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**THE EFFECTIVENESS OF FAMILY THERAPY AND SYSTEMIC INTERVENTIONS FOR  
ADULT-FOCUSED PROBLEMS**

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**Running head:** Effectiveness of family therapy for adults

**ABSTRACT**

This review updates a similar paper published in JFT in 2000. It presents evidence from meta-analyses, systematic literature reviews and controlled trials for the effectiveness of couples and family therapy for adults with various relationship and mental health problems. The evidence supports the effectiveness of systemic interventions, either alone or as part of multimodal programmes, for relationship distress, psychosexual problems, domestic violence, anxiety disorders, mood disorders, alcohol abuse, schizophrenia and adjustment to chronic physical illness.

## INTRODUCTION

This paper summarizes the evidence base for systemic practice with adult-focused problems, and updates a similar paper published in JFT eight years ago (Carr, 2000). It is also a companion paper to a review of research on the effectiveness of systemic interventions for child-focused problems (Carr, 2008). The overall effectiveness of systemic therapy is now well established. In a review of 20 meta-analyses of couples and family therapy trials for a range mental health problems across the lifecycle, Shadish and Baldwin (2003) concluded that the average treated case fared better after therapy and at 6-12 months follow-up than in excess of 71% of families in control groups who, for the most part, received standard services. This research finding provides strong support for a policy of funding systemic therapy as an integral part of mental health services. However, more detailed conclusions than this are essential if family therapists are to use research to inform their routine practice. There is a need for specific evidence-based statements about the types of systemic interventions that are most effective for particular types of problems. The present paper addresses this question with particular reference to relationship distress, psychosexual problems, domestic violence, anxiety disorders, mood disorders, alcohol abuse, schizophrenia, and adjustment to chronic physical illness. This particular set of problems has been chosen because extensive computer and manual literature searches showed that, for each of these areas, controlled trials of systemic interventions have been reported.

**Currently there is an international trend favouring evidence-based practice and increasing pressures for health systems to prioritise the provision of evidence-based interventions. For mental health professionals from various psychotherapeutic traditions there is competition for limited resources. To successfully compete for such resources, it is vital for systemic practitioners to be conversant with the evidence base for marital and family therapy and to become**

**skilled in evidence based systemic practices. For these reasons the present review is both timely and significant.**

**A broad definition of systemic practices has been taken In this paper, which covers family therapy and other family-based interventions such as carer psychoeducation and support groups, which engage family members in the process of resolving problems for adults over the age of 18. Extensive computer and manual literature searches were conducted for systemic interventions with a wide range of adult-focused problems. Major data bases, family therapy journals, and mental health journals were searched, as well as major textbooks on evidence based practice. Where available, meta-analyses and systematic review papers were selected for review, since these constitute the strongest form of evidence. If such papers were unavailable, controlled trials, which constitute the next highest level of evidence, were selected for review. Only in the absence of such trials, were uncontrolled studies selected. This strategy was adopted to permit the strongest case to be made for systemic evidence-based practices with a wide range of adult-focused problems, within the space constraints of a single paper.**

## **RELATIONSHIP DISTRESS**

Relationship distress, dissatisfaction and conflict are extremely common problems and currently in western industrialized societies where 40-50% of marriages end in divorce. In a proportion of cases, couples therapy alleviates relationship distress. In a systematic review of 6 meta-analyses of couples therapy, Shadish and Baldwin (2003) found an average effect size .84, which indicates that the average treated couple fared better than 80% of couples in control groups. Caldwell et al. (2007) estimated that the free provision of effective couples therapy would lead to considerable and significant cost savings because it would prevent a range of legal and health care costs arising from divorce and divorce-

related health problems. Most trials of systemic interventions for distressed couples have evaluated behavioural or emotionally focused couples therapy. In a meta-analysis of 23 studies, Wood et al. (2005) found that for mildly distressed couples, both of these approaches were equally effective, but with moderately distressed couples, emotionally focused couples therapy was more effective than behavioural marital therapy.

### **Emotionally focused couples therapy**

This approach rests on the premise that an insecure attachment bond underpins relationship distress and related conflict (Johnson, 2004). Partners are anxious that their attachment needs will not be met within their relationship, and this anxiety fuels chronic relationship conflict. The aim of emotionally focused couples therapy is to help partners understand this, and develop ways to meet each other's attachment needs, so that they experience attachment security within their relationship. The best predictors of a good outcome in emotionally focused couples therapy are the strength of the therapeutic alliance, and the female partner's belief that her male partner still cares about her (Johnson et al. 1999; Johnson, 2003).

### **Behavioural couples therapy**

This approach rests on the premise that an unfair relationship bargain underpins relationship distress and related conflict (Jacobson and Christensen, 1998). Partners fail to negotiate a fair exchange of pleasing responses to each other, and this sense of injustice fuels chronic relationship conflict. The aim of behavioural marital therapy is to help partners develop communication and problem solving skills, and behavioural exchange procedures so they can negotiate a fairer relationship. Cognitive components have been added to this basic model to help couples challenge destructive beliefs and expectations which contribute to relationship distress, and replace these with more benign

alternatives (Epstein and Baucom, 2002). In a review of controlled studies, Byrne et al. (2004a) concluded that these cognitive innovations add little to the effectiveness of behavioural couples therapy. Integrative behavioural couples therapy, a refined version of behavioural marital therapy, includes a strong emphasis on building tolerance for partners' negative behaviours, acceptance of irresolvable differences, and empathic joining around such problems. A single trial has shown that this approach does not enhance the overall effectiveness of traditional behavioural marital therapy, but may lead to more rapid and sustained improvement in couples that stay together (Christensen et al., 2006). Younger couples with non-traditional values, and lower levels of distress, who are more emotionally engaged with each other, and who do not opt for premature closure during conflict resolution, benefit most from behavioural marital therapy (Jacobson and Addis, 1993).

### **Insight-oriented marital therapy**

In a comparative trial, Snyder et al. (1991) found that, four years after treatment, only 3% of cases who had completed insight oriented marital therapy were divorced, compared with 38% of those in behavioural marital therapy. Insight oriented marital therapy holds considerable promise as a particularly effective approach to couples therapy. This approach to marital therapy rests on the premise that the inadvertent use of unconscious defences and relational patterns, which evolved within partner's families of origin or previous relationships, underpin relationship distress and conflict. The aim of therapy is to help partners understand how family-of-origin experiences, or experiences in previous relationships, compel them to inadvertently engage in destructive interaction patterns, and then to replace these with more constructive alternatives (Snyder and Schneider, 2002).

The results of this review suggest that in developing services for distressed couples, emotionally focused couples therapy is currently the treatment of choice. Behavioural couples therapy and insight oriented couples therapy are second line

alternatives. Programmes should span up to 20 sessions over at least 6 months, with the intensity of input matched to couples' needs.

## **PSYCHOSEXUAL PROBLEMS**

Hypoactive sexual desire in men and women; orgasmic disorder, dysparunia and vaginismus in women; and erectile disorder and premature ejaculation in men are the main psychosexual problems for which systemic interventions have been developed. The overall prevalence of these various psychosexual problems ranges from 8 to 33% (Laumann et al., 1999). Relationship distress typically accompanies such difficulties (Leiblum, 2006).

### **Hypoactive sexual desire**

Systematic reviews of trials of sex therapy for hypoactive sexual desire, conclude that 50-70% of cases showed improvements in levels of desire following therapy, but in up to half of these cases, improvement in desire was not sustained at three year follow-up, although improved sexual satisfaction continued (Duterte et al., 2007; Seigraves and Althof, 2002). Effective programmes are couples-based and involve both cognitive and behavioural elements. Cognitive interventions focus on challenging beliefs, attitudes and expectations that diminish sexual desire and psychological intimacy. Master's and Johnson's (1970) sensate focus exercise is the main behavioural intervention in effective therapy for hypoactive sexual desire. This begins with psychoeducation about the human sexual response. Couples are advised to refrain from sexual intercourse and sexual contact, except as outlined in prescribed homework exercises. These involve giving and receiving pleasurable caresses, along a graded sequence progressing over a number of weeks from non-sexual, to increasingly sexual areas of the body, culminating in full intercourse.

### **Female orgasmic disorder**

In a narrative review of 29 psychological treatment outcome studies for female orgasmic disorder, involving over 500 participants, Meston (2006) concluded that directed masturbation combined with sensate focus exercises was effective in most cases. This couples-based sex therapy involves a graded programme which begins with psychoeducation and is followed by a series of exercises that are practiced over a number of weeks by the female with partner support initially, and later with partner full participation. These exercises involve visual and tactile total body exploration; masturbation using sexual fantasy and imagery; optional use of a vibrator; masturbating to orgasm in the presence of one's partner; and later explaining sexual techniques that are effective for achieving orgasm to one's partner, and finally practicing these as a couple. Meston (2006) concluded that this intervention was more effective than systematic desensitization and sensate focus.

### **Female sexual pain disorders**

Female dyspareunia and vaginismus are most commonly associated with vulvar vestibulitis syndrome. In this syndrome burning pain occurs in response to touch or pressure, due to erythema of the tissues surrounding the vagina and urethra openings. In a systematic narrative review of outcome studies, Meston and Bradford (2007) concluded that couples-based cognitive behavioural sex therapy was particularly effective for reducing dyspareunia and vaginismus in women with vulvar vestibulitis syndrome. Effective programmes included psychoeducation; cognitive therapy to challenge beliefs and expectations underpinning anxiety about painful sex; and systematic desensitization. Systematic desensitization involves initially abstaining from attempts at intercourse; learning progressive muscle relaxation; and then pairing relaxation with the gradual insertion of a

series of dilators of increasing diameter into the vagina, until this can be achieved without discomfort; and finally progressing through sensate focus exercises to intercourse.

### **Male erectile disorder**

Prior to 1998 and the marketing of Sildenafil (Viagra), psychological interventions based on Masters and Johnson's (1970) sensate focus sex therapy was the main treatment for male erectile problems. It was shown to be effective in up to 60% of cases. However, with the introduction of sildenafil and other phosphodiesterase Type 5 (PDE-5) inhibitors, these have come to be first line intervention for erectile disorder (Bekkering et al., 2007).

However, not all cases respond to PDE-5 inhibitors, and there is an emerging practice of using multimodal programme involving PDE-5 inhibitors combined with psychological interventions in such cases because they have synergistic effects (McCarthy and Fucito, 2005). In a study of 53 cases of acquired erectile disorder, Banner and Anderson (2007) found that those who received sildenafil and cognitive behavioural sex therapy had a 48% success rate for erectile function and 65% for satisfaction. In contrast, those who received sildenafil alone had only a 29% erection success rate, and only a 37% satisfaction rate.

### **Premature ejaculation**

For premature ejaculation, Masters and Johnson (1970) developed a couples based sex therapy programmes which includes the stop-start and squeeze techniques. In this programme, each time ejaculation is imminent, couples cease intercourse and squeeze the base of the penis to prevent ejaculation. Once the male has controlled the impulse to ejaculate, intercourse is resumed, until ejaculation is again imminent, and the procedure is repeated. The programme is practiced over a number of weeks. In a narrative review of mainly uncontrolled trials, Duterte et al. (2007) concluded that success rates with this method may be initially as high as 80% but decline in the long-term to 25% at follow-up.

The short lived effectiveness of psychological interventions led to the development of pharmacotherapies for premature ejaculation. In an extensive review of controlled trials and meta-analyses, Hellstron (2006) concluded that antidepressants (such as fluoxetine and clomipramine) are effective in alleviating premature ejaculation, but currently dapoxetine hydrochloride (DPX), a serotonin transport inhibitor, is the pharmacological treatment of choice for this condition, because of its rapid onset of action, and profile of minimal side-effects compared with antidepressants. Hellstron (2006) also concluded that there is evidence from a number of trials to show that topical formulations which contain aesthetic agents can increase ejaculatory latency times. It is probable that multimodal programmes that combine pharmacotherapy and couples sex therapy will be developed and evaluated in the future.

### **General prognostic factors for psychosexual problems**

In an extensive review, Hawton (1995) concluded that motivation for treatment (particularly the male partner's motivation); early compliance with treatment; the quality of the relationship (particularly as assessed by the female partner); the physical attraction between partners; and the absence of serious psychological problems, are predictive of a positive response to treatment for psychosexual difficulties.

The results of this review suggest that in developing services for couples with psychosexual difficulties, couples-based sex therapy should be provided within a context that allows for multimodal programmes involving sex therapy and medication to be offered for disorders such as erectile dysfunction and premature ejaculation, and that also permits couples to receive therapy for relationship distress. Programmes for psychosexual problem tend to be brief (up to 10 sessions) over 3 months, with the intensity of input matched to couples' needs, especially where there is comorbid relationships distress.

## **DOMESTIC VIOLENCE**

Stith and Rosen (2003) in a narrative review of six studies, found that couples therapy was effective in reducing domestic violence. However, couples therapy is only effective for cases of domestic violence in which couples are committed to staying together, and in which the violent partner can agree to a no-harm contract. There is also evidence from one comparative trial that multicouple therapy may be more effective than single couple therapy for such cases. In this trial Stith et al. (2004) found that male violence recidivism rates were 25% for the multi-couple group, and 43% for the individual couple group. Key elements of treatment included the perpetrator taking responsibility for the violence; solution-focused practices; challenging beliefs and cognitive distortions which justify violence; anger management training; communication and problem-solving skills training; and relapse prevention. Anger management training focuses on teaching couples to recognize anger cues; to take time out when such cues are recognized; to use relaxation and self-instructional methods to reduce anger-related arousal; to resume interactions in a non-violent way, and to use communication and problem solving skills more effectively for conflict resolution.

This review suggests that in developing services for couples within which domestic violence has occurred, initial assessment for treatment suitability is essential. Where the assessment shows that couples wish to stay together, and the violent partner can agree to a no-harm contract, group-based couples therapy with a specific focus on violence reduction should be offered.

## **ANXIETY DISORDERS**

Family based therapies are effective for two of the most debilitating anxiety disorders - agoraphobia with panic disorder and obsessive compulsive disorder. The 12 month prevalence rates for panic disorder with agoraphobia and obsessive compulsive disorder

are 3% and 1% respectively, and both conditions are more common among women (Kessler et al., 2005) Although some people with these disorders respond to serotonin reuptake inhibitors (Dougherty et al., 2007; Roy-Byrne and Cowley, 2007), a significant proportion are not helped by medication, cannot tolerate medication side effects, or do not wish to take medication for other reasons. Also, relapse is common once medication is no longer taken. All of these reasons provide a rationale for a psychotherapeutic approach to anxiety disorders. Furthermore, systemic interventions create a context within which families can support recovery, and a forum within which family interaction patterns and belief systems that often inadvertently maintain anxiety disorders can be transformed.

### **Panic disorder**

Recurrent unexpected panic attacks are the central feature of panic disorder (APA, 2000; WHO, 1992). Normal fluctuations in autonomic arousal are misperceived as signals for the inevitable onset of panic attacks, and so these fluctuations in arousal are anxiety provoking. Secondary agoraphobia often develops, where there is an avoidance of public places in which panic attacks are expected to occur. Family members often come to share this belief system and inadvertently become involved in patterns of interaction that maintain the constricted lifestyle of the person with agoraphobia. Effective family-based treatment aims to disrupt this process and enlist the aid of family members in helping the symptomatic person expose themselves in a planned way to feared situations, and control their anxiety within these contexts.

In a review of 12 studies of couples-based treatment for panic disorder for agoraphobia, Byrne et al. (2004b) concluded that partner-assisted, cognitive-behavioural exposure therapy provided on a per-case or group basis led to clinically significant improvement in agoraphobia and panic symptoms for 54-86% of cases. This type of couples therapy was as effective as individually based cognitive-behavioural treatment,

widely considered to be the treatment of choice. Treatment gains were maintained at follow-up. In some studies couples-based interventions had a positive impact on co-morbid relationship distress, although this has also been found in studies of individually-based exposure therapy. The most effective couples programmes include communication training; partner-assisted exposure; enhancement of coping skills; and cognitive therapy to address problematic beliefs which underpin avoidant behaviour. With partner assisted exposure, the symptomatic person and their partner go on a series of planned outings to a hierarchy of places or situations that are increasingly anxiety provoking or threatening. In these situations the partner supports the symptomatic person in using coping skills, such as controlled breathing, relaxation and self-talk to successfully manage anxiety and control panic.

### **Obsessive compulsive disorder (OCD)**

OCD is characterized by obsessive thoughts elicited by specific cues (such as dirt) and compulsive, anxiety reducing rituals (such as hand washing) (APA, 2000; WHO, 1992). However, compulsive rituals only have a short-term anxiety reducing effect. Obsessional thoughts quickly return and the rituals are repeated. Family members, particularly partners, often inadvertently become involved in patterns of interaction that maintain compulsive rituals by assisting with them, not questioning their legitimacy, or engaging in conflict about them. In effective family-based treatment for obsessive compulsive disorder, the aim is to disrupt family interaction patterns that maintain compulsive rituals, and enlist the aid of family members in helping the person with the condition overcome their obsessions and compulsions.

Five trials of systemic couples or family-based approaches to the treatment of OCD, reviewed by Renshaw et al. (2005), have shown that such approaches are as effective, or in some instances more effective, than individually based cognitive behaviour therapy for

adults with OCD (Emmelkamp et al., 1990; Emmelkamp and DeLange, 1983; Grunes et al., 2001; Mehta, 1990; Van Noppen et al., 1997). Systemic therapy may be provided in conjoint or separate sessions, or in multiple family sessions. Effective protocols involve psychoeducation about OCD combined with exposure and response prevention. The aim of psychoeducation is to help family members reduce the extent which they over-accommodate or antagonistically respond to the symptomatic person's compulsive rituals or accounts of their obsessions. **With exposure and response prevention, the therapist coaches partners in supporting their obsessive-compulsive spouses while they enter a hierarchy of increasingly anxiety provoking situations (such as coming into contact with dirt) in a planned manner and preventing themselves from engaging in compulsive anxiety reducing responses (such as repeated hand-washing).**

In planning systemic services for people with panic disorder and OCD, treatment protocols as described in the preceding sections should be offered on an outpatient basis over 10-20 sessions, depending on client need. In cases that do not respond to systemic therapy, a multimodal programme involving systemic therapy and serotonin reuptake inhibitors is appropriate (Dougherty et al., 2007; Roy-Byrne and Cowley, 2007).

## **MOOD DISORDERS**

Effective family based treatments have been developed for major depression and bipolar disorder. Both conditions have a profound impact on quality of life, with depression being more common than bipolar disorder. The 12 month prevalence of major depression is approximately 7% and of bipolar disorder is 3% (Kessler et al., 2005).

### **Depression**

Major depression is an episodic disorder characterized by low mood, loss of interest in normal activities, and most of the following symptoms: psychomotor agitation or retardation, fatigue, low self-esteem, pessimism, inappropriate excessive guilt, suicidal ideation, impaired concentration, and sleep and appetite disturbance (APA, 2000; WHO, 1992). Over the course of their lifetime, on average, people with major depression have four episodes, each of about four months duration. Integrative theories of depression propose that episodes occur when genetically vulnerable individuals become involved in stressful social systems in which there is limited access to socially supportive relationships (Carr and McNulty, 2006). Systemic interventions aim to reduce family stress and increase support, although there are other factors that provide a rationale for systemic interventions for depression in adults. Not all people with major depression respond to antidepressant medication or wish to take it, because of side effects. Also, in the year following treatment, relapse rates following pharmacotherapy are about double those of relapse rates following psychotherapy (65% vs. 29%, Vittengl et al., 2007).

Narrative reviews of controlled trials of systemic interventions for depression support the effectiveness of outpatient and inpatient systemic couples therapy, family therapy based on the McMaster model, emotionally focused couples therapy, behavioural marital therapy, cognitive marital therapy, and conjoint interpersonal therapy (Barbato and D'Avanzo, 2006; Beach, 2003; Gupta et al., 2003; Lemmens et al. In press). All of these approaches to couples therapy require fewer than 20 conjoint therapy sessions and focus on both relationship enhancement and mood management.

**Systemic couples therapy.** In two trials, systemic couples therapy was found to be more effective than standard care (Leff et al., 2000; Lemmens et al., In press). Leff et al. (2000) found that systemic couples therapy was more effective than antidepressants in reducing depressive symptoms in outpatients, after treatment and at 2 years follow-up. It was also no more expensive than antidepressant medication, because clients who

received medication used a range of other health services to compensate for the limited effects of antidepressants. In a comparative trial of depressed inpatients, Lemmens et al. (In press) found that when offered to single families, or in multifamily groups, systemic couples therapy (with some additional family sessions involving children) combined with antidepressant medication led to a significantly higher rate of treatment responders and to fewer patients being on antidepressants at 15 months follow-up, compared with standard treatment. The therapeutic approach used in these studies was manualised and involved enactment of couples issues in therapy sessions, disruption of problematic behavioural cycles, setting tasks to develop less problematic ways of interacting, and helping couples cope better with the way depression affected their lives (Jones and Asen, 2002).

**McMaster Family therapy.** In a comparative study of depressed inpatients, Miller et al. (2005) found that family therapy combined with antidepressant medication led to more rapid recovery and a higher improvement rate, than antidepressants combined with cognitive therapy. The McMaster model is a manualized structured, problem-centred, systemic approach to therapy, which begins with systematic assessment, and proceeds with a task-focused approach to helping families replace problem-maintaining family interaction patterns, with transactions characterized by clear communication, effective collaborative problem-solving, and emotional connectedness (Ryan et al., 2005).

**Emotionally focused couples therapy.** In a comparative trial, Dessaulles et al. (2003) found that emotionally-focused couples therapy was as effective as antidepressants in alleviating depression. This manualized therapeutic approach involved helping couples use non-problematic ways to express and meet each other's attachment needs (Johnson, 2004).

**Behavioural marital therapy.** In 3 trials behavioural marital therapy was as effective as individual cognitive behaviour therapy in alleviating depressive symptoms and more effective than individual therapy in alleviating co-morbid marital distress (Beach and

O'Leary, 1992; Emanuels-Zuurveen and Emmelkamp, 1996; Jacobson et al., 1991). In one of these trials, Beach and O'Leary (1992) also showed that behavioural couples therapy improved the quality of the marital relationship, which in turn accounted for the alleviation of depressive symptomatology. Behavioural marital therapy aims to improve communication and conjoint problem-solving, and to increase the frequency of satisfying experiences within the relationship. These aims are achieved through problem-solving and communication skills training, and contingency contracting, where couples negotiate increased rates of mutually satisfying exchanges (Beach et al., 1990).

**Cognitive marital therapy.** Two trials of cognitive marital therapy have been conducted. Teichman et al. (1995) found that cognitive marital therapy was more effective than standard individual cognitive therapy for depressive symptoms, and Emanuels-Zuurveen and Emmelkamp (1997) found that spouse-assisted cognitive therapy and standard cognitive therapy were equally effective. A central process in cognitive marital therapy is using guided discovery, Socratic questioning and behavioural experiments to identify and modify cognitive factors that maintain dysphoria and relationship distress (Epstein and Baucom, 2002).

**Conjoint interpersonal therapy.** In a controlled trial, Foley et al. (1989) found that conjoint interpersonal couples therapy was as effective as standard individually administered interpersonal therapy in improving both depression and interpersonal functioning. Conjoint interpersonal therapy aims to alter negative interpersonal situations which maintain depression. In particular, interpersonal therapy helps couples to address unresolved difficulties in the following domains: loss, role disputes, role transitions, and interpersonal deficits (Weissman et al., 2000).

## **Bipolar disorder**

Bipolar disorder is a recurrent mood disorder characterized by episodes of mania or

hypomania, depression, and mixed mood states (APA, 2000; WHO, 1992). Genetic factors play a central role in the aetiology of bipolar disorder, but its course is affected by exposure to stress, individual and family coping strategies, and medication adherence (Lam and Jones, 2006). The primary treatment for bipolar disorder is pharmacological, and involves initial treatment of acute manic or depressive episodes, and subsequent prevention of further episodes with mood stabilizing medication such as lithium (Geddes et al., 2004; Keck and McElory, 2007). The primary aim of systemic therapy is to reduce relapse and rehospitalization rates, and increase quality of life by improving medication adherence and enhancing the way individuals with bipolar disorder and their families manage stress and vulnerability to relapse. Systematic reviews and meta-analyses concur that when included in multimodal programmes involving mood stabilizing medication, systemic therapy and a range of different types of individual therapy significantly reduce relapse rates in people with bipolar disorder (Benyon et al., 2008; Gutierrez and Scott, 2004; Jones et al., 2005; Mansell et al., 2005, Milkowitz and Craighead, 2007; Sajatovic et al., 2004; Scott et al. 2007).

Results from 5 trials show that family therapy alone or in combination with interpersonal social rhythm therapy was effective in reducing relapse, and in some instances, rehospitalization in patients with bipolar disorder on maintenance mood stabilizing medication (Miklowitz, George et al., 2003; Miklowitz and Goldstein, 1990; Miklowitz, Richards et al., 2003; Miklowitz et al., 2007; Rea et al. 2003). In these trials family therapy was conducted over 21 sessions and included family-based psychoeducation, relapse prevention, communication and problem-solving skills training (Miklowitz and Goldstein, 1997). In three trials, other less intensive family-based interventions have not yielded these positive effects (Clarkin et al., 1990, 1998; Miller et al., 2004).

From this review it may be concluded that effective systemic therapy for mood disorders may be offered on an inpatient or outpatient basis, and treatment may span 7-20 sessions. Systemic services for mood disorders are best offered within a context that permits the option of multimodal treatment, where appropriate medication may be combined with systemic interventions as described above. Because of the recurrent, episodic nature of mood disorders, services should make long-term re-referral arrangements, so intervention is offered early in later episodes.

## **ALCOHOL ABUSE**

Harmful alcohol use constitutes a significant mental health problem. The 12 month prevalence of alcohol abuse is 3% (Kessler et al., 2005). In a systematic quantitative review of 381 clinical trials involving over 75,000 clients and 99 different treatment modalities, Miller et al. (2003) rank ordered interventions, in terms of the evidence base for their overall effectiveness and placed two systemic interventions in the top 7 most effective treatments. These were: community reinforcement (Smith and Meyers, 2004) and behavioural marital therapy (O'Farrell and Fals-Stewart, 2006). O'Farrell and Fals-Stewart (2003) conducted a systematic narrative review of 38 controlled studies of systemic interventions for the treatment of alcohol problems and concluded that these approaches were effective in helping families promote the engagement of family members with alcohol problems in treatment, and in helping people with alcohol problems recover. This conclusion is shared by other reviewers (Finney et al., 2007; McCrady and Nathan, 2006).

### **Community Reinforcement and Family Training**

For helping families promote the engagement of family members with alcohol problems in therapy, O'Farrell and Fals-Stewart (2003) concluded that Community Reinforcement and Family Training (Smith and Meyers, 2004) was more effective than all other family-based

methods, leading to engagement rates above 60% in controlled trials. This approach helps sober family members improve communication, reduce the risk of physical abuse, and encourage sobriety and treatment seeking in people with alcohol problems. It also helps sober family members engage in activities outside the family, to reduce dependence on the person with the alcohol problem.

### **Behavioural couples therapy**

For helping people with alcohol problems recover, O'Farrell and Fals-Stewart (2003) concluded that behavioural couples therapy was more effective than other systemic and individual approaches. Compared with individual approaches, behavioural couples therapy produced greater abstinence, fewer alcohol-related problems, greater relationship satisfaction, and better adjustment in children of people with alcohol problems. It also showed greater reductions in domestic violence, and periods in jail and hospital, leading to very significant cost savings. The most effective forms of behavioural couples therapy incorporate either a disulfiram contract, or a sobriety contract into a treatment programme which includes problem-solving and communication training and relationship enhancement procedures. The therapy aims to reduce alcohol abuse, enhance family support for efforts to change, and promote patterns of interaction conducive to long-term abstinence (O'Farrell and Fals-Stewart, 2006).

### **Social behavioural network therapy**

Social behavioural network therapy, a novel systemic intervention developed in the UK, was found to be as effective as individually-based motivational enhancement therapy in the largest ever UK alcohol abuse treatment trial (UKATT Research Team, 2005). Social behaviour network therapy helps clients address their alcohol problems by building supportive social networks and developing coping skills (Copello et al. 2002).

In planning systemic services, this review suggests that therapy for alcohol abuse may be offered on an outpatient basis initially over a time limited period. A clear distinction should be made between the processes of engagement, and treatment. For individuals who are alcohol dependent, systemic services should be provided within a context that permits a period of inpatient or outpatient detoxification to precede therapy. Because relapses following recovery from alcohol abuse are common, services should make long-term re-referral arrangements, so intervention is offered early following relapse.

## **SCHIZOPHRENIA**

Schizophrenia is a recurrent episodic psychotic disorder characterized by positive and negative symptoms and disorganization (APA, 2000; WHO, 1992). Delusions and hallucinations are the main positive symptoms of schizophrenia. Negative symptoms include poverty of speech, flat affect and passivity. While genetic and neurodevelopmental factors associated with pre- and perinatal adversity play a central role in the aetiology of schizophrenia, its course is affected by stress, individual and family coping strategies, and medication adherence (Kuipers et al., 2006; Walker, 2004). The primary treatment for schizophrenia is pharmacological. It involves the initial treatment of acute psychotic episodes, and the subsequent prevention of further episodes with antipsychotic medication (Sharif et al., 2007). About half of medicated clients with schizophrenia relapse, and relapse rates are higher in unsupportive or stressful family environments, characterized by high levels of criticism, hostility or overinvolvement (Kuipers, 2006). The aim of psychoeducational family therapy is to reduce family stress and enhance family support, so as to delay or prevent relapse and rehospitalization.

Pfammatter et al. (2006) conducted a review of three meta-analyses of psychoeducational family therapy (Pharoah et al., 2005; Pilling et al., 2002; Pitschel-Walz et al., 2001) and a new meta-analysis of the 31 most methodologically robust available

randomized controlled trials involving over 3,500 clients. They found that compared with medication alone, multimodal programmes which included psychoeducational family therapy and antipsychotic medication led to lower relapse and rehospitalization rates, and improved medication adherence. One to two years after treatment, the average effect sizes across these four meta-analyses for relapse and rehospitalization rates were .32 and .48 respectively. This indicates that the average case treated within the context of a multimodal programme involving medication and family therapy fared better in terms of relapse and rehospitalization than 63% and 68% of cases, respectively, who received medication only. The effect size for medication adherence was .30. This indicates that the average case treated with family therapy, showed better medication adherence than 62% of those who did not receive family therapy. In a review of 18 studies containing over 1,400 cases, the authors of the UK NICE guidelines for schizophrenia concluded that, to be effective, psychoeducational family therapy must span at least 6 months and include at least 10 sessions (NICE, 2003).

Psychoeducational family therapy may take a number of formats including therapy sessions with single families (Kuipers et al., 2002); therapy sessions with multiple families (McFarlane, 2004); group therapy sessions for relatives; or parallel group therapy sessions for relative and patient groups. Family therapy for schizophrenia involves psychoeducation, based on the stress-vulnerability or bio-psycho-social models of schizophrenia, with a view to helping families understand and manage the condition, antipsychotic medication, related stresses, and early warning signs of relapse. Emphasis is placed on blame-reduction, and the positive role family members can play in the rehabilitation of the family member with schizophrenia. Psychoeducational family therapy also helps families develop communication and problem-solving skills. Skills training commonly involves modelling, rehearsal, feedback and discussion. Effective interventions typically span 9-12 months, and are usually offered in a phased format with 3 months of

weekly sessions; 3 months of fortnightly sessions; 3 months of monthly sessions; followed by 3 monthly reviews and crisis intervention as required.

From this review it may be concluded that systemic therapy services for families of people with schizophrenia should be offered within the context of multimodal programmes that include antipsychotic medication. Because of the recurrent, episodic nature of schizophrenia, services should make long-term re-referral arrangements, so intervention is offered early in later episodes.

### **CHRONIC PHYSICAL ILLNESS**

With chronic illness such as heart disease, cancer or chronic pain, systemic interventions are offered as one element of multimodal programmes involving medical care (McDaniel et al., 1992; Rolland, 1994). Systemic interventions include couples and family therapy, as well as multifamily support groups, and carer support groups. These interventions provide psychoeducation about the chronic illness and its management. They also offer a context within which to enhance support for the person with the chronic illness, and other family members. They provide, in addition, a forum for exploring ways of coping with the condition, and its impact on family relationships. In a meta-analysis of 70 studies, Martire (2004) found that systemic interventions for people with chronic illnesses were more effective than standard care. The studies included cases with dementia, heart disease, cancer, chronic pain, stroke, arthritis, and traumatic brain injury. Couples therapy (but not family therapy) was particularly effective in alleviating depression in people with chronic illnesses. Systemic interventions that aimed to improve the well-being of other family members and carers were particularly effective when they explicitly focused on relationship issues. Such interventions alleviated care-giving burden, depression, and anxiety. These systemic interventions included groups for relatives of people with chronic illnesses as well as family therapy. These findings suggest that systemic services for

people with chronic illnesses deserve development as part of multimodal programmes for people with such conditions, **a conclusion consistent with previous systematic reviews (e.g., Campbell & Patterson, 1995).**

## DISCUSSION

A number of comments may be made about the evidence reviewed in this paper. 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 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. This is because participants in research trials tend to have fewer co-morbid problems than typical service users, and most trials are conducted in specialist university affiliated clinics where therapists carry small caseloads, receive intensive supervision, and follow flexible manualized treatment protocols. Clearly, an important future research priority is to conduct treatment effectiveness trials in which evidence based practices are evaluated in routine non-specialist health service clinics with typical clients and therapists. Fifth, controlled trials of systemic therapy for prevalent problems such as personality disorders have not been reported in the literature, although clinical models for their treatment have been developed (MacFarlane, 2004). Clearly these should be a priority for future research. Such**

trials should include relatively homogeneous samples, and involve the flexible use of treatment manuals. Sixth, the contribution of common factors (such as the therapeutic alliance) and specific factors (such as techniques specified in protocols) to therapy outcome have rarely been investigated, and future research should routinely build in an exploration of this issue into the design of controlled trials (Sprenkle and Blow, 2004). Seventh, the bulk of systemic interventions which have been evaluated in controlled trials have been developed within the cognitive-behavioural, psychoeducational, and structural-strategic psychotherapeutic traditions. More research is required on social-constructionist and narrative approaches to systemic practice, which are very widely used in the UK, Ireland and elsewhere. Eighth, for some adult-focused problems such as schizophrenia and bipolar disorder, the research evidence shows that systemic therapy is particularly effective, not as an alternative to medication, but when offered as one element of a multimodal treatment programme involving pharmacotherapy. A challenge for systemic therapists using such approaches in routine practice, and for family therapy training programmes will be to develop coherent overarching frameworks within which to conceptualize the roles of systemic therapy and pharmacotherapy in the multimodal treatment of such conditions. Ninth, because there is so little evidence on the conditions under which systemic therapy is not effective for the adult-focused mental health problems covered in the paper, it is probably appropriate for practitioners to use evidence-based systemic interventions in situations where family members are available and willing to engage in therapy, to contribute to problem resolution and to disengage from family processes that maintain the identified patients presenting problems.

The results of this review are broadly consistent with the important role accorded to systemic interventions and family involvement in psychosocial

**treatment within NICE guidelines for a range of adult mental health problems including schizophrenia (NICE 2003), depression (NICE 2004), bipolar disorder (NICE, 2006), and OCD (NICE, 2005). In contrast, the potentially helpful role of family-based interventions found in this review is not reflected in NICE guidelines for the treatment of panic disorder with agoraphobia (NICE, 2007).**

**The findings of this review have clear implications for training and practice. Family therapy training programmes should include coaching in evidence-based practices in their curricula. Qualified family therapists should make learning evidence-based practices, relevant to the client group with whom they work, a priority when planning their own continuing professional development.** Experienced clinicians working with clients who present with the types of problems discussed in this papers may benefit their clients by incorporating essential elements of effective family-based treatments into their own style of practice. To facilitate this, a list of accessible treatment manuals is included at the end of both papers. The incorporation of such elements into one's practice style is not incompatible with the prevailing social constructionist approach to family therapy, as I have argued elsewhere (Carr, 2006)

### **TREATMENT RESOURCES**

Snyder, D. and Whisman, M. (Eds) (2003) *Treating Difficult Couples. Helping Clients with Coexisting Mental and Relationship Disorders*. New York: Guilford. Gives guidance on working with couples with a range of different adult mental health problems.

Gurman, A. and Jacobson, N. (Eds) (2002) *Clinical Handbook of Couple Therapy* (Third Edition). New York: Guilford. Gives guidance on working with couples with a range couples therapy models and a range of different relationship difficulties including adult mental health problems.

### **Relationship distress**

Epstein, N. and Baucom, D. (2002) *Enhanced Cognitive-Behavioural Therapy For Couples: A Contextual Approach*. Washington, DC: American Psychological Association.

Gottman, J. (1999) *The Marriage Clinic: A Scientifically-Based Marital Therapy*. New York: Norton.

Jacobson, N. and Christensen, A. (1998) *Acceptance and Change in Couple Therapy: A Therapist's Guide to Transforming Relationships*. New York: Norton.

Johnson, S. (2004) *The Practice of Emotionally Focused Couple Therapy: Creating Connection* (Second Edition). New York: Guilford.

### **Psychosexual problems**

Hawton, K. (1985) *Sex Therapy: A Practical Guide*. Oxford: Oxford University Press.

Leiblum, S. (2006) *Principles and Practice of Sex Therapy* (Fourth Edition). New York: Guilford.

McCarthy, B., and McCarthy, E. (2003) *Rekindling Desire: A Step-By-Step Program To Help Low-Sex And No-Sex Marriages*. New York: Brunner/Routledge.

Schnarch, D. (1991) *Constructing the Sexual Crucible: An integration of Sexual and Marital Therapy*. New York: Norton.

Wincze, J. and Carey, M. (2001) *Sexual Dysfunction: A Guide for Assessment and Treatment* (Second edition). New York: Guilford.

### **Anxiety disorders**

Baucom, D., Stanton, S. and Epstein, N. (2003) Anxiety disorders. In D. Snyder and M. Whisman, (Eds) *Treating Difficult Couples. Helping Clients with Coexisting Mental and Relationship Disorders* (pp. 57-87). New York: Guilford.

### **Mood disorders**

Beach, S., Sandeen, E. and O'Leary, K. (1990) *Depression in Marriage: A Model for Aetiology and Treatment*. New York: Guilford Press.

Jones, E. and Asen, E. (1999) *Systemic Couples Therapy for Depression*. London: Karnac.

Milkowitz, D. and Goldstein, M. (1997) *Bipolar Disorder: A Family-Focused Treatment Approach*. New York: Guilford.

Ryan, B., Epstein, N., Keitner, G., Miller, I. and Bishop, D. (2005) *Evaluating and Treating Families: The McMaster Approach*. New York: Routledge.

Weissman, M., Markowitz, J. and Klerman, G. (2000) *Comprehensive Guide to Interpersonal Psychotherapy*. New York: Basic Books.

### **Alcohol and drug abuse**

Copello, A., Orford, J., Hodgson, R. and Tober, G. (2002) *Social Behaviour and Network Therapy Manual*. Birmingham: University of Birmingham and the UKATT. Available from Gary.Slegg@new-tr.wales.nhs.uk

O'Farrell, T. and Fals-Stewart, W. (2006) *Behavioural Couples Therapy for Alcoholism and Substance Abuse*. New York: Guilford.

Smith, J. and Meyers, R. (2004) *Motivating Substance Abusers to Enter Treatment. Working with Family Members*. New York: Guilford.

### **Schizophrenia**

Anderson, C. Reiss, D. and Hogarty, G. (1986) *Schizophrenia and the Family*. New York: Guilford.

Barrowclough, C. and Tarrrier, N. (1997) *Families of Schizophrenic Patients - Cognitive Behavioural Intervention* (New Edition). London: Nelson Thornes

Bloch Thorsen, G., Gronnestad, T., and Oxnevad, A. (2006) *Family and Multi-family work with Psychosis*. London: Routledge.

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Kuipers, E., Leff, J. and Lam, D. (2002) *Family Work for Schizophrenia* (Second Edition)  
London: Gaskell.

Leff, J. (2005) *Advanced Family Work for Schizophrenia*. London: Gaskell.

McFarlane, W. (2004) *Multifamily Groups in the Treatment of Severe Psychiatric Disorders*. New York: Guilford.

Smith, G., Gregory, K. and Higgs, A. (2007) *An Integrated Approach to Family Work for Psychosis: A Manual for Family Workers*. London: Jessica Kingsley.

### **Chronic physical illness**

Rolland, J. (1994) *Families, Illness, and Disability: An Integrative Treatment Model*. New York: Basic Books.

McDaniel, S., Hepworth, J. and Doherty, W. (1992) *Medical Family Therapy*. New York: Basic Books.

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<http://www.nature.com/ijir/journal/vaop/ncurrent/abs/3901626a.html>
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