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THE EVIDENCE-BASE FOR COUPLE THERAPY, FAMILY THERAPY AND SYSTEMIC INTERVENTIONS FOR ADULT-FOCUSED PROBLEMS

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ABSTRACT

This review updates similar papers published in JFT in 2000 and 2009. It presents evidence from meta-analyses, systematic literature reviews and controlled trials for the effectiveness of couple 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, intimate partner violence, anxiety disorders, mood disorders, alcohol problems, schizophrenia and adjustment to chronic physical illness.

INTRODUCTION

This paper summarizes the evidence-base for systemic practice with adult-focused problems, and updates previous similar papers (Carr, 2000, 2009). It is also a companion paper to a review of research on the effectiveness of systemic interventions for child-focused problems (Carr, 2014). The overall effectiveness of systemic therapy is now well established. Sprenkle (2012) edited a special issue of the *Journal and Marital and Family Therapy* (JMFT) on research and concluded that a large and growing evidence-base now supports the effectiveness of systemic interventions. This work updates previous special issues of JMFT (Pinsof and Wynne, 1995; Sprenkle, 2002). In a review of 20 meta-analyses of couple 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. In a series of US studies using a four large databases, Crane and Christenson (2012) showed that the medical cost-offset associated with couple and family therapy covers the cost of providing therapy, and in many cases leads to overall cost savings.

The results of exant evaluation and cost-effectiveness research provides strong support for a policy of funding systemic therapy as an integral part of adult mental health services. However, more detailed conclusions than this are essential if systmemic 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, intimate partner violence, anxiety disorders, mood disorders, alcohol problems, 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.

A broad definition of systemic practices has been taken in this paper, which covers couple and 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. As with previous reviews, extensive computer and manual literature searches were conducted for systemic interventions with a wide range of adult-focused problems. For the present review the search extended to July 2013. Major data bases, couple and 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. It was intended that this paper be primarily a 'review of the reviews', with a major focus on substantive findings of interest to practicing therapists, rather than on methodological issues. This overall review strategy was adopted to permit the strongest possible case to be made for systemic evidence-based practices with a wide range of adult-focused problems, and to offer useful guidance for therapists, within the space constraints of a single paper.

RELATIONSHIP DISTRESS

In western cultures, by the age of 50 about 85% of people have been married at least once; about a third to half of couples separate or divorce; about half of all divorces occur in the first 7 years of marriage; of couples that remain married about 20% experience relationship distress; and compared with distressed or separated couples, those who sustain mutually satisfying relationships have better physical and mental health, live

longer, have better financial prosperity, engage in better parenting practices and their children have better academic achievement and psychological adjustment (Halford and Snyder, 2012; Lebow et al., 2012). Systematic reviews show that evidence-based couple therapy, which typically involves about 20 sessions over 6 months, is effective for many couples (Lebow et al., 2012; Snyder and Halford, 2012). About 40% of couples benefit a lot from couple therapy and about 30% benefit somewhat. In a 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 couple therapy would lead to 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 some version of behavioural couple therapy 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 couple therapy was more effective than behavioural couple therapy.

Emotionally focused couple therapy

This approach rests on the premise that an insecure attachment bond underpins relationship distress and related conflict (Johnson, 2004, 2008). 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 couple 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. Therapy progresses through an intial stage of de-escalating destructive pusuer-distancer interactional patterns;

a middle phase of facilitating partners' authentic expression of, and resposne to each other's attachement needs; and a closing phase where these more adaptive patterns of attachment behaviour are consolidated. Process reseach confirms that the postive effects of emotionally focused couple therapy on relationship distress arise from expressing and responding to attachment needs in an emotionally meaningful way during therapy; and a growing body of outcome research shows that emotionally focused couple therapy is particulalry effective with trauma survivors (Lebow et al., 2012). The best predictors of a good outcome in emotionally focused couple therapy are the strength of the therapeutic alliance, and the female partner's belief that her male partner still cares about her (Johnson, 2008).

Behavioural couple therapy

This approach rests on the premise that an unfair relationship bargain underpins relationship distress and related conflict (Jacobson and Margolin, 1979). Partners fail to negotiate a fair exchange of preferred responses to each other, and this sense of injustice fuels chronic relationship conflict. The aim of behavioural couple 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 (Baucom et al., 2008). In a review of controlled studies, Byrne et al. (2004a) concluded that these cognitive innovations add little to the effectiveness of behavioural couple therapy. Integrative behavioural couple therapy, which evolved from traditional behavioural couple therapy, includes a strong emphasis on building tolerance for partners' negative behaviours, acceptance of irresolvable differences, and empathic joining around such problems, as well as including behavioural change techniques from tradtional behaviorual

couple therapy (Dimidjian et al., 2008). In a major comparative study of the effectivness of traditional and integrative behavioural couple therapy for severely distressed couples, summarized in Lebow et al. (2012), there were two key findings. Both treatments led to improvements in relationship satisfaction by enhancing couple communication, positive behaviour, and acceptance of partners' incompatiabilities. At 5 years follow-up, about half of treated couple were clincally recovered and only a quarter had divorced. A growing body of research shows that behavioural couple therapy is particulalry effective for treating couples with alcohol problems (Powers et al., 2008).

Model integration and common factors in couple therapy

There is an increasing trend towards identifying factors common to effective approaches to couple therapy and integrating different models of clincial practice. In one of the most coherent statements about common factors in couple therapy, Benson et al. (2012) proposed that five principles are common to evidence-based couple therapies. These are (1) altering the couple's view of the presenting problem to be more objective, contextualized, and dyadic; (2) decreasing emotion driven, dysfunctional behaviour; (3) eliciting emotion based, avoided, private behaviour; (4) increasing constructive communication patterns; and (5) promoting strengths and reinforcing gains. To implement these factors effectively, therapists typically have a clinical case formulation which explains the couple's interactional pattern that underpins their distress.

Affective-reconstructive (or insight-oriented) couple therapy is a particularly well developed integrative model, supported by a clinical trial. The aim of affective reconstructive couple 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 Mitchell, 2008). This approach rests on the premise

that the inadvertent use of unconscious defences and relational patterns, which evolved within partners' families of origin or previous relationships, underpin relationship distress and conflict. Therapeutic tasks are conceptualized as progressing sequentially along a six level hierarchy from collaborative alliance, though containing crises, strengthening the couple, promoting relationship skills, challenging cognitive aspects of relationship distress, to exploring developmental origins of relationship distress (Snyder and Balderrama-Durbin, 2012; Abbott and Snyder, 2012). To address tasks at these six levels, therapists may draw on practices from multiple 'pure' couple therapy models. In a comparative trial, Snyder et al. (1991) found that, four years after treatment, only 3% of cases who had completed insight-oriented, affective-reconstructive couple therapy were divorced, compared with 38% of those in behavioural couple therapy. Affective-reconstructive couple therapy holds considerable promise as a particularly effective approach to helping distressed couples.

The results of this review suggest that in developing services for distressed couples, emotionally focused couple therapy and behavioural couple therapy are currently the treatments of choice. Affective reconstructive couple therapy is an emerging promising approach. 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 couples seek help. International epidemiological surverys show that the overall prevalence of these various psychosexual problems, which increase with age, ranges from 20–30% for men and 40–45% for women (Lewis et al., 2010). Relationship distress typically accompanies such difficulties (Binik and Hall, 2014).

Systematic reveiws and a major meta-analysis conclude that couples treated with psychosocial interventions show greater improvemnts than untreated controls (Berner and Günzler, 2012; Frühauf et al., 2013; Günzler and Berner, 2012). In a meta-analysis of 20 studies, Frühauf et al. (2013) found an effect size of 0.58 across all disorders indicating that the average treated couple fared better after therapyy than 73% of cases in wating list control groups. In this meta-analysis therapy was particulalry effective for women with hypoactive sexual desire and orgasmic disorders. Most studies included in this meta-anlaysis evalauted interventions that combined elements or Masters and Johnson's (1970) sex therapy with various cognitive behavioural interventions. Masters and Johnson's sex therapy is couple-based and includes psychoeducation about the sexual response cycle, counselling, and exercises such as sensate focus. In this exercise couples are invited initally to refrain from sexual intercourse, but rather to give and receive 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. These exercises are intended to reduce performance anxiety and facilitate the experience of sexual pleasure.

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 dysparunia 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 eurethra openings. In a systematic narrative review of outcome studies, Meston and Bradford (2007) concluded that couple-based cognitive behavioural sex therapy was particularly effective for reducing dysparunia 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 intervention 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., 2008). 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 systemic 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. Similar results favouring couple therapy combined with sildenafil compared with medication alone were found by Aubin et al. (2009).

Premature ejaculation

For premature ejaculation, Masters and Johnson (1970) developed a couple-based sex therapy programmes which includes the stop-start and squeeze techniques. In this programme, each time ejaculation in immanent, 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 immanent, 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, Hellstrom (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. Hellstrom (2006) also concluded that there is evidence from a number of trials to show that topical formulations which contain

anaesthetic 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, couple-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.

INTIMATE PARTNER VIOLENCE

Methodologically robust family violence surveys show that intimate partner violence is not exclusivley a male to female process. About 12% of men and women engage in intimate partner physical violence, and in about 4% of cases severe violence occurs (Esquivel-Santoveña and Dixon, 2012; Langhinrichsen-Rohling et al., 2012). Systematic reviews and meta-analyses of treatment programmes for intimate partner violence conclude that most traditional programmes for violent males have small effects; the most effective programmes for mild to moderate intimate partner violence are couple-based; and

effective programmes address both violence and substance use which often contributes signficanlty to violence (Barner and Carney, 2011; Murphy and Ting, 2010a,b; O'Farrell and Clements, 2012; Stith et al., 2012; Stover et al., 2009). Thus couple therapy is approapriate for treating relativley low-level situational violence and preventing it from esacalating into severe violence. It is not appropriate for couples in which one partner perpetrates chronic severe 'caracterological' violence. To safely offer couple therapy partners must agree to a no-harm contract, and commit to work together for the duration of treamtent which is usually about 6 months.

Behavioural couple therapy for intimate partner violence and substance use (Fal-Stewart et al., 2009) and domestic violence focused couples treatment (Stith et al., 2011) are the two most stongly supported evidence-based couple therapy programmes for intimate partner violence.

In behavioural couple therapy partners engage in a sobriety contract and also learn skills for increasing positive interactions, communicating, problem-solving and managing conflict in constructive ways (Fal-Stewart et al., 2009). Non-substance using partners support substance using spouses in their attempts to remain sober. From a review of a series of controlled trials and naturalistic studies O'Farrell and Clements (2012) concuded that behavioural couple therapy halves the rate of intimate partner violence.

Domestic violence focused couples treatment is an 18 week programme facilitated by a team of 2 co-therapists and may be offered to single couple or in a muticouple group format (Stith et al., 2011). For the first 6 weeks partners are seen separately, with separate therpaists working with male and female partners. During this phase of the programme clients develop a vision of a healthy relationship which serves as a guide for the later phase of therapy. They also receive psychoeducation about intimate partner violence and develop safety skills required for conjoint work including self-soothing through meditation, safety plans, and a time-out procedure fro de-escalating potentially

violent incidents. Partners with substance use problems are engaged in a motivational enhancement intervention to address their co-occurring alcohol and drug use problems during the first phase of the programme. In the conjoint phase of the programme co-therapists convene brief separate meetings with partners at the beginning and end of each session to confidentially monitor risk of violence. The main focus of the conjoint phase of the programme is helping couples make constructive changes in their lives and resolve conflicts in a non-violent way. A solution-focused brief therapy practice model is used (Franklin et al., 2011). The primary emphasis is on working towards positive visualized goals by increasing the frequency and intensity of naturally occurring positive interactions within the couple. In a comparative trial Stith et al. (2004) found that that while single and multi-couple formats for this approach to treatment are effective, multicouple therapy may be more effective. Male violence recidivism rates were 25% for those treated in a multi-couple format, and 43% for those treated in an individual couple format.

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 or individual couple therapy spanning about 6 months of weekly sessions, with a specific focus on violence reduction and substance use should be offered.

ANXIETY DISORDERS

Family based therapies are effective for three of the most debilitating anxiety disorders: agoraphobia with panic disorder, obsessive compulsive disorder (OCD), and post-traumatic stress disorder (PTSD). Reviews of international surveys show that the lifetime prevalence rate for panic disorder with agoraphobia is 2-5%, for OCD is 2-3%, and for PTSD is 1-2% in western Europe, 6-9% in North America and over 10% in countries where there is sectarian violence (Kessler et al., 2010). Although some people with these

disorders respond to serotonin reuptake inhibitors, a significant proportion are not helped by medication, cannot tolerate medication side effects, or do not wish to take medication for other reasons. Furthermore, relapse is common once medication is discontinued (Anthony and Stein, 2009). All of these reasons provide a rationale for a psychotherapeutic approach to anxiety disorders. 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 with agoraphobia

Recurrent unexpected panic attacks are the central feature of panic disorder (American Psychiatric Association, 2013; World Health Organization, 1992). Normal fluctuations in autonomic arousal are misperceived as signals for the inevitable onset of panic attacks. These fluctuations in arousal are, therefore, anxiety provoking. When people with panic disorder consistenlty avoid public places in which they expect panic attacks to occur, and this is accompanied by a sense of relief and safety, secondary agoraphobia develops. Partners and other family members may inadvertently maintain the constricted lifestyle of the person with agoraphobia by doing apparenlty helpful things to enable the anxious family member to avoid situations which they believe will trigger panic attacks. Effective couple therapy aims to disrupt this process and enlist the aid of non-anxious partners 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 couple therapy 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 couple 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 couple-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 couple-based programmes include communication training; partner-assisted graded exposure to anxiety provoking situations; enhancement of coping skills; and cognitive therapy to address problematic beliefs and expectations which underpin avoidant behaviour. With partner-assisted graded 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 non-anxious 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) (American Psychiatric Association, 2013; World Health Organization, 1992). However, compulsive rituals only have a short-term anxiety reducing effect. Obsessional thoughts quickly return and the rituals are repeated. Partners and other family members 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, and these processes may lead to significant relationship distress (Renshaw et al. (2005). In effective couple or family-based treatment for obsessive compulsive disorder, the aim is to disrupt family interaction patterns that maintain compulsive rituals, and enlist the aid of partners and family members in helping the person with the condition overcome their obsessions and compulsions.

Five trials of systemic couple or family-based approaches to the treatment of OCD, reviewed by Renshaw et al. (2005) and a more recent pilot study (Abramowitz et al., 2013) have shown that such approaches are as effective, or in some instances more effective, than individually based cognitive behaviour therapy for adults with OCD. 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 partners and other family members reduce the extent to 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 non-anxious partners in supporting their symptomatic partners 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).

Post-traumatic stress disorder (PTSD)

PTSD occurs following catastrophic trauma such as natural or man-made disasters, life-threatening accidents, rape, armed combat, torture, or terrorist attacks. PTSD is characterized by recurrent intrusive traumatic memories (flashbacks and nighmares); intense anxiety in response to these memories and ongoing hyperarousal in anticipation of their recurrence; and attempts to regulate anxiety and hyperarousal by avoiding cues that trigger traumatic memories and attempts to suppress these memories when they intrude into consciousness (American Psychiatric Association, 2013; World Health Organization, 1992). Recurrent, traumatic memories occur in response to internal or external cues that symbolize the traumatic event or aspects of it. Because they anticipate the recurrence of traumatic memories, people with PTSD experience chronic hyperarousal which may lead

to uncontolled anger, difficulty concentrating, hypervigilance, and sleep difficulties. There may also be feelings of guilt or shame for having survived the trauma, beleifs that the world is unsafe, a loss of trust in others, loss of interest in sex and low mood. In PTSD, avoidance of trauma-related situations and attempts to suppress traumatic memories (a process in which both symptomatic and non-symptomatic partners may engage) may initially be relatively unsuccessful and lead, paradoxically, to an increase in the frequency and intensity of flashbacks, panic attacks and violent outbursts. However, in chronic cases, frequent, recurrent attempts to keep trauma-related memories out of consciousness eventually results in an inability to recall traumatic memories and emotional numbing. With emotional numbing, not only are trauma-related emotions such as anxiety and anger excluded from consciousness, but also tender feelings such as love and joy are no longer experienced. PTSD is associated with signficant relationships distress (Taft, et al., 2011). There is evidence from a small number of trials that both cognitive-behavioural and emotionally focused couple therapy can ameliorate PTSD symptomatology and increase realtionship satisfaction.

Emotionally focused couple therapy. In a controlled trial involving 24 couples in which one partner had post-traumatic symptoms arising from sexual abuse, Dalton et al. (2013) found that compared with waitlist controls, those who engaged in emotionally focused couple therapy showed signficant reduction in trauma symptoms and relationship distress. Two open trials of couples in which one partner had PTSD due to childhood sexual abuse (McIntosh and Johnson, 2008) or military combat experiences (Weissman et al., 2011) showed that emotionally focused couple therapy reduced trauma symptoms and increase relationship satisfaction. In these trials, emotionally focused couple therapy involvign up to 30 sessions and progressed through three stages. In the intial stage there was a de-escalation of destructive interactional patterns arising from the couples' difficulty in managing trust issues associated with prior traumatic experiences. During the middle

phase of therapy, partners' authentic expression of, and resposne to each other's attachement needs were faclitatied. This involved partners expressing and responding to the sense of hurt, betrayal, anxiety, anger and avoidance of closness or distance assocated with prior trauma. In the closing phase more adaptive patterns of attachment behaviour were consolidated (Johnson, 2002).

Cogntive behavioural coupel therapy. In a controlled trial Monson et al. (2012) found that among couples in which one partner had PTSD, those who engaged in 15 sessions of cogntive behavioural couple therapy showed a reduction in PTSD symptoms and increased relationship satisfaction compared with waitlist controls. Couple therapy involved a prelimary phase of psychoeducaiton about PTSD and development of couple safety routines for managing anger. In the middle phase key issues were communication and problems-solving skills training and faciliating a reduction in avoidance of trauma-related cues. In the final phase couples' belief systems were restructured with a focus on a range of themes including acceptance, blame, trust, control, closeness and intmacy (Monson and Fredman, 2012).

In planning systemic services for people with panic disorder, OCD, and PTSD, treatment protocols as described in the preceding sections should be offered on an outpatient basis over about 15-30 sessions, depending on client need. In cases that do not respond to systemic therapy, a multimodal programme involving systemic therapy and serotonin reuptake inhibitors may be appropriate (Antony and Stein, 2009).

MOOD DISORDERS

Effective family based treatments have been developed for major depressiver disorder and bipolar disorder. Both conditions have a profound impact on quality of life, with depression being more common than bipolar disorder. In a major US study, the lifetime prevalence of

major depressive disorder was 14.4% and of bipolar disorder was 2.3% (Kessler et al., 2012).

Depression

Major depressive disorder is an episodic condition 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 (American Psychiatric Association, 2013; World Health Organization, 1992). Over the course of their lifetime, on average, people with major depression have four episodes, each of about four months duration. Depressive episodes occur when genetically vulnerable individuals become involved in stressful social systems in which there is limited access to socially supportive relationships (Gotlib and Hammen, 2009; Hollon and Sexton, 2012). Systemic interventions aim to reduce relationship disress 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 and a meta-analaysis of controlled trials support four main conclusions about the treatment of depression with systemic therapy (Barbato and D'Avanzo, 2008; Beach and Whisman, 2012; Whisman et al., 2012). First, systemic interventions are more effective than no treatment. Second, they are as effective as individual approaches for the treatment of depression. Third, couple therapy and individual cogntive behaviour therapy (widely considered to be the treatment of choice) are equally effective. Fourth, for those with relationship distress, couple therapy leads to greater

improvments in relationship satisfaction than individual cognitive behaviour therapy. Fifth, a range of couple and family-based interventions effectively alleviate depression. These include systemic couple therapy (Jones and Asen, 2002; Leff et al., 2000); emotionally focused couple therapy (Denton et al., 2012; Johnson, 2004); various versions of behavioural couple therapy including traditional behavioural couple therapy (Jacobson et al., 1991), cognitive behavioural couple therapy (Beach et al., 1990), coping oriented couple therapy (Bodenmann et al. 2008) and brief couple therapy (Cohen et al., 2010); conjoint interpersonal therapy (Foley et al., 1989; Weissman et al., 2000); family therapy for depression based on the McMaster model, (Miller et al., 2005; Ryan et al., 2005); and behavioural family therapy for families of depressed mothers of children with disruptive behaviour disorders (Sanders and McFarland, 2000). All of these approaches to couple and family therapy require fewer than about 20 conjoint therapy sessions and focus on both relationship enhancement and mood management. They also involve a staged approach to address mood and relationship issues (Beach and Whisman, 2012). In the initial phase, the focus is on increasing the ratio of positive to negative interactions, decreasing demoralization, and generating hope by showing that change is possible. Therapists take the initiative in structuring sessions, facilitating positive within-session experiences and motivating clients to have similar or related experience between sessions. Once some initial positive changes have occurred, the second phase focuses on helping clients jointly reflect on positive and negative recurrent patterns of interaction, related constructive and destructive belief systems, and underlying relationship themes. Therapists help clients jointly reflect on positive and negative aspects of their lives between sessions, and facilitate the development skills and competencies for doing this autonomously without falling back into problematic patterns. Relapse prevention is the main theme of the third phase of therapy. Here the primary concern is helping clients develop plans for anticipating and managing situations in which low mood and relationship

distress are likely to recur.

Bipolar disorder

Bipolar disorder is a recurrent condition characterized by episodes of mania or hypomania, depression, and mixed mood states (American Psychiatric Association, 2013; World Health Organization, 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 (Miklowitz and Craighead, 2007). 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 and Miklowitz, 2013). 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; Schöttle et al., 2011 Scott et al. 2007).

Results from a series of trials show that family therapy alone or in combination with interpersonal social rhythm therapy was effective in reducing relapse, and in some instances, rehospitalization rates in patients with bipolar disorder on maintenance mood stabilizing medication (Miklowitz, George et al., 2003; Miklowitz and Goldstein, 1990; Miklowitz otto et al., 2007; Miklowtiz, Richards et al., 2003; Rea et al. 2003). In these trials family therapy was conducted over 21 sessions and included family-based psychoeducation, communication and problem-solving skills training, and relapse

prevention (Miklowitz, 2008). A trial of a 15 session adaptation of Miklowitz's (2008) systemic therapy for groups for carers of people with bipolar disorder showed that this intervention led to decreases in depressive symptoms in both carers and patients, compared with routine video-based health education about bipolar disorder (Perlick et al., 2010). In three trials, other less intensive family-based interventions have not yielded these positive effects (Clarkin et al., 1990, 1998; Miller et al., 2004). Madiagan et al. (2012) found that solution-focused group thrapy and family psychoeducation both had positive effects on caregiver knowledge about bipolar disorder and family burden.

From this review it may be concluded that effective systemic therapy for mood disorders may be offered may span 15-21 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 PROBLEMS

Harmful alcohol use constitutes a significant mental health problem. In the US the lifetime prevalence of alcohol abuse is 13.2% (Kessler et al., 2005). Martin and Rehm (2012) conducted a systematic review of all major reviews and meta-analyses of studies evaluating the treatment of alcohol problems conducted since 2000 and found strong support for the effectiveness for brief interventions, motivational interviewing and cognitive behavioural interventions, notably the behavioural couple therapy (O'Farrell and Fals-Stewart, 2006). In a systematic narrative review of controlled studies conducted since 2000, O'Farrell and Clements (2012) concluded that systemic interventions were effective in helping sober families promote the engagement of family members with alcohol problems in treatment, and in helping people recover from alcohol problems. This

conclusion is shared by other major reviews (Finney et al., 2007; McCrady and Nathan, 2006; Powers et al., 2008; Ruff et al., 2010; Templeton et al., 2010).

Community Reinforcement and Family Training

For helping sober family members promote the engagement of family members with alcohol and substance use problems in therapy, O'Farrell and Clements (2012) concluded that Community Reinforcement and Family Training (Smith and Meyers, 2004) was more effective than all other family-based methods. It led to average engagement rates of 55-86% across 5 controlled trials for families of people with alcohol and other drug problems. This approach helps sober family members improve communication, reduce the risk of physical abuse, and encourage sobriety and treatment seeking in people with alcohol and drug problems. It also helps sober family members engage in activities outside the family, to reduce dependence on the person with the alcohol problem.

Behavioural couple therapy

For helping people with alcohol problems recover, O'Farrell and Clements (2012) concluded that behavioural couple therapy was more effective than other systemic and individual approaches. Compared with individual approaches, behavioural couple therapy produced greater abstinence, fewer alcohol-related problems, greater relationship satisfaction, and better adjustment in children of people with alcohol problems. Behavioural couple therapy also led to greater reductions in domestic violence, and periods in jail and hospital, and this was associated with very significant cost savings. Behavioural couple therapy has been shown to be effective with couples in which male and female partners have alcohol problems, in gay and lesbian couples, in couples with other drug problems and in couples with comorbid ,combat-related PTSD. Behavioural couple therapy is as effective in community clinics as in specialist services. Behavioural

couple therapy typically involves 12 sessions and includes alcohol-focused interventions to promote abstinence, and relationship-focused interventions to increase positive feelings, shared activities, and constructive communication within couples. The most effective forms of behavioural couple 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 use, enhance family support for efforts to change, and promote patterns of interaction and problem-solving skills 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 and cost-effective as individually-based motivational enhancement therapy in the largest ever UK alcohol abuse treatment trial (UKATT Research Team, 2005a,b). Social behaviour network therapy helps clients address their alcohol problems by building supportive social networks (usually involving partners and family members) and developing coping skills (Copello et al. 2009).

In planning systemic services, this review suggests that therapy for alcohol problems may be offered on an outpatient basis initially over about 12 sessions. 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 problems are common, services should make long-term re-referral arrangements, so intervention is offered early following relapse.

SCHIZOPHRENIA

The term schizophrenia refers to a collection of seriously debilitating conditions characterized by positive and negative symptoms and disorganization (American Psychiatric Association, 2013; World Health Organization, 1992). Delusions and hallucinations are the main positive symptoms of schizophrenia. Negative symptoms include poverty of speech, flat affect and passivity. Although just under 1% of people suffer from schizophrenia, the World health Organization has ranked it as second only to cardiovascular disease in terms of overall disease burden internationally (Murray and Lopez, 1996). 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 (Lieberman and Murray, 2012). 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 (Miyamoto et al., 2012). 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 (Barrowclough and Lobban, 2008). The aim of psychoeducational family therapy is to reduce family stress and enhance family support, so as to delay or prevent relapse and rehospitalization.

A series of international systematic reviews and meta-analyses involving over 50 studies conducted around the world provide robust support for the effectiveness of psychoeducaitonal family therapy (as one element of a multimodeal progamme which includes antipsychotic medication) in the treatment of schizophrenia in adulthood (Jewell et al., 2009; Lobban et al., 2013; Lucksted et al., 2012; Murray-Swank and Dixon, 2004; Pfammatter et al., 2006; Pharoah et al., 2005; Pilling et al., 2002; Pitschel-Walz et al., 2001; Rummel-Kluge and Kissling, 2008; Taylor et al., 2009). Compared with medication alone, multimodal programmes which include psychoeducational family therapy and

antipsychotic medication lead to lower relapse and rehospitalization rates, and improved medication adherence. For example, Pfammatter et al. (2006) found that one to two years after treatment, effect sizes 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 50 studies Lobban et al. (2013) found that family intervention for schizophriena in most studies had a postive effect on the adjustment of non-symptomatic family members. There is also a consensus that longer systemic intervention programmes are more effective than shorter ones.

Psychoeducational family therapy may take a number of formats including therapy sessions with single families (e.g., Kuipers et al., 2002); therapy sessions with multiple families (e.g., McFarlane, 2004); group therapy sessions for relatives; or parallel group therapy sessions for relative and patient groups. Regardless of the format, systemic interventions for schizophrenia aim to (1) provide families with information about the condition, (2) help families acquire skills to cope with it and to manage crises, and (3) support for families, and help them to develop a supportive family culture. Effective family therapy programmes involve psychoeducation, based on the stress-vulnerability or bio-psycho-social models of schizophrenia. Through psyhoeducation families learn to understand and manage the condition, antipsychotic medication, related stresses, and early warning signs of relapse. Therapists provide families with support and crisis intervention as required. Throughout treatment 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, problem-solving and coping skills. Skills training commonly involves modelling, rehearsal, feedback and discussion. Effective systemic 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., 2013; Rolland, 1994). Systemic interventions include couple and family therapy, as well as multifamily support groups, and carer support groups. These interventions provide psychoeducaiton 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 52 randomised controlled trials (including 8,896 patients) with a range of conditons including cardiovascular disease, stroke, cancer and arthritis, Hartmann et al., (2010) found that systemic interventions led to significantly better physical health in patients and better physical and mental health in both pateints and other family members compared with routine care. Systemic interventions included groups for relatives of people with chronic illnesses as well as couple and family therapy. Depression, anxiety, quality of life, and

caregiver burden were the most common indices of spouses' mental health. Effect sizes were small to medium ranging from 0.28 to 0.35 indicating that the average case treated with systemic therapy fared bettern than 61- 64% of cases who recevied routine care. Effects were stable over long follow-up periods. Longer interventions involving spouses, rather than other family members, tended to be more effective. Relationship-focused family interventions tended to be more effective than exclusivley educational interventions. 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 those from other systematic reviews and meta-analyses (Baik and Adams, 2011; Baucom et al., 2012; Campbell and Patterson, 1995; Hopkinson et al., 2012; Martire, 2004; Northouse et al., 2010).

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 routine health service settings. It is probable that the evidence-based practices described in this paper are somewhat less effective when used in routine community clincs by busy therapists, 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, few controlled trials of systemic therapy for prevalent problems such as borderline personality disorder have been reported in the literature, although there are some exceptions (Balfour and Lanman, 2012; Kamalabadi et al., 2012). 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 (Davis et al., 2012). 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, although there are a exceptions (Seikkula et al., 2013). 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 consistent with those of reviews that take a narrower definition of systmeic therapy and exclude some of the family-based interventions covered in the present review (e.g., Baucon et al., 2012; Sexton et al., 2013; von Sydow et al., 2010). Our results are more somehwat more optimistric that those taken by reviewers who have used more stringent methodological criteria for making decisions about programme effectivness (e.g., Meis et al., 2013).

The results of this review are broadly consistent with the important role accorded to systemic interventions and family involvement in psychosocial treatment within NICE and other guidelines for a range of adult mental health problems including OCD (NICE, 2005a), depression (NICE 2009a), bipolar disorder (NICE, 2006), alcohol problems (NICE, 2011a), and schizophrenia (Dixon et al., 2010, NICE 2009b). 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, 2011b) or PTSD in adults (NICE, 2005b).

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. This argument has recently been endorsed in the UK and the US in statements of core competencies for systemic therapists (Northey, 2011; Stratton et al., 2011). 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 paper 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 this and the accompanying paper (Carr, 2014). 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, 2012).

TREATMENT RESOURCES

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Psychosexual problems

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PTSD

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Alcohol problems

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Schizophrenia

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