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## **The Evidence Base of Systemic Family and Couples Therapies**

by

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# The Evidence Base of Systemic Family and Couples Therapies<sup>1</sup>

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## 1 Overview

Systemic family and couples therapy (SFCT) has evolved into a variety of forms to meet the needs of the people who come for therapy. Our clients differ not only by bringing the full range of psychological and relationship difficulties and the variety that our society has imaginatively created in family structures and relationships, but 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 SFCT and explains why it offers a very different resource from all the other therapies, which strive to bring about change within individuals.

The survey of systematic reviews of the range of applications of SFCT finds that all point to a strong positive conclusion about the general effectiveness of the approach. Substantial reviews report on each of the extensive range of conditions, for children and adults, for which SFCT has been researched. These reviews demonstrate efficacy and in many cases effectiveness in the conditions for which significant amounts of comparative research data have been published. However there are significant areas in which published research does not yet allow conclusions to be drawn.

Major programmes for well developed and documented forms of family therapy are reviewed. They demonstrate high levels of effectiveness and cost-effectiveness. Most involve therapies for adolescent substance abuse and conduct disorder. So funding, and thereby evidence, follows political priorities and neglects other areas of need in the population.

The research review concludes that systemic family and couples 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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<sup>1</sup> Please reference as: Stratton, P (2010). *The Evidence Base Of Systemic Family and Couples Therapy*. Association for Family Therapy, UK. The report is available at [www.aft.org.uk](http://www.aft.org.uk) .

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# The Evidence Base of Systemic Family and Couples Therapies

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## 2 Orientation to the Report

Current estimates of the cost of mental illness state that one adult in six is experiencing symptoms of mental illness and one in four will experience mental illness during their lifetime. Mental illness is the largest single cause of disability in our society and costs the English economy at least £77 billion a year.

These estimates are based on the person diagnosed as ill. But when one person has a mental illness all members of their family suffer, so these figures are a serious underestimate. However, most people with a mental illness are part of a family whose members want to help them. 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.

Most cases of psychological difficulty benefit from being treated with the person in the context of supportive relationships. In some cases trying to help the person without directly influencing the others in their relational network is cumbersome or even impossible.

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

### 2.1.1 Systemic therapy breaks the mould

Therapies designed to treat individual people have a remarkable record of achievement, being successful in about 75% of cases. However, with up to 25% of people in need not being helped and large numbers dropping out of treatment before it is completed, we have no reason for complacency. Systemic family and couples therapy offers something completely different. 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.

As this review demonstrates, Systemic Family and Couples Therapies provide effective help for people with an extraordinarily wide range of difficulties. 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 Family Therapy 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.

The review of the existing evidence base finds substantial evidence for the efficacy and the effectiveness of family interventions. Where economic analyses have been carried out, family therapy is found to be no more costly, and sometimes significantly cheaper, than alternative treatments without loss of efficacy.

In the light of such a strong evidence base for the effectiveness of Family Therapy, we conclude that trained family therapists need to be employed not just to provide Family Therapy services but also:

- to support training of future family therapists through supervision;

- to provide training and support for professionals applying specific family interventions such as Expressed Emotion and Brief Solution Focused approaches;
- to provide supervision and, where appropriate, training of other professionals working with families;
- to develop the research base of their practice by participating in networked research.

### **3 Review of Research Evidence**

In evaluating research evidence it is clear from published reviews that it is necessary to be explicit about how systemic family and couples therapists view the approach. Reviews conducted without involvement from family therapists may take definitions that the field would not recognise. For example Henken et al. (2007) for a Cochrane review of family therapy for depression defined family therapy as treatment for a nuclear family thereby excluding systemic research with other family constellations, or with adults, including couples therapy. Family therapists stopped restricting their practice in this way 40 years ago. Brimble et al. (2009) reviewing treatments for ADHD considered "behavioural approaches such as family therapy" (p.36) which appears to assume that all family therapy is behavioural. We therefore offer a generic definition as follows.

#### **3.1 What is systemic family therapy?**

Systemic family therapy is an approach to helping people with psychological difficulties which is radically different from other therapies. It does not see its work as being to cure mental illnesses that reside within individuals, but 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.

Our sense of who we are is intimately associated with our relationships – both to other people and 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 often with 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 relationships that have gone awry.

### **3.1.2 Systemic Therapy**

Relationship problems are usually best treated within those relationships. Often that means working with 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. But always, resolving it within the web of relationships is what is effective. 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.

### **3.1.3 How Systemic Family Therapy Works**

Systemic family therapy has developed over some 50 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 clients and families. These include:

- 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.

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 most often consists of about seven sessions, spread over six months.

### **3.2 Overviews and meta-analyses of efficacy and effectiveness.**

Extensive early analyses by Hazelrigg et al. (1987) and Shadish et al. (1993) reviewed research that reflected the weak methodology of many studies of that time. Thus Hazelrigg et al. (1987) found only 20 of 281 studies that met their criteria. They concluded that Family Therapy did have a positive effect post treatment, particularly for behavioural measures (mean

effect size Cohen's  $d = 0.50$  Vs. no treatment controls and  $d = 0.65$  Vs. alternative treatment controls), but was only slightly more effective than alternative therapies. Shadish et al. (1993) included only trials with random assignment and distressed participants. Over a 25-year period (1963-1988), 163 studies met these criteria with only 71 being of Family Therapy. This study also found a positive effect for Family Therapy ( $d = 0.51$ ) and with no difference between immediate post-treatment and follow-up scores, indicating that the benefits persisted. There was some suggestion that family therapies might do less well than individual therapies for children and adolescents.

While these early reviews are useful indicators of the effectiveness of the forms of family therapy that have informed current approaches, they have limited use in evaluating current approaches. The therapies being researched would now be regarded as only of historical importance in this rapidly developing field. Even the most recent research in the Shadish et al. (1993) analysis would have been planned in the early 1980s, with the earliest dating from around 1960.

Over the past decade the technology of meta-analysis has become more rigorous and increasing numbers have been published. Shadish & Baldwin (2003) identified 140 meta-analyses in psychotherapy. The most substantial update of meta-analyses comes from this publication, in which the authors undertook a meta-analysis of 20 meta-analyses of couple and family therapy. It is thus a meta- meta-analysis. The average effect size across all meta-analyses was .65 after family therapy, and .52 at six to twelve months' follow-up. 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.'*

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.
- There is little evidence for differential efficacy among the various approaches within marriage and family interventions, particularly if mediating and moderating variables are controlled.

The most recent overview, by Sydow et al. (2010), is a meta-content analysis of 38 randomised control trials (RCTs) of adult index patients suffering from mental disorders, published up to 2008. A unique feature of this review is that research was selected as 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). Although the review applied rigorous criteria, the variable nature of the research precluded a full meta-analysis and so the label of 'meta-content analysis' (Sydow, 1999) was used. Another exceptional aspect is that as far as possible, all languages of publication were included. For example 8 RCTs from China were considered although 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 found a sound evidence-base for the efficacy of systemic therapy for adult index patients with mental disorders in at least five broad diagnostic groups.

Carr (2009a, 2009b) has comprehensively reviewed the evidence for children and adults. His findings in terms of the conditions for which systemic therapy has been found to be efficacious are listed in the subsequent sections of this report. His overall conclusions are that, for children:

“First, for a wide range of child-focused problems, systemic interventions are effective. Second, these interventions are brief, rarely involving more than twenty sessions, and may be offered by a range of professionals on an outpatient basis. Third, treatment manuals have been developed for many systemic interventions and these may be flexibly used by clinicians in treating individual cases. Fourth, most evidence-based systemic interventions have been developed within the cognitive behavioural, structural and strategic traditions.” (Carr 2009a, p.29).

With respect to adults he concludes:

“First, well-articulated systemic interventions are effective for a wide range of common adult mental health and relationship problems. Second, these interventions are brief and may be offered by a range of professionals on an outpatient or inpatient basis, as appropriate. Third, for many of these interventions, useful treatment manuals have been developed which may be

flexibly used by clinicians for adults in treating individual cases. Fourth, an important issue is the generalizability of the results of the studies reviewed in this paper to typical health service settings. It is probable that the evidence-based practices described in this paper are somewhat less effective when used in typical health service settings by busy clinicians, who receive limited supervision, and carry large case loads of clients with many co-morbid problems.” (Carr, 2009b, p.63)

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. (in press) “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.”.

Crane and Payne (in press) 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.

The extensive reviews by Shadish and Baldwin (2003), Carr (2009a, 2009b) and Sydow et al (2010), despite their differences in methodology, give a clear positive answer about the effectiveness of systemic family and couples therapy. These reviews are the most appropriate resource for the common form of practice: Of selecting or integrating a range of systemically-based approaches to therapy, in whatever therapeutic context is most appropriate and available; and adapting them to the unique needs of the clients, who may present with a wide range of difficulties. However, the research methodology that, following its development in physical medicine has come to be defined as gold standard, requires a tightly defined form of therapy applied to a population of patients all suffering from a single reliably diagnosed condition.

While the requirements of such research are very different from the practice that has been found to be most effective in systemic therapy, considerable numbers of studies have been carried out to meet the requirements of this medical paradigm. We first consider research that

meets one or other of the criteria before considering specific studies that have been designed to fully meet gold standard randomised controlled trial (RCT) requirements. There are two potential approaches to grouping more specific outcome studies. One is by the form of therapy, the other by the diagnostic category of the referred person.

### **3.2.1 Form of family therapy**

Family Therapy started from a common basis in research applications of systems thinking but has developed in many directions during its 50-year history. Shadish et al. (1993) classified the 71 Family Therapy studies into 22 different theoretical models and still had 7 studies left over that they were unable to classify. Although Carr (2009a) claims that ‘Practitioners require specific evidence-based statements about the types of family based interventions that are most effective for particular types of problems.’ (p.4), the limited number of studies comparing different forms of family therapy makes it unlikely that strong evidence will be found to favour any particular approach. In fact, reviews that compare different approaches find much common ground between the therapies as practiced, and negligible differences in outcome.

#### ***3.2.1.1 Common ground among therapies.***

Henggeler & Sheidow (2003), in reviewing three effective but apparently very different treatments for adolescent conduct disorder and delinquency (Functional Family Therapy, Multisystemic Therapy, and Oregon Treatment Foster Care), conclude that ‘they share several commonalities in their conceptualization, delivery, and procedures’.

Weissman & Sanderson (2002) state that: ‘The efficacy of the various family interventions (behavioural, supportive, & systems) appear to be equivalent (Baucom, Shoham, Mueser, Daiuto & Stickle, 1998). Indeed, the only direct comparison of two evidence-based family interventions found that supportive family therapy and behavioural family therapy were not significantly different. These findings are not surprising considering the family intervention strategies across the three theoretical orientations share many common essential treatment components (Baucom et al., 1998).’

Pinsof et al. (1995, 1996) reviewed the outcome literature for a variety of presenting difficulties. They concluded that Family Therapy works, and for some presenting difficulties is more efficacious than individual interventions (e.g. marital distress, and anorexia in young adolescents), but that there are as yet no data to support the differential efficacy of different

Family Therapy models. Family Therapy may be more cost effective than residential and inpatient treatments, but may not be sufficient in itself to address some severe disorders and problems (e.g. Schizophrenia, adolescents' conduct difficulties). More recent research in these areas is reviewed below.

McFarlane et al. (2003) reviewing the effectiveness of multiple family/ psychoeducation treatment for people with schizophrenia calls the title a misnomer because the treatment actually had more aspects of family intervention. Macdonald, (1997) claimed that systemic psychotherapy often incorporates a Brief Therapy approach making it a cost-effective modality.

We conclude that the research leads to the conclusions already reached by clinical practice: that rigid adherence to a specification of a particular approach to therapy is not the most effective strategy and therefore is not in the best interests of the client(s). The approach needed by the research paradigm that has been imported from medicine is therefore quickly abandoned by the conscientious therapist in favour of a more integrative practice (Rivett & Street, 2003; Vetere & Dallos, 2003; Norcross & Beutler 2010). We now turn to research that is more defined by the condition to which the therapy is being applied.

### **3.3 Reviews of the effectiveness of Family Therapy across conditions.**

There have been several recent, careful reviews that assess the range of evidence available in relation to different conditions. The reviews consistently identify certain conditions of children, adolescents and adults as effectively treated by Family Therapy. 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 mainly list the conditions for which Family Therapy is indicated as a treatment, with additional information where this is likely to be useful.

### 3.3.1 Family therapy with children and adolescents

The most comprehensive current review is provided by Carr (2009a). Carr selected conditions for which meta-analyses, RCTs or experimental single-case studies were available. His review therefore excludes conditions for which other forms of evidence are available.

Carr (2009a) concludes that evidence supports the effectiveness of systemic interventions either alone or as part of multimodal programmes for:

- sleep, feeding and attachment
- problems in infancy;
- child abuse and neglect;
- conduct problems . including:
  - childhood behavioural difficulties,
  - attention and overactivity (ADHD),
  - delinquency and drug abuse;
- emotional problems (including anxiety, depression, grief, bipolar disorder and suicidality);
- eating disorders (including anorexia, bulimia and obesity);
- somatic problems (including enuresis, encopresis, recurrent abdominal pain, and poorly controlled asthma and diabetes).

At the end of reviewing each condition Carr makes recommendations for the format of intervention that is indicated by the research. As one example, in relation to adolescent conduct disorder he concludes from the evidence:

“From this review it may be concluded that in developing services for families of adolescents with conduct disorder, it is most efficient to offer services on a continuum of care. Less severe cases may be offered functional family therapy, up to thirty sessions over a six-month period. Moderately severe cases and those that do not respond to circumscribed family interventions may be offered multi-systemic therapy up to twenty hours per month over a period of up to six months. Extremely severe cases and those who are unresponsive to intensive multi-systemic therapy may be offered treatment foster care for a period of up to a year and this may then be followed with ongoing multi-systemic intervention. It would be essential that such a service involve high levels of supervision and low case loads for frontline clinicians because of the high stress load that these cases entail and the consequent risk of therapist burnout.” (p. 16).

He also gives useful information on the best length of treatment. Often 12 sessions.

The findings by Carr are consistent with earlier reviews but offer a more comprehensive set. For example Cottrell and Boston (2002) concluded that family interventions are effective for: Conduct disorders; Substance misuse; and Eating disorders; and as a second-line treatment for depression and chronic illness. Asen (2002), from a more selective review, also concludes that there is strong evidence for using Family Therapy with conduct problems of children and eating problems in adolescence.

### **3.3.2 Family therapy with adults**

Sydow et al.2010 report specifically on *systemic therapy* for ‘mental disorders’ rather than the broad definition of family therapy and systemic interventions adopted by Carr (2009b) . Their meta-content analysis of RCTs published in English, German, Spanish, and Chinese found that systemic therapy was efficacious for the treatment of:

- mood disorders,
- eating disorders,
- substance use disorders,
- mental and social factors related to medical conditions and physical disorders,
- schizophrenia.
- Systemic therapy may also be efficacious for anxiety disorders

In the second of his linked articles, reviewing therapy with adults, Carr (2009b) found good support for Family Therapy in the following range:

- relationship distress,
- psychosexual problems,
- domestic violence,
- anxiety disorders,
- mood disorders,
- alcohol abuse,
- schizophrenia,
- adjustment to chronic physical illness.

The findings of Sydow and Carr are consistent with earlier reviews but offer a more comprehensive set, at least partly reflecting the availability of new research (Stratton et al, 2010). For example Asen (2002) concluded that the evidence supported Family Therapy with: Psychotic disorders; Mood disorders; Drug and alcohol misuse; Anorexia (adult as well as adolescent) and bulimia; Distress in couple relationships.

Sprenkle (2002) reported effectiveness of Family Therapy with: severe mental illness; alcohol and substance misuse; relationship dysfunction and chronic physical illness.

Carr (2000) also listed a more specific range which included: agoraphobia with panic disorder; major depression and bipolar disorder; obsessive-compulsive disorder.

Between them, these reviews of the conditions for which SFCT has been adequately researched demonstrate efficacy and in many cases effectiveness in the conditions 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.

### **3.4 High quality Randomised Control Trials (RCTs)**

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, so the diagnostic conditions for which fully specified RCTs are available are inevitably limited. Furthermore, interpretation of older trials is limited by the fact that standards and understanding of methodological issues in RCTs have progressively advanced, while the approaches to therapy researched may no longer be practised in those forms.

Many of the well funded RCTs concern adolescents: delinquency, conduct disorder and drug addiction/ substance abuse. As Northey et al. (2003) 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.” (p.523). 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.

### **3.4.1 Multi-Dimensional Family Therapy (MDFT)**

One of the most comprehensive research programmes has been carried out by Howard Liddle and associates (Liddle, 2009). 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 community based treatment and the team work with the adolescent, the parents, the whole family together and systems with which the family are involved in the community. Sessions take place weekly for a period up to 6 months and may be held in the clinic, home, school, court, or other relevant agencies. Rowe and Liddle (2008) reviewed the evidence base for MDFT and concluded that it is effective in reducing alcohol and drug misuse, behavioural problems, emotional symptoms, negative peer associations, school failure, and family difficulties associated with drug misuse.

In a recent publication Liddle et al. (2009) state: “This controlled trial ( $n = 83$ ) provided an experimental test comparing multidimensional family therapy (MDFT) and a peer group intervention with young teens. Participants were clinically referred, were of low income, and were mostly ethnic minority adolescents (average age = 13.73 years). Treatments were manual guided, lasted 4 months, and were delivered by community agency therapists. Adolescents and parents were assessed at intake, at 6-weeks post-intake, at discharge, and at 6 and 12 months following treatment intake. Latent growth curve modelling analyses

demonstrated the superior effectiveness of MDFT over the 12-month follow-up in reducing substance use (effect size: substance use frequency,  $d = 0.77$ ; substance use problems,  $d = 0.74$ ), delinquency ( $d = 0.31$ ), and internalized distress ( $d = 0.54$ ), and in reducing risk in family, peer, and school domains ( $d = 0.27, 0.67, \text{ and } 0.35$ , respectively) among young adolescents.” (p. 12).

Liddle et al. (2008) examine the efficacy of two adolescent drug abuse treatments: individual cognitive behavioral therapy (CBT) and multidimensional family therapy (MDFT). “... Both treatments produced significant decreases in cannabis consumption and slightly significant reductions in alcohol use, but there were no treatment differences in reducing frequency of cannabis and alcohol use. Significant treatment effects were found favoring MDFT on substance use problem severity, other drug use and minimal use (zero or one occasion of use) of all substances, and these effects continued to 12 months following treatment termination. **Conclusion** Both interventions are promising treatments. Consistent with previous controlled trials, MDFT is distinguished by the sustainability of treatment effects.” (p. 1660).

Overall, their fully documented claims include:

MDFT has demonstrated better results than several other state-of-the-art treatments, including family group therapy, peer group treatment, individual cognitive-behavioural therapy (CBT), and comprehensive 6-month residential treatment.

In addition to successfully treating adolescents who are heavy drug users, MDFT has worked effectively as a community-based prevention model and has successfully treated younger adolescents initiating drug use.

Substance use is significantly reduced in MDFT to a greater extent than all comparison treatments investigated (between 41% and 66% reduction from intake to discharge).

Treatment gains are enhanced in MDFT after treatment discharge; MDFT clients continue to decrease substance use after discharge up to 12-month follow-up, while teens in individual CBT and residential treatment increase drug use following treatment.

Psychiatric symptoms show greater reductions during treatment in MDFT (range of 35% to 80% within treatment reduction) than comparison treatments – MDFT clients also continue to improve following discharge while teens in CBT show relapse of emotional and behavioural problems after treatment.

School functioning improves more dramatically in MDFT than comparison treatments -- MDFT clients return to school and receive passing grades at higher rates (43% in MDFT vs. 17% in family group therapy and 7% in peer group therapy).

Family functioning improves to a greater extent in MDFT than family group therapy or peer group therapy using observational measures and these improvements are maintained up to 12-month follow-up.

Trials of MDFT are currently under way in five European countries but unfortunately not, at present, in the UK.

#### ***3.4.1.1 Treatment Engagement and Retention***

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.

#### ***3.4.1.2 Cost Savings of Multidimensional Family Therapy***

Average weekly costs of treatment are significantly less for MDFT (\$164) than community-based outpatient treatment (\$365) (French et al. 2003).

An intensive version of MDFT designed as an alternative to residential delivers better outcomes at 1/3 the cost (average weekly costs of \$384 vs. \$1,138)

### **3.4.2 Further major researched approaches**

#### ***3.4.2.1 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. 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.

Results indicated that across different presenting problems and samples, the average effect of MST was  $d = .55$ ; following treatment, youths and their families treated with MST were functioning better than 70% of youths and families treated alternatively. Results also showed

that the average effect of MST was larger in studies involving graduate student therapists (i.e., efficacy studies;  $d = .81$ ) than in studies with therapists from the community (i.e., effectiveness studies;  $d = .26$ ). In addition, MST demonstrated larger effects on measures of family relations than on measures of individual adjustment or peer relations.

“The overarching objective of MST (i.e., empowering parents to facilitate pragmatic changes in the youth’s and the family’s natural environments) appears to be robust with this population. More empirical support is required before MST can be considered an effective treatment of substance abuse in adolescents or an effective community-based alternative to the hospitalization of youths presenting psychiatric emergencies.” (Curtis et al, 2004, p. 417)

In response, Henggeler (2004) states 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 so severe as in the US.

#### ***3.4.2.2 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 (Sexton & Alexander, 1999).

“In a review of a series of large-scale effectiveness studies, Sexton and Alexander (2003) found that FFT was \$5,000–\$12,000 less expensive per case than juvenile detention or residential treatment and led to crime and victim cost savings of over \$13,000 per case. The same review concluded that in a large-scale effectiveness study, the dropout rate for FFT was about 10% compared to the usual dropout rates of 50–70% in routine community treatment of adolescent offenders.” (Carr, in press).

### ***3.4.2.3 Brief strategic family therapy (BSFT)***

BSFT was developed to work with adolescent substance abuse in minority, particularly Hispanic, families. 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 while attempting to draw other family members into the therapy (Szapocznik et al., 2002).

“In a thorough review of research on BSFT, 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 is also empirical support from controlled trials 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.” (Carr, in press)

### ***3.4.2.4 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. 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. 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)

### **3.4.3 Issues of transporting treatment packages**

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 NICE evaluation is that the dominant consideration is the difference between the experimental and the control treatment, regardless of quality of the comparison treatment. Thus MST and FFT are accepted but MDFT cannot be considered because it produced results only non-significantly better than the high quality comparison, at less than 35% of the cost (**see section 1.5.1.2**) 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 (see section 1.5.2.1). 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. What is encouraging is that all of these substantially researched therapies developed in the US are undergoing trials in the UK and other European countries. However, so far these trials have not produced convincing results.

### **3.5 Wider perspectives**

#### **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.

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. But we know from medical research that patients give much more positive evaluations when asked by their 'doctor' than when asked by a

researcher outside of the therapeutic environment. Reimers & Treacher (1995) increased therapists' awareness of the issue, warning that we could be overestimating the acceptability of our practices. So we need research into current practice to know whether the therapist's prioritising of client satisfaction is matched by the clients' accounts of their experiences.

Most research has used qualitative analysis of interviews, which are needed to obtain a detailed picture of clients' experience. A sample from recent studies:

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.

Stanbridge et al. (2003) compared perceptions before and after family therapy in the Somerset early intervention for psychosis service. Pre-intervention perceptions about family therapy were characterised by "fear and apprehension" with four families' anticipating negative outcomes (based on bad experiences with mental health services in the past). Post-intervention, 10 families were very satisfied with therapy, and all families found family therapy helpful in coping more effectively. What families reported liking were the collaborative relationship with the therapist, and therapist's qualities (non-judgmental approach, empathic).

Context matters. McWey (2008) interviewed 20 families to explore their perceptions of a home based family therapy for low income at risk families. Families perceived in-home family therapy as useful. They reported appreciation for availability and support received from therapists but wished for more frequent and long-term sessions.

Children may have different experiences than the adults. 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'.

It will be interesting to discover how the relatively recent practice of holding multi-family groups (MFG) is experienced. Schafer (2008) interviewed nine men and three women. Clients found MFG therapy very helpful especially in the context of: rebuilding broken family relationships; developing shared understanding; and improving communication and self-awareness. They did find it challenging at first but came to feel safer once they got to know each other.

Singer (2005) offers useful detail from clients in individual, couples and family therapy. Among their findings are that clients did not identify specific interventions as helpful but they strongly emphasized the importance of therapists' qualities, behaviour and personality. Interestingly, when clients' expectations are not met during therapy, they hardly ever mention it to their therapists.

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.

Chenail et al (in press) review 47 studies relevant to clients' experience of couple and family therapy. Overall they 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.

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

Using large-scale data from real-world practice, Crane et al. (2005) 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 is 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 (in press) 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.”

Family Therapy can also be a source of necessary collaboration between services. Reder, McClure & Jolley (2000) cite the example of a single mother with depression who has a 7-year-old child with profound sleep disturbance. How likely would it be that the management of both would be fully integrated and therefore effective without a family-based treatment?

A significant aspect of cost-effectiveness is the use that will be made of medical and social services following psychological therapy. Crane & Christenson (2008). demonstrate that after marital and family therapy the referred patient reduces their use of costly health service resources. Even more exciting, in some circumstances the beneficial effect is greater for the partner of the referred person. “Health care use reductions were most prominent for high utilizers and were found across a number of different types of outpatient care. With high utilizers, those who participated in MFT showed significant reductions of 68% for health screening visits, 38% for illness visits, 56% for laboratory/x-ray visits, and 78% for urgent care visits.” (p.127).

### **3.5.3 What do Systemic Family and Couples Therapists do?**

We offered a broad description at the start of this review. A much more detailed account has been created by the competency framework analysis commissioned by the UK agency Skills for Health (2010). This analysis defines 30 systemic competences in addition to a further 10 generic competences shared with other therapies. Each is unpacked into a listing of specific aspects of that competence (Stratton, 2010; Stratton et al, in press) generating a complete list of some 240 forms of practice. But 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).

## **4 Conclusions**

As Northey et al. (2003) concluded from their review “The fact that only a handful of extant family therapy models have been systematically tested is disconcerting. The field of family therapy has a long history of working with children and the careful evaluations of the models

typically used by marriage and family therapists are seriously needed.” At present anyone who actually 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.

#### **4.1.1 Future research directions**

The available research into efficacy of family therapy is generally positive, but the research base is limited. Efficacy trials are, however, only the start of the story because efficacy does not necessarily amount to the kind of therapeutic change implied by the term ‘effectiveness’. The fact that a treatment produces cost-effective improvements under specialist conditions does not guarantee effectiveness in everyday practice (Chorpita, 2003). Although effectiveness usually achieves lower scores than measures of efficacy, controlled trials may sometimes underestimate the value of a therapy. As Fonagy et al. (2004) state “Outcome measures should cover more domains than that of symptomatology: a treatment may be more effective in the long run if it has a beneficial impact across other domains of functioning, even if the effect on symptoms is no greater”.

Therapy conducted in controlled 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.

There is therefore a strong justification for including 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.

## 4.2 Why Family Therapy is an essential provision.

It works and it makes immediate emotional and cultural sense to clients.

While this review attempts a balanced assessment of the evidence it has been written by researchers and practitioners from a position that systemic family therapy is an important part of the provision for people who are coping with mental health and other problems. However, that conviction itself has developed from the range of accepted sources described in the previous sections.

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 Family Therapy to be effective.

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

- It has proven effectiveness for 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.
- Responsive and effective therapy for families in the UK needs to develop through practice in the UK, rather than relying only on methods developed by practitioners in the USA and elsewhere.
- 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.

As Crane & Morgan (in press) say: ***“In summary, given that family therapy has been shown to be effective in numerous reviews and that including it in health care systems does not seem to increase health care costs, now may be the time to begin to educate policy makers and begin to offer this form of care to families who desire to receive it.”***

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