therapy but no attempt has been made to grade the strength of the evidence in each case.

Child conditions N=40

- anorexia,
- anxiety disorders
- anxiety over abandonment

- Asperger disorder
- asthma poorly controlled
- attachment dependence
- attachment problems in infancy
- attention deficit hyperactivity disorder,
- behavioural difficulties,
- bipolar disorder
- bulimia
- commission of serious crimes Conduct disorder
- conduct disorders, /conduct problems
- delinquency
- depression
- diabetes (Type 1)
- diabetes when poorly controlled
- drug misuse
- eating disorders
- emotional problems
- encopresis
- enuresis
- externalizing symptoms
- feeding difficulties
- grief
- internalizing symptoms
- maladaptive emotion regulation
- medically unexplained symptoms
- mood disorders
- obesity
- oppositional defiant disorder
- perceived family cohesion
- psychosis, first episode
- rearrests
- reduced family conflict
- self-harm
- sleep difficulties
- somatic illness, psychological factors in
- somatic problems
- substance abuse, getting adolescent substance abusers into treatment

Adult conditions N=32

- affective disorders
- alcohol problems
- alcoholics Getting into treatment
- alcoholics: Coping for family members of unwilling to seek help
- alcoholism
- anxiety disorders
- child abuse
- child neglect
- chronic physical illness: adjustment to
- couple discord
- Couple violence associated with alcoholism or drug abuse
- couple violence: Situational (not characterological)
- depression
- depression when combined with couple discord
- eating disorders
- emotional connectedness increased
- medical conditions, psychosocial factors related to
- mood disorders
- obsessive-compulsive disorders,

- personal social systems
- physical and psychological health, improvement of
- psychological functioning and goal attainment
- psychosexual problems
- relational autonomy
- relationship distress
- schizophrenia
- schizophrenia (adult), Family management of
- schizophrenia, psychosocial factors related to
- self-esteem, and self-acceptance
- somatoform disorders
- substance abuse
- substance abusers: Getting adults into treatment.

These impressive lists are of conditions for which evidence of effectiveness or at least efficacy of CFT has been published. Many would benefit from further research and we would certainly not claim definitive evidence for them. Each of them is listed earlier in this report so that the evidence in each case can be examined. In particular we can make no claim that CFT for these conditions is more effective than alternative appropriate treatments – the judgement must be that when it is appropriate to work with and through relationships, the relevant systemic approach should be available for clients to choose.

Between them, these reviews of the conditions for which SFCT has been adequately researched demonstrate efficacy and in many cases effectiveness for a remarkably wide range of concerns. However, there are still significant areas in which published research does not yet allow conclusions to be drawn. In view of the exceptional range of arenas in which SCFT does have evidence it could well be argued that, where evidence is lacking because research has not been reported, it would be reasonable to extrapolate from comparable areas. Forms of SCFT that have proven effective with similar problems should be proposed with a presumption of value until proved otherwise.

3.5 Considerations beyond simple effectiveness

This report has been compiled to answer the (deceptively) simple question ‘does systemic family and couple therapy work?’ Now that we have reviewed the major sources of evidence it becomes apparent that this question can be unpacked to go back to the research for more specific guidance, or to recognise that we need further research to provide more precise answers.

- 1) There is a legitimate general form of the question: can we say that SFCT is capable of producing beneficial effects in at least some arenas?
- 2) It is clear from the preceding discussion that there are many versions of therapy that could come under the heading of SFCT. So the question should be in the plural: ‘Do systemic and couple therapies work?’, giving us the job (guided by research experiences) of deciding which versions to include in our question.
- 3) SFCTs have a very limited contribution to make to repairing the roof. We need a recursive process in which we start from a judgement about what we would expect them to work for, then explore the available evidence to indicate which of these are supported. In the process, check whether there are other areas of useful application.
- 4) Examine the ways that ‘to work’ is investigated and establish

some ground rules for how much reliance can be placed on different kinds of evidence.

- 5) Keep in mind the various contexts with an interest in the question, to be aware both of how they influence the forms that research has taken, while remaining open to discovering that there might be better ways of approaching the question. In which case we may wish to propose a change in the stance taken by these interested parties.
- 6) Finally, expand the question in the direction of being able to say more precisely which forms of SFCT work for which concerns, in which circumstances.

3.5.1 User acceptability and dropout

Because clients' needs, contexts and resources vary so substantially, it is not likely that one or even a few forms of psychotherapy will be optimal for everyone. Providers therefore rightly emphasise the need for patient choice. We have little data about expectations of systemic family and couples therapies, and are likely to find major differences in expectation among different cultural groups. What has been researched is the perceptions of clients following therapy. There are no RCTs of client satisfaction nor of premature dropping out from therapy, so we have to find such evidence scattered through reports with other objectives. Chenail *et al.* (2012) did undertake a qualitative meta-synthesis of 49 articles to develop an "inductive grounded formal theory of CFT client experience/evaluation/preferences". This article is a detailed and informative account of this qualitative methodology and also richly informative about client reactions. "(a) that family members appreciate being actively and fairly involved throughout therapy so it is important to ask for feedback early and often and (b) that family members appreciate what each other contributes to therapy so it is important to encourage and celebrate such contributions" (p. 259).

Overall these authors conclude that the factors that impact clients' perceptions are:

- Clients' commitment to change, motivation
- Clients' recognition of therapists' efforts to provide opportunities to change
- Clients' appreciation of the relationship or alliance they have with their therapists
- Clients' preconceptions and expectations for their therapy's helpfulness.

Systemic family and couples therapies have developed a strong tradition of exploring with their clients whether the therapy is meeting their needs. It was narrative therapy (White & Epston, 1990) that theorized this practice and made it an explicit component of the therapeutic process. Guiding the therapy by explicitly adapting it to what the client says is useful has, like many narrative therapy practices, become widely integrated into all forms of systemic practice over the last two decades.

Parra-Cardona *et al.* (2016) compared two culturally adapted versions of Parent Management Training. "Participants exposed to the culturally enhanced intervention, which included culture-specific sessions, also reported high satisfaction with components exclusively focused on cultural issues that directly impact their parenting practices (e.g., immigration challenges, biculturalism)" (p. 321-322).

"According to the correspondence of quantitative indicators of satisfaction and qualitative narratives, current findings suggest that a multidimensional and rigorous process of adaptation is likely to

be associated with increased participant satisfaction and perceived relevance with adapted components (Barrera *et al.*, 2013). In addition, parents randomly assigned to the CE intervention consistently reported the relevance of the culture-specific sessions, which allowed them to process the impact of immigration, contextual adversity, and biculturalism on their parenting practices" (Parra-Cardona *et al.*, 2016, p. 335).

Sheridan *et al.* (2010) interviewed 15 parents of adolescents after participating in family therapy. They report that parents valued the therapeutic process and relationship, and the contribution the therapist made to both. Important factors in parental experience of family therapy were: Supportive therapeutic climate; therapist's qualities (such as sensitivity); and noticing positive results which motivates parents to continue with therapy. The supportive therapeutic environment seemed to help parents go through the family therapy experience.

Children may have different experiences than the adults. In a classic but still important study Strickland-Clark *et al.* (2000) applied a grounded theory methodology to interviews with five children (ages 11 to 17). Children emphasised the importance of being heard during family therapy, of additional support during sessions and being able to talk freely about issues. Some children found it difficult to engage in the therapy and to express their emotions because they felt that their experiences are not always acknowledged or understood during sessions. Some children reported conflicts between their feelings and what they observed during therapy. Children described therapy as challenging and perceived therapy sessions as opportunities to solve problems (but also to make judgments!). Children sometimes do not speak during therapy because they do not want to upset their parents by saying 'wrong things'.

One indication of acceptability is whether clients drop out of therapy early. As reported above (3.4.1.1) MDFT clients stay in treatment longer than clients in outpatient and residential comparison treatments. 95% of clients in intensive outpatient MDFT stayed in treatment for 90 days as compared to 59% in residential. Hamilton *et al.* studied data from 434,317 patients whose therapy had been funded by CIGNA Behavioral Health. Individual therapy had lower dropouts than family therapy. But much of the family therapy was provided by other professionals with limited systemic training. Fully trained marital and family therapists had the lowest rates of dropout. These findings suggest that it is not family therapy as such that keeps clients engaged but family therapy as provided by well trained and experienced therapists.

3.5.2 Cost-effectiveness

It is extremely difficult to accurately gauge the cost of different treatments and yet this is a crucial factor in provision, especially at times of economic constraint. Where studies have been reported, and taking account of the costs of treatment up to two years after the completion of therapy, family therapy has been found to be no more costly, and often substantially less costly than other therapies. Research reviewed earlier in this report, such as Leff *et al.* (2000) and the major approaches to adolescent drug and conduct problems, has consistently found lower costs than alternative treatments especially when these alternatives are ineffective. For example Multisystemic therapy was less costly than treatment as usual because of the low success rate of the alternative. Multidimensional

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therapy was much less costly because the comparison, although almost as effective in the short term, was an extremely expensive residential provision.

Crane and his co-workers continue to provide substantive cost-benefit comparisons. Using large-scale data from real-world practice, Crane (2008) analysed the relative costs of different treatments. One of the many advantages of this approach is that reliable long-term outcomes can be recorded and because the examination of data are retrospective, there is no chance for data to be contaminated by researcher bias. After establishing from the published evidence that family therapy is an effective treatment for adolescent conduct disorder, they find that family therapy in the clinic required 32% less care costs than those seen individually ($n=164$ and 3086 respectively) while those receiving in-home family therapy ($n=503$) were least costly, averaging at most 15% of the costs of any in-office treatment.

Moore *et al.* (2011) from comparable data concluded that trained marital and family therapists had the lowest dropout rates and recidivism and were more cost effective than psychologists, medical doctors, and nurses. The review of family-based substance abuse programmes by Morgan and Crane (2010) “identified eight cost-effectiveness family-based substance abuse treatment studies. The results suggest that certain family-based treatments are cost-effective and warrant consideration for inclusion in health care delivery systems”. Morgan *et al.* (2013) “examined the cost of substance use disorders treatment in a large healthcare organization. A survival analysis demonstrated that family therapy utilised the least number of sessions ($M = 2.41$) when treating substance use disorders followed by individual therapy ($M = 3.38$) and mixed therapy ($M = 6.40$). Family therapy was the least costly of the three types, at \$124.55 per episode of care for a client, with individual therapy costing \$170.22 and mixed therapy \$319.55. The ratio of family therapists utilising family therapy was more than three to one compared to other licensed professionals. The percentages of clients coming back for more than one episode of care are fewest for family therapy (8.9%) followed by mixed therapy (9.5%) and individual therapy (12.0%)” (Abstract, p. 2).

Crane *et al.* (2013) examined claims data for 164,667 individuals diagnosed with depression. First they found a saving because the family therapy required fewer sessions on average: “The average number of sessions utilized per patient for family therapy was 5.10 ($SD = 5.75$), 7.86 for individual therapy ($SD = 10.21$), and 13.02 for mixed therapy ($SD = 13.04$). The mean cost using raw data was \$248.65 ($SD = 313.04$) for family therapy only, \$391.31 ($SD = 566.72$) for individual therapy only, and \$631.69 ($SD = 686.48$) for mixed therapy” (p. 462).

Crane and Christenson (2012) provide a useful summary of the main findings from 19 of their studies. The summaries cover the medical offset effect which found reductions in use of health care (with associated costs) not just for the patient but for members of their family. In one study the biggest reduction in health care use (a decrease of 58%) was found in those who reported an improvement in general family functioning after treatment.

Sydow *et al.* (2013) include an analysis of cost effectiveness in their systematic review. In relation to MST they conclude:

“In most U.S. trials, MST had a favorable cost-effect ratio (Henggeler, Melton, Brondino, Scherer & Hanley, 1997). In the Swedish trial, MST costs, on average, SEK 105,400 (approximately \$14,000) per youth. While placement intervention costs were not reduced, nonplacement intervention costs were (reduction of SEK

*62,100). However, this did not offset the extra costs of providing MST (c14: Olsson, 2010). The picture changes when longer follow-up intervals are analyzed: The economic analysis of 13.7-year follow-up data of a trial that compared MST to individual therapy (Borduin *et al.*, 1995; Schaeffer & Borduin, 2005) took into account expenses of the criminal justice system and the costs of crime victims. The cumulative benefits were estimated to be ranging from \$75,110 to \$199,374 per MST participant compared to individual therapy participant. This implies that every dollar spent on MST provides \$9 to \$24 savings to taxpayers and crime victims in the 14 years ahead (c5: Klietz, Borduin & Schaeffer, 2010)” (p. 604).*

Distelberg *et al.* (2016) measured the cost saving achieved by entering the ‘Mastering Each New Direction’ (MEND) programme. For a sample of 20 families they compared pre-post costs. They found a “direct cost-benefit ratio of \$5,320/\$15,249, or 0.35. Stated otherwise, for every \$1 spent on the program there is a \$2.87 saving (\$15,248/\$5,320) of direct medical expenses. ... In addition to the above direct benefits (e.g., reduction in medical expenses), participation in the program was associated with indirect benefits such as missing less work, and less need for caregivers. For example, there was an average reduction of 4.50 fewer days of missed work. Using the area-adjusted median income, we estimated that the annual benefit for missing less work to be equal to \$11,683 annually. Inclusive of the annual cost for caregiver needs, the total annual indirect benefit = \$15,267 per patient, bringing the total benefit of MEND to \$30,516 (\$15,267 + \$15,249). Given this total benefit, the cost-benefit ratio for participating in the program was calculated to be \$5,320/\$30,515 = 0.17, or \$5.74 of savings for every dollar spent in the first 12 months after the MEND program” (p. 378).

As cost, and therefore cost-effectiveness of treatment become ever increasing concerns, we are fortunate to have researchers tackling the difficult task of comparing the costs of SFCT with other treatments. The studies summarised here show both that SFCT is less costly than alternatives, and offers substantial long-term savings that do much more than cover the costs of treatment.

3.5.3 What do Systemic Family and Couples Therapists do?

We offered a broad description at the start of this review. By now it will be apparent that there is a very wide range of ways of implementing therapy under the broad remit of systemics. Meanwhile the increasing evidence for common factors in effective therapies, and the now widespread willingness to incorporate whatever might be useful for the client by therapists is resulting in a (perhaps rather functional) blurring of boundaries. And research reports are not always as helpful as they should be. Stratton *et al.* (2015) found remarkably few of the 225 outcome studies that they reviewed provided a clear specification of the therapy used. The issue becomes acute when planning training or specifying the requirements for accreditation of courses. There is also an expanding amount of process research being undertaken in the systemic therapy field which addresses the question of what kinds of processes occur in effective systemic therapy, the ‘how’ and ‘what’ questions of process and change. Research to identify what it is that systemic family therapists ‘do’ from ‘real-life’ clinical practice (eg Friedlander *et al.*, 2014).

Piercy (2015) in reviewing what should now be taught in marital and family therapy says: “While applications of social constructionist theories continue to be alive and well ... contemporary family

therapies are shapeshifting into ones with fewer gurus and more variation and accountability ... Feminist family therapies, for example, have evolved to more overtly include, beyond gender and power, the intersectionality of race, culture, class, and sexual orientation ... Family therapy scholarship on diversity and oppression has expanded to include nationalism (Platt & Laszloffy, 2013) and to more directly address lesbian, gay, bisexual, and transgender" (p. 1).

A simpler account of the requirements in the US, derived from an analysis of requirements for certification, is provided by Crane *et al.* (2010) comparing: "...training for family-based interventions in six core mental health disciplines (Clinical Psychology, Psychiatry, Psychiatric Nursing, Professional Counseling, Marriage and Family Therapy, and Social Work) a marriage and family therapist is required to have three times more family therapy coursework than any other professional mental health discipline. Also, before becoming licensed a marriage and family therapist, must complete 16 times more face-to-face family therapy hours than a mental health professional from any other discipline" (p. 357).

A much more detailed account has been created by the competency framework analysis commissioned by the UK agency Skills for Health (Pilling *et al.*, 2010). This analysis worked from manuals that had been the basis for successful outcomes in RCTs and extracted the competences they specified. The lists were reviewed by an expert committee and concluded with a list of five Domains of: Generic Therapeutic Competences; Basic Systemic Competences; Specific Systemic Techniques; Problem Specific Competences/Specific Adaptations; and Metacompetences. The Domains break down to 30 broad headings of systemic competences in addition to a further 10 generic competences shared with other therapies. Each of the headings is unpacked into a listing of specific aspects of that competence (Stratton *et al.*, 2011) generating a complete list of some 240 forms of practice. Perhaps surprisingly, trainers and experienced therapists recognise this extensive listing as substantially present in their repertoire. Northey (2011) compares the competences survey conducted in the UK with the 2003 initiative of the American Association for Marriage and Family Therapy which embarked on a similar endeavour, resulting in the development of the 'marriage and family therapy core competencies' (MFT-CC; Nelson *et al.*, 2007). Northey points out that the specification of competences is only the first step towards a number of goals in relation to training, registration, and documenting the development of therapies. The interactive map of competences is available at:

https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks/Systemic_Therapy

4. Conclusions

This report has had the advantage of being able to bring together a substantial number of rigorous reviews, while also having available high quality individual research studies to help clarify specific issues. The message from these sources is consistently that systemic family and couple therapy is effective in a variety of forms and contexts, for whatever conditions and circumstances have been researched.

Despite the many positive findings compiled in this report, and the very substantial number of conditions for which SFCT can make a useful contribution to treatment, there are many areas of everyday systemic practice that have not been researched. At present anyone who seriously wants to judge whether systemic family and couples therapy will be effective in an area lacking direct evidence will need to look at the evidence for similar conditions and circumstances, and extrapolate.

4.1 Future research needs

The available research into the efficacy of family therapy is certainly positive, but the research base has limitations. In their detailed examination of family therapy research Sexton and Datchi (2014) say *"Despite the acknowledged importance of family therapy research, there are still questions about its impact on 'real life' practice. Despite all the flaws of each, research and practice are critical interacting elements of a dialectic relationship"* (p. 415).

Relevance to practice

One theme running through this report has been the ways that available research does not correspond to the patterns of work of therapists. Stratton *et al.*, (2015) after reviewing 225 reports of outcome studies conclude that a combination of funding and journal publication strategies mean that some conditions are less likely to receive research funding as research is concentrated in areas of societal concern, and that negative findings are unlikely to be published. Lebow (2014b) while discussing the risk of *"overselling our findings"* adds the pressures against doing research to replicate important findings, and of getting failures to replicate published at all. There are, however, recent positive moves such as journals that now require a section on clinical applications in all research reports. Additional to quantitative studies, qualitative and process research is readily perceived as clinically relevant to therapists, while providing a bridge between outcome research and clinicians' practice.

Appropriate measures

A number of authors point to the need for more consistency in the measure used. Sanderson *et al.* (2009) reviewed 274 outcome studies and reported that a total of 480 different outcome instruments were employed. Stratton *et al.* (2015) found *"great diversity in the outcome measures employed and most studies used more than one type of outcome measure"* (p.7). Only 58 % of the studies gathered measures from more than one person in the family with only 25% of the studies using a family system measure. In their review of high quality RCTs Sydow *et al.* (2010) reported that *"The studies applied heterogeneous outcome measures. The use of common measures of individual and family functioning (e.g., CORE: Barkham *et al.*, 1998; SCORE: Stratton, Bland, Janes & Lask, 2010) is not yet common"* (p. 478).

This lack of consistency makes it difficult to directly compare and combine different research outcomes. It would be useful if there

could be some consensus on measures that are appropriate in family therapy. Apart from consistency in choice of measures by researchers we also need instruments that are meaningful to therapists. We sometimes miss good opportunities to gather practice based evidence because the approved measures are not seen by therapists as relevant to their work with clients. But we do have appropriate measures that can if necessary be used alongside others that may be needed for statutory purposes or the particular needs of the therapy. Hamilton and Carr (2016) concluded that five of the measures they reviewed are suitable for clinical use in family therapy: The McMaster Family Assessment Device (FAD); Circumplex Model Family Adaptability and Cohesion Evaluation Scales (FACES-IV); Beavers Systems Model Self-Report Family Inventory (SFI); Family Assessment Measure III (FAM III); and the Systemic Clinical Outcome Routine Evaluation (SCORE). With one new system currently under-going validation, the Systemic Therapy Inventory of Change (STIC).

What therapy was the research investigating?

Many reviewers have commented on the limited information in published studies about the precise nature of the therapy being examined. Clearly this information is crucial in making judgements about what may be responsible for positive outcomes and it is crucial for practitioners in deciding whether the research is relevant to their ways of working. One potential solution is the use of manuals. Even in carefully selected RCTs Sydow *et al.* (2010) found a lack of *"Clear definition of the interventions applied. Manual-like publications or treatment Manuals were applied in only 15 trials"* (out of 38) (p. 478). Practitioners may be resistant to the idea of using a manual in case its prescriptive nature interferes with the flexibility of therapy. In fact, manuals can be highly adaptable (e.g. Pote *et al.*, 2003) without losing their capacity to be informative about the process of the therapy undertaken (Stratton, 2013).

Process and progress

Consideration of using manuals points to a crucial area, beyond the scope of this report: that of process research. Systemic therapists have largely attempted to avoid the polarisation between quantitative research into outcomes and qualitative research into process which has occurred in many fields. Knowing an outcome may speak to policy makers but is quite uninformative if we do not know the therapeutic processes that led to that outcome. Qualitative process research seeks to identify significant processes in the therapeutic interactions. Further integration of process research with outcome measurement should be enhanced by the continuing substantial developments in systemic qualitative methodologies (cf Simon & Chard, 2014; Tseliou, 2013) and would be further enabled by allocation of funding for this crucial aspect of systemic psychotherapy research.

Transportability

Therapy conducted in controlled research conditions by specialists who are often the originators of the particular approach needs to be followed by trials in more realistic field conditions. Are the methods still effective when transported to less specialist locations with no input from the originators? There is a woeful shortage of data on the progression from efficacy through effectiveness to transportability and one can only speculate about the factors that might be relevant

in maintaining the results shown by research. As the models reviewed in Section 3.3 are taken out to trials in many contexts and countries, the issue of transportability has become salient. It is, for example, one of the criteria in Darwiche and de Roten's (2015) evaluations.

When considering the transportability of treatments developed and tested in the US to other countries, the quality of comparison treatment becomes crucial. MDFT was tested against a high cost, high quality six month residential programme of intensive treatment, while other therapies appear to have been tested against a 'therapy as usual' with minimal therapeutic value, sometimes simply a judicial procedure and detention. A weakness of the UK's National Institute for Health and Clinical Excellence (NICE) evaluation is that the dominant consideration is the difference between the experimental and the control treatment, regardless of the quality of the comparison treatment. A further concern is that therapies that were formulated and researched while being applied by fully trained systemic therapists have progressively moved towards implementation by operatives with much less training. For example, even the original research on Multisystemic Therapy found that the average effect was larger when applied by graduate student therapists than in studies with therapists from the community. In such circumstances the early evidence cannot be guaranteed to apply when the approach is transported to a different culture in a downgraded (and less systemic) application.

A systemic therapy should be a comparator when researching other therapies

Most of the research studies that we have been able to consider were conducted from a base of SFCT rather than a systemic therapy being included as an alternative treatment when a different treatment is being investigated. One aspiration of this report is to contribute to the case that when research is planned to investigate other forms of therapy, SFCT has a strong claim to being a plausible comparison treatment: it has proven effectiveness and offers a clear difference from individual and group therapies. If a particular therapy is to be investigated to realistically judge whether it is a preferred option, and if the client group is one for which SFCT has proven usefulness, then there is a compelling case that the relevant form of SFCT should provide the comparison. As this argument becomes accepted, it will create a substantial increase in the research available.

There is therefore a strong justification for including Systemic Family Therapy in future comparison outcome trials, and for conducting more coherent and rigorous outcome research on Family Therapy. There are positive developments. Further substantial RCTS are currently under way, for example into adolescent self harming (SHIFT project), and a comparison of manualised family therapy treatments for eating disorders, while others are being planned. As the existing evidence base of systemic family and couples therapy becomes recognised, we can hope that research in the forms and on the scale that is necessary, will be funded.

"It is innovation that pushes any system, family therapy included, to remain exciting and viable in the difficult world of practice. It is innovation from research and clinical practice that will engender the excitement and advancement of family therapy practice" (Sexton & Datchi, 2014, p. 429).

"Ultimately, our field best advances through bridging research and practice with each related to and solidly grounded in the other" (Lebow, 2016, p. 4).

4.2 Why Family Therapy is an essential provision

As this report clearly shows, it works and it makes immediate emotional and cultural sense to clients.

There is strong evidence of both efficacy and effectiveness in a range of specific conditions. Family Therapy is used for an extremely wide range of problems, many without a clear (DSM-type) diagnostic definition, so there is no prospect that there will ever be evidence for every application of the approach to treatment. However, if we take the conditions that have been researched as representative, then we can deduce the range of problems for which it would be appropriate to expect Systemic Therapy to be effective. However, *"the amount of systemic service and clinicians performing those services in mental health systems falls far behind the body of evidence for the utility of systemic intervention and family therapy"* (Lebow, 2014a, p. 366).

The considerable increase in the evidence base of SFCT lends further weight to the statement by Crane and Payne (2011): *"As a number of family therapy approaches have been shown to be effective ... at least offering this approach to patients seems warranted where it is appropriate. There should be at least short-term cost benefits and reasonable outcomes as measured by success and recidivism rates. In addition, including family therapy as a treatment modality in health care systems does not seem to increase health care costs Now may be the time to begin to educate policy makers"* (p. 285).

In summary, reasons to ensure and expand the provision of Family Therapy include:

- It has proven effectiveness for all those conditions for which it has been properly researched.
- There is very substantial supportive evidence for its effectiveness from diverse research and clinical experience.
- Trained family therapists draw on a good range of approaches with clear theoretical rationales. Current models of family therapy pay explicit attention to issues of culture, ethnicity, gender, discrimination and wider physical and societal contexts.
- Most governments place a high value on families, and claim to be motivated to improve the wellbeing of their citizens. Systemic family therapy offers proven resources that could coordinate these two objectives if more widely deployed.
- Properly trained family therapists have transferable skills in relation to team working, consultation, organisation etc.
- Family therapists can support other professionals in their work with families.

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