Reviewing the evidence for the effectiveness of systemic, family and couple interventions (SFCT)

Bill Petitt, Marianne Cederblad, Ingegerd Wirtberg

This article was originally written for the Swedish context and published (in Swedish) in The Swedish Family Associations newsletter.

Introduction

The requirement that, in order to gain official credence and acceptance, a psychotherapy method must be able to demonstrate a well-researched evidence base has become firmly and irrevocably established. Cognitive-behavioural models have long been in the forefront of such research, and have received much attention and praise as a result of their endeavours. At the same time, at least in Sweden, it might seem that family-based and other so-called systems-based models have lagged behind not only in doing research, but also have failed to properly inform the world about those research results that are in fact available. Happily, appearances can mislead: there is in fact a great deal of available research, all of which strongly supports the assumption that family, couple, and systemic approaches are effective, and this information is presented below. With this in mind, one might ask why do family and systems models appear to have a markedly weaker profile in the professional and public eye, when compared for example to cognitive-behavioural approaches?
This leads to the primary reason for writing this article, which is to provide information concerning the evidence base for family/couple/systemic therapy in a single document, thus making it more easily accessible to everyone. We focus on the “reviews of the reviews” – i.e. those reviews that collect and collate those published practitioner reviews, systematic reviews and meta-analyses that in turn collect and collate the available research carried out within specific problem areas (for example mood disorders, behavioural disorders, relationship dissatisfaction etc.). The principle focus in the present article is on those interventions that are applied within the constellation of the couple (both as partners and parents) and the family (couple- and family-therapy: CFT), no matter what their theoretical orientations are. (The major exceptions are the three reviews from von Sydow and her colleagues who, for political and ideological reasons, chose the theoretical base of what they define as systemic therapy for their analyses.) This means that three principle areas are examined and presented: parent training, couple therapy, and family therapy (which also includes multi-family constellations).

It is hoped that family- and couple- and other systems-based therapists will be able to share this information with their employers and with their colleagues – thereby informing the world that their methods and models often can be shown to have an evidence base, even if more research is needed (as it always will be).

It is unfortunate when different therapy models compete from a theoretical, ideological or moral perspective. Neither the profession nor the client is served by such bickering. The value of a therapeutic model is to be found in empirical research, in how well it may serve the client in his search for help. Donabedian’s words hold true for psychotherapy (even if he was speaking of medicine), when he said: “We have granted the health professions access to the most secret and sensitive places in
ourselves, and entrusted to them matters that touch on our well-being, happiness and survival. In return, we have expected the professions to govern themselves so strictly that we need have no fear of exploitation or incompetence” (Donabedian, 1978; p. 856). This thought underlines why it is important that the therapist be able, whenever possible, to point to empirical research whenever she makes decisions concerning how and why she chooses to try and help the client with the problem that he presents.

A scientific model always has two parts – firstly empirical data, and secondly a number of “best guesses”. The best guesses constitute the glue that is used to order and stick empirical data together to form a coherent idea of what they might mean in real world terms. Perhaps the real interest and value of a model is that it contains predictive elements that can be tested in further empirical research. Thus if the model on offer contains the presupposition that the context of the couple, family and its network are vital for individual development, and therefore are logical contexts for interventions designed to solve human problems and promote health, then we have created a prediction that can clearly be the basis of an empirical research program. If we are not prepared to test our assumptions, then we presumably rely on belief rather than reason.

**Research**

As noted in the introduction, we have chosen to ride on the broad shoulders of other, eminent researchers. The strategy we used was simple: we began with four major sources - the reviews produced by Kirsten von Sydow and her colleagues (three articles: Retzlaff et al., 2013; Von Sydow et al., 2010, 2013), the reviews of Allan Carr (two articles: Carr, 2014a, 2014b), the review produced by Peter Stratton for the British Family Therapy Association (one article: Stratton, 2011), and the review by
Sexton et al. included in Bergin & Garfield’s Handbook of psychotherapy and behaviour change (Sexton et al., 2013). The major aim of these writers is to summarize the bulk of the evidence available. We then searched the literature for other relevant articles. It should be noted that there are many other articles containing descriptions of single research projects they are not presented here as we have only chosen those that offer systematic research reviews and meta-analyses. The collected sources are listed at the end of the article under references.

No matter what the difficulties there may be in attempting to assimilate the significance of hundreds of differently designed research programs, the assembled data strongly suggests that those therapy models that can loosely be tied together under the heading “systemic” are effective treatment choices for many sorts of problem, and also are cost effective. We shall begin by presenting a summary of the systematic review as presented by Alan Carr (2014a & 2014b).

The systematic reviews of Carr (Carr, 2014a & 2014b)

Carr has published his systematic reviews three times to date: in 2000, 2009 and 2014. In the present review, he divides the material into two sections: the first presents the research that examines clinical interventions with adults, whilst in the second he examines interventions that target children and adolescents. Below, we present a selective overview of his findings in the form of two tables.

Systemic therapy with adults (Carr, 2014b)

<table>
<thead>
<tr>
<th>Problem category</th>
<th>Intervention type</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Models of choice: EFCT, BCT, MICF</td>
<td>affect size: 0.84</td>
</tr>
<tr>
<td>2. Psychosexual problems</td>
<td>40% of couples benefit a lot; 40% of couples benefit somewhat</td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>(Female orgasmic disorder, female sexual pain disorder, male erectile disorder, premature ejaculation)</td>
<td>most common model: Masters &amp; Johnson combined with CBCT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Affect size 0.58</td>
<td></td>
</tr>
</tbody>
</table>

| 3. Intimate partner violence | BCT for intimate partner violence, & substance abuse; Domestic violence focused couple treatment | effective only for low to moderate violence |

<table>
<thead>
<tr>
<th>4. Anxiety disorders</th>
<th>small number of studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panic disorder with agoraphobia</td>
<td>Partner assisted, CB exposure therapy</td>
</tr>
<tr>
<td>OCD</td>
<td>CBCT with exposure &amp; response training, &amp; psycho-education</td>
</tr>
<tr>
<td>PTSD</td>
<td>CBCT &amp; EFCT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Mood disorders</th>
<th>4 conclusions: 1. CFT is better than no therapy; 2. CFT is as effective as IT; 3. Couple therapy and cognitive therapy equally effective; 4. when accompanied by relational distress, couple therapy is model of choice.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>SCT, EFCT, BCT, CBCT, coping oriented couple therapy, brief couple therapy, conjoint interpersonal therapy, brief therapy (McMasters model), BFT.</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>medication + FT together with psycho-education; systemic therapy with groups of carers; solution-focused group therapy; family psycho-education.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Alcohol problems</th>
<th>strong support that CFT is effective - large trials of SBNT showed it was as cost-effective and result effective as IT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social behavioural network therapy (SBNT); CT with MI; Brief therapy &amp; CBT</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Schizophrenia</th>
<th>effect size for relapse and rehospitalisation: after 1-2 years 0.32 and 0.48 respectively</th>
</tr>
</thead>
<tbody>
<tr>
<td>medication + psycho-education in various constellations</td>
<td></td>
</tr>
<tr>
<td>Problem category</td>
<td>Intervention type</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Children &amp; adolescents</td>
<td></td>
</tr>
<tr>
<td>1. Problems of infancy</td>
<td></td>
</tr>
<tr>
<td>Sleep problems</td>
<td>Systemic (unspecified)</td>
</tr>
<tr>
<td>Feeding problems</td>
<td>Family therapy (unspecified)</td>
</tr>
<tr>
<td>Attachment problems</td>
<td>FT, VIPP, child-parent psychotherapy</td>
</tr>
<tr>
<td>2. Child abuse and neglect</td>
<td></td>
</tr>
<tr>
<td>Physical abuse and neglect</td>
<td>CBT for physical abuse; parent-child interaction therapy for physical abuse; MST for physical abuse and neglect</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>Mostly trauma focused CBT – goal to reduce trauma, improve adjustment, strengthen supportive relationships</td>
</tr>
<tr>
<td>3. Conduct problems</td>
<td></td>
</tr>
<tr>
<td>Childhood behaviour problems</td>
<td>Parent training; video feedback and modelling; Eyberg’s parent-child interaction training (preschool children); Incredible years; behavioural parent training therapy, Triple-P</td>
</tr>
<tr>
<td>Attention and overactivity problems</td>
<td>Medication, FT, parent training, school-based interventions</td>
</tr>
<tr>
<td>Pervasive conduct problems in adolescence</td>
<td>BSFT; FFT; MST; MDFT</td>
</tr>
<tr>
<td>Drug misuse in adolescence</td>
<td>BSFT; FFT; MST; MDFT</td>
</tr>
</tbody>
</table>

Table 1: Interventions with adults by problem category (Carr, 2014b).

Systemic therapy with children and adolescents (Carr, 2014a)

<table>
<thead>
<tr>
<th>Problem category</th>
<th>Intervention type</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children &amp; adolescents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Problems of infancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep problems</td>
<td>Systemic (unspecified)</td>
<td>Much more effective than medicine in long term results</td>
</tr>
<tr>
<td>Feeding problems</td>
<td>Family therapy (unspecified)</td>
<td>Effective</td>
</tr>
<tr>
<td>Attachment problems</td>
<td>FT, VIPP, child-parent psychotherapy</td>
<td>Effective</td>
</tr>
<tr>
<td>2. Child abuse and neglect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical abuse and neglect</td>
<td>CBT for physical abuse; parent-child interaction therapy for physical abuse; MST for physical abuse and neglect</td>
<td>Effective in reducing risk of future abuse and neglect</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>Mostly trauma focused CBT – goal to reduce trauma, improve adjustment, strengthen supportive relationships</td>
<td>Model of choice</td>
</tr>
<tr>
<td>3. Conduct problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood behaviour problems</td>
<td>Parent training; video feedback and modelling; Eyberg’s parent-child interaction training (preschool children); Incredible years; behavioural parent training therapy, Triple-P</td>
<td>FT much more effective than individual therapy (effect size 0.45 against 0.23). Inclusion of fathers is a positive factor for outcome</td>
</tr>
<tr>
<td>Attention and overactivity problems</td>
<td>Medication, FT, parent training, school-based interventions</td>
<td>Medicine can help at first, but all effects stop after three years; FT, or FT plus medication are models of choice</td>
</tr>
<tr>
<td>Pervasive conduct problems in adolescence</td>
<td>BSFT; FFT; MST; MDFT</td>
<td>Effect size 0.7. Models of choice</td>
</tr>
<tr>
<td>Drug misuse in adolescence</td>
<td>BSFT; FFT; MST; MDFT</td>
<td>Effective: models of choice</td>
</tr>
</tbody>
</table>
### 4. Emotional problems

<table>
<thead>
<tr>
<th>Condition</th>
<th>Treatment Options</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety (separation anxiety, selective mutism, phobias, social anxiety disorder, generalised anxiety disorder)</td>
<td>FT, CBFT (FRIENDS)</td>
<td>As effective as individual therapy, more so when parents also suffer from anxiety – also improves family relationships</td>
</tr>
<tr>
<td>School refusal</td>
<td>FT</td>
<td>Better than individual therapy; model of choice</td>
</tr>
<tr>
<td>OCD</td>
<td>Medication; FT</td>
<td>Ft better than medication alone; model of choice FT + medication</td>
</tr>
<tr>
<td>Depression</td>
<td>ABFT; child-focused CBT; interpersonal therapy; psychoeducation</td>
<td>As effective as individual therapy: remission in 2/3-3/4 of cases</td>
</tr>
<tr>
<td>Grief</td>
<td>FT + IT</td>
<td>Promising</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>psycho-education + medication: the goal is to reduce relapse rates by lessening family stress</td>
<td>Helps with family relationships, increases knowledge, and reduces symptoms of depression and mania</td>
</tr>
<tr>
<td>Self harm</td>
<td>ABFT, MST, DBT combined with multi-family therapy, nominated support network therapy</td>
<td>As effective as individual therapy; results show improved adjustment</td>
</tr>
</tbody>
</table>

### 5. Eating disorders

<table>
<thead>
<tr>
<th>Condition</th>
<th>Treatment Options</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anorexia nervosa</td>
<td>FT (Maudsley model the most researched)</td>
<td>½-2/3 achieve healthy weight; after six years 60-90% have fully recovered; only 10-15% are still seriously ill. Model of choice.</td>
</tr>
<tr>
<td>Bulimia nervosa</td>
<td>FT (Maudsley model)</td>
<td>As effective as CBT. Promising</td>
</tr>
<tr>
<td>Obesity</td>
<td>FT (Malmö model – based on systemic/solition focused)</td>
<td>At six months follow-up: 70% showed partial or full recovery.</td>
</tr>
</tbody>
</table>

### 6. Somatic problems

<table>
<thead>
<tr>
<th>Condition</th>
<th>Treatment Options</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enuresis</td>
<td>Family training using alarm</td>
<td>60-90% become dry</td>
</tr>
<tr>
<td>Encopresis</td>
<td>Multi-model intervention – medical assessment &amp; intervention + BFT; narrative FT</td>
<td>Slight evidence that the narrative approach is better.</td>
</tr>
<tr>
<td>Recurrent abdominal pain</td>
<td>BFT</td>
<td>4 trials show good results</td>
</tr>
<tr>
<td>Poorly controlled asthma</td>
<td>FT (unspecified)</td>
<td>FT more effective than IT</td>
</tr>
<tr>
<td>Poorly controlled diabetes</td>
<td>FT (unspecified)</td>
<td>Successful. Model of choice</td>
</tr>
</tbody>
</table>
Table 2: Interventions with children and adolescents by problem category (Carr, 2014a).

List of abbreviations: ABFT – Attachment Based Family Therapy; BCT – Behavioural Couple Therapy; BSFT – Brief Strategic Family Therapy; CBCT – Cognitive Behavioural Couple therapy; CBFT – Cognitive Behavioural Family Therapy; CBT – Cognitive Behaviour Therapy; CFT – Couple and family therapy; DBT – Dialectical Behaviour Therapy; EFCT – Emotionally Focused Couple Therapy; FFT – Functional Family Therapy; FT – Family Therapy; IT – Individual Therapy; MDFT – Multi Dimensional Family Therapy; MICF – Model Integration and Common Factors; MST – Multisystemic therapy; SCT – Systemic Couples Therapy; Triple P – Positive Parenting Program; VIPP – Video Intervention to promote Positive Parenting

Comment on Carr’s systematic reviews

Carr’s reviews (Tables 1 & 2) inform us that systemic therapy appears to be effective with a fairly wide range of problems. Some possible difficulties are also apparent: there is a wide range of treatment models, many unspecified. Comparison between models is largely lacking. The term “systemic” appears to have little clear significance, unless one thinks of any and all interventions as systemic, no matter what their theoretical base, as long as the couple, family or network is the constellation with which the interventions are applied. We shall return to this discussion in the next article.

For several problems some form of CFT is stated to be the intervention of choice. What is not apparent from a cursory glance is that “the big four” (FFT, MST, MDFT & BSFT) are the most thoroughly researched - 82% of all family therapy research has to date focused on MST, FFT, CBFT & MDFT (Sexton & Datchi, 2014). They are also manualised, and distinct in content and structure. An examination of the tables shows that a number of interventions are general ones, and therefore it is difficult to
know what aspects or components are thought to be effective, which is not helpful for the clinician looking for guidance in her daily practice.

However, the sheer weight of the evidence suggests that the couple, the family and the network are very often a fruitful constellation to target - a supposition that is supported by the rest of the reviews examined here.

We shall now examine the reviews presented presented by von Sydow and her colleagues.

**Three systematic reviews of systemic therapy (ST) interventions presented by von Sydow et al.**

The three systematic review articles published by von Sydow and her colleagues are a little unusual - and therefore of special interest - as they had an openly defined political purpose: to lift and highlight the effectiveness of systemic therapy (Retzlaff et al., 2013; von Sydow et al., 2010, 2013). In their home country (Germany) their purpose was achieved, and systemic therapy was awarded the status of a scientific method. Their method consisted of first creating an operational definition of "systemic therapy", and then to search the literature for studies that fitted that definition. These results were than compared with the effectiveness of other interventions. There are some problems with their methodology (see the final article in this series), but we begin by presenting their results in the three categories they used: firstly the effective of systemic therapy firstly with adults, secondly with children and adolescents with internalised disorders, and thirdly with children and adolescents with externalised disorders.

1. **Comparative effectiveness with adults**
Von Sydow and her colleagues (von Sydow et al., 2010) made the following comparisons in their meta-content analysis of 38 Random Controlled Trials (RCTs) with adult patients: "In 34 of 38 RCT, systemic therapy is either significantly more efficacious than control groups without any psychosocial intervention, or systemic therapy is equally or more efficacious than other evidence based interventions (e.g. CBT, family-psychoeducation, GT, or antidepressant/neuroleptic medication)” (p. 477). Comparative results were particularly good for affective disorders, eating disorders, substance use disorders, psychosocial factors related to medical conditions, and schizophrenia. The dropout rate was lower for systemic therapy than other forms. No adverse effects were recorded. It was also noted that in some cases systemic therapy was not sufficient by itself (with schizophrenia, heroin dependence, severe depression), but treatment results were improved by the addition of other psychotherapeutic or pharmacological interventions.

2. **Comparative effectiveness with children and adolescents – internalising and other disorders**

Von Sydow and her colleagues (Retzlaff et al., 2013) make a virtually identical observation in their review of 38 RCTs of systemic therapy applied to children and adolescents with internalising and other disorders as they did above in the case of interventions that targeted adults: in 33 of 38 RCT studies, “ST was either significantly more efficacious than control groups without a systems oriented intervention, or ST was more efficacious than other evidence-based interventions” (p. 642). They concluded that, “ST in its different settings (family, group, multi-family group, individual therapy) is an efficacious approach for the treatment of children and adolescents suffering from internalising, psychological disorders, such as mood and eating disorders and psychological factors affecting physical illness” (p. 644).
3. Comparative effectiveness with childhood and adolescent externalising disorders

Von Sydow and her colleagues (von Sydow et al., 2013) draw virtually identical conclusions in their comparisons of 47 randomised controlled trials of systemic therapy carried out with children and adolescents with externalising disorders: thus, in 42 of the 47 RCTs, ST “…was either significantly more efficacious than control groups without a psychosocial intervention, or systemic therapy was equally or more efficacious that other evidence-based interventions…” (p. 608). ST was also effective “in multiple domains of functioning (primary and secondary mental symptoms, family outcomes, problems with the justice system, and school performance” (p. 608). Also of interest is that engagement and retention rates are higher for system therapy, when compared to other approaches. Finally, treatment results are long-lasting, and no adverse results were noted.

It should be noted that in the case of childhood and adolescent dissociative disorders and juvenile delinquency only ”the big four” treatment models - brief strategic family therapy (BSFT), multi-systemic therapy (MST), multi-dimensional family therapy (MDFT), and functional family therapy (FFT) - are currently empirically supported, together with cognitive behaviour therapy (CBT), parent training and multidimensional foster care (MDFC). Von Sydow et al. also point out that it is of interest that while generally ignored in ADHD research, three studies point to the efficacy of ST as an intervention for that diagnosis.

Comment on von Sydow et al.’s systematic reviews

Following the criteria suggested by Sexton et al. (2011), many of the interventions referred to by von Sydow and her colleagues fit at best into the category of “promising”, for the simple reason that a single RCT study does not qualify an
intervention to be considered as “fully evidence-based”. The difficulties of assessing the meaning and weight of the three analyses as a whole are made more complicated by the fact that there are many different types of interventions, based on different theories, and applied in different constellations. Many are also not standardised interventions (lacking a manual), which further compounds the difficulties in trying to assess their total worth.

The problems with the proposed argument - that the different interventions share a sufficiently common theoretical base so that they can be considered to be of the same sort – will be further discussed in the final article. Perhaps the real value of the three analyses is the same as that noted for Carr above: once again there is a strong indication that the couple, family and network are fruitful constellations for the application of interventions, no matter what their theory is.

We shall now summarise the review offered by Pater Stratton for the Association for Family Therapy in the U.K.

**Stratton’s presentation of the evidence base of systemic family and couples therapies (SFCT) (Stratton, 2011): conclusions and comments**

Stratton’s stated purpose is to present the general evidence base for SFCT. To do this, he uses the work of Carr, and of von Sydow et al., both of which are presented here. He also extensively cites the work of Shadish and Baldwin (2003), “…in which the authors undertook a meta-analysis of 20 meta-analyses of couple and family therapy. It is thus a meta-meta-analysis. The average effect size across all meta-analyses was .65 after family therapy, and .52 at six to twelve months, follow up.” (Stratton, 2011; p. 8) He draws three major conclusions from Shadish & Baldwin’ meta-analysis:
1. Marriage and family interventions are clearly efficacious compared to no treatment.

2. Those interventions are at least as efficacious as other modalities such as individual therapy, and may be more effective in at least some cases.

3. There is little evidence for differential efficacy among the various approaches within marriage and family interventions, particularly if mediating and moderating variables are controlled (Stratton, 2011; p. 8).

However, he notes later that “the big four” (MDFT, MST, FFT and BSFT) are the most researched, and the best researched; he also adds Systemic Couples Therapy (SCT) to this group, despite that only one RCT has been carried out (Leff et al., 2000).

He finds no disadvantages to SFCT. He recognises however the need for further research, stating that while available evidence is positive, “…the evidence base is limited” (p. 26). He particularly notes the distinction between efficacy and effectiveness (see, for example, Weisz, 1999; Hunsley & Lee, 2007).

On the whole, and for obvious reasons, his summary both echoes and affirms the work of Carr and of von Sydow et al. He also writes with an ideological enthusiasm in regard to systemic psychotherapy. While he notes that, “Therapies designed to treat individual people have a remarkable record of achievement…” he then goes on to say: “Systemic family and couples therapy offers something completely different. It was not developed by taking people out of the central context within which they live their lives, treating a ‘mental illness’ or some other dysfunction inside them and then returning them to that context. Instead, the therapy takes place within their system of close relationships. The family context that both challenges and supports each one of
us” (p. 3). The briefest review of the literature reveals however, that systemic therapy is frequently applied in an individual constellation.

Enthusiasm to one side, he also emphasises that SFCT has a relatively low drop-out rate, one that is often lower than traditional individual therapy (IT) (p. 21) It is also costs no more (see the next section). Perhaps the only criticism of Stratton’s summary is related to his enthusiasm for systemic based interventions that perhaps makes him tend to over-generalize the value of the evidence for the category as a whole, and leads him to suggest that it is both more self-evident and stronger than it actually is. The value of his summary is that it presents clearly and cogently a case for providing CFT on a much wider basis by puncturing the assumed superior value and lower cost of IT, and pointing out that the established evidence base for its positive results is quite substantial. Again his conclusions substantiate the findings of both Carr and von Sydow.

Below we summarise the review presented by Sexton et al. (2013) in the latest edition of Bergin & Garfield’s *Handbook of psychotherapy and behaviour change (6th edition)*. This review is the fourth in line: earlier ones were presented in 1978, 1986, and 2004, and are summarised in Sexton’s article.

**Sexton et al.’s systematic review (2013) of the effectiveness of couple and family-based clinical interventions between 2003 and 2010.**

Sexton at al.’s systematic review examined all individual research studies and meta-analyses published between 2003 and 2010. It is to be found in the sixth edition of Bergin and Garfield’s “Handbook of psychotherapy and behaviour change” (Lambert, 2013). The literature search selected studies using constellation criteria: interventions that targeted the couple/family for application were chosen. It should also be noted
that the authors made strict judgements concerning the quality of the studies that were included in their review, judging from seven criteria: interventions (how specific or generalised), type of clinical problems, strength of outcomes, client characteristics, clinical contexts, quality of the studies, strength of the evidence. They divide interventions into three categories: family-based interventions for children and adolescents, couples-based interventions for adults, and parent training programs.

Below the three categories of results are selectively summarised in table form.

Single study, family based interventions 2001-2010 (Sexton et al., 2013) by problem category

<table>
<thead>
<tr>
<th>Problem category</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Child and youth behaviour problems</td>
<td>75 studies: 25 reported positive results; 35 reported mixed results; 11 reported that FT &amp; PT were as good as other interventions; 4 reported no significant success. Model of choice</td>
</tr>
<tr>
<td>2. Youth substance use/abuse problems</td>
<td>23 studies: 9 had positive outcomes; 13 reported mixed results, 1 reported no result. I meta-analysis: FT is successful. Model of choice</td>
</tr>
<tr>
<td>3. Bipolar</td>
<td>12 studies: 6 showed positive results; 5 mixed results; 1 not better than other methods. Promising</td>
</tr>
<tr>
<td>4. Youth depression</td>
<td>9 studies: 3 showed significantly positive results; 3 mixed results; 2 no better than alternative; 1 no result. Promising</td>
</tr>
<tr>
<td>5. General medical conditions</td>
<td>12 studies: 6 showed significantly positive results; 6 mixed results. Promising</td>
</tr>
</tbody>
</table>

Table 3: Family therapy interventions with children and adolescents by problem category (Sexton et al., 2013).
Meta-analyses: only four meta-analyses were noted during this period, and only two examined specific programs – in this case MST. Both affirmed the strength of the intervention.

Single study, couple-based interventions 2001-2010 (Sexton et al., 2013) by problem category and strength:

<table>
<thead>
<tr>
<th>Problem category</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Relationship satisfaction</td>
<td>11 studies: 7 showed positive results; 3 studies showed success is moderated by initial level of distress</td>
</tr>
<tr>
<td>2. Alcohol and substance use/abuse</td>
<td></td>
</tr>
<tr>
<td>3. Infidelity</td>
<td>5 studies: 4 positive results (particularly effective with intimate partner violence associated with infidelity)</td>
</tr>
<tr>
<td>4. Intimate partner violence</td>
<td>2 studies: no effects</td>
</tr>
<tr>
<td>5. General mental health and depression</td>
<td>5 studies: 1 showed positive effects on mental health; 1 showed the same on depression; 3 studies showed mixed results on depression</td>
</tr>
</tbody>
</table>

Table 4: Couple therapy interventions by problem category (Sexton et al., 2013).

Meta-analyses: 2 meta-analyses were included. One focused on depression, and showed positive results for relationship satisfaction, but not for depression. The second focused on alcohol and substance use: CT is shown to be superior to all other controls – model of choice.
Single study, parent skills training interventions 2001-2010 (Sexton et al., 2013 by intervention program

<table>
<thead>
<tr>
<th>Training Program</th>
<th>Strength</th>
<th>Problem category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PCIT</td>
<td>9 studies: 3 had significant, positive outcomes; 3 had mixed results; 3 showed no difference</td>
<td>Strongest for problem behaviours related to developmental disorders &amp; hyperactivity; weakest with general behaviour problems, verbal &amp; sexual aggression</td>
</tr>
<tr>
<td>2. Triple P</td>
<td>9 studies: 4 had significant, positive outcomes; 2 mixed results; 1 no difference</td>
<td>Most studies focused on externalising disorders</td>
</tr>
<tr>
<td>3. IYPT</td>
<td>7 studies: 4 significant. Positive outcomes; 3 suggested outcome mediated by client and outcome measures</td>
<td>Mostly focused on conduct disorders</td>
</tr>
<tr>
<td>4. PMT</td>
<td>6 studies: 3 significant, positive; 3 mixed</td>
<td>Strongest for general behaviour problems, weakest for mental health</td>
</tr>
<tr>
<td>5. PT</td>
<td>6 studies: 3 significant, positive; 3 mixed</td>
<td>Focus on behaviour problems, hyperactivity, &amp; youth development disorders</td>
</tr>
</tbody>
</table>

Table 5: Parent training interventions by program (Sexton et al., 2013).

Il's Training; PT – general approach Parent Training; Triple P – Positive Parenting Program.

Meta-analyses: 6 analyses. Programs included – PST, BPT, Triple P, PCIT, IYPT, PMT & PT. Average effect size of 0.44.

Abbreviations: BPT – Behavioural Parent Training; IYPT – Incredible Years Parent Training; PCIT – Parent Child Interaction Training; PMT – Parent Management Training; PST – Parenting Skill
Comments

In looking at the tables above, it should be remembered that they cover studies carried between 2003 and 2010. So, for example, in the systematic review from 2004 (Sexton et al., 2004) some evidence was found to support couple therapy as an effective treatment for depression. Apparent differences are generally explained by the focus and purpose of the research, and the outcome measures used. Sexton’s review is included here to demonstrate that research is alive and well, and gets ever more sophisticated.

The authors mention a number of points of general interest:

1. From the first systematic review from 1991, over 200 studies suggested broad CFT interventions were more effective than in no treatment control groups in more than 2/3 of the studies, and that CFT was equally if not more effective than individual therapy in problems associated with family conflicts (Gurman & Knisken, 1991). Other systematic reviews over the years have continued to consistently offer strong evidence that CFT is successful for a wide range of problems (Gurman, 1973; Gurman & Kniskern, 1981, 1991; Gurman, Kniskern & Pinsof, 1986; Shadish & Baldwin, 2003).

2. Already noted in the first study, and consistently affirmed in later studies, is that systematic and structured approaches are generally more effective than general ones.

3. Therapist and client factors were noted very early as being important moderators of outcomes. Three of the major variables appear to be: the therapeutic alliance, model specific fidelity and adherence, and client factors (of which socio-economic factors are very important).

4. They also suggest important areas for future research and practice: these include - broaden the range of clinical problems studied; expand CFT research
beyond the study of outcomes; study the variables that may increase the
efficacy of CFT when implemented in community settings; adopt systematic
interventions where available, do more comparative studies; use more diverse
research methods.

Cost effectiveness

One question that has not received sufficient attention concerns cost analysis. This
means examining the consequences when the state or some other agency offers family
therapy: is the cost of that treatment offset by future gains (for example in lesser
consumption of future services, medicine, other treatments etc.). Caldwell et al.
(2007), using available data, made a theoretical calculation concerning the cost
benefits of offering marital therapy to 50,000 couples, and concluded that, using the
available data, it would be a very profitable affair. If correct, then work such as the
meta-analysis carried out Shadish and Baldwin (2003) where they demonstrate the
effectiveness of marital therapy, means that if the state were to offer such
interventions it would effectively save a great deal of money in the long-term.

The work of Crane and his colleagues is of great interest here (Christensen et al.,
2014; Crane & Christensen, 2012; Crane, Hillin & Jakubowski, 2005; Crane & Payne,
2011. See also: Doherty et al., 2014). Being allowed access to the data banks of large
health plan providers meant that the population studied was extremely large, and the
results were unambiguous: family-based interventions were no more costly, often
cheaper, and were clearly more effective. One unexpected and important effect was
that other family members showed savings in terms of future care measure
consumption as well as the identified patient.
Reflecting on the research: some conceptual issues.

Some problems with defining “family/couple/systems therapy”

There are conceptual and practical problems in any discussion concerning “family therapy” or “systemic therapy”. Some of these problems stem from the complex issue of how a family may be thought of and defined (Bernardes, 1987; Asen, 2002), others stem from clinical practice, where therapists work with a variety of client constellations (Breunlin & Jacobsen, 2014), and yet others emerge from the different theoretical orientations that are subsumed under the names of family/couple/systems therapies.

For these reasons, it is not easy to capture the essence of family therapy. For example, Breunlin and Jacobsen (2014) offer a distinction between, “…Whole Family Therapy (WFT), defined as treating the whole family, and Relational Family therapy (RFT), defined as working with a subsystem of the family or an individual while retaining a system lens” (p. 462). Unfortunately, this distinction simple generates more questions. For example: what is “a systems lens”? Does this include psychodynamic family therapy, or cognitive family therapy? When a client in individual therapy wishes to focus on his family relationships – does this automatically transform the therapy model being used (of whatever kind) into family or systems therapy?

Pinsof (1995) suggests a different approach based on two basic distinctions – those of theoretical orientation (the explicit theory that a given approach contains) and constellation (who is present when the theory is used as an intervention, and applied in practice: individuals, couples, families, network etc.). The advantage with this
suggestion is that it can be used to systematically categorize different theoretical models of therapy in practice, and in doing so perhaps also facilitate a more eclectic approach.

Using Pinsof’s suggestion to examine the field of family/couple/systems therapy (the three most common used labels) reveals a multiplicity of both theoretical orientations and constellations. Such a disparate range of models presents potential difficulties in an attempt to integrate the value of available research, and has consequences for planned research. This difficulty can here be exemplified in the reviews of “systemic therapy” (ST) produced by von Sydow and her colleagues (2010), where their operational definition of what constitutes “systemic therapy” is as follows: “…we operationalized ‘systemic psychotherapy’ as any couple, family, group, multifamily group, or individual focused therapeutic intervention that refers to either one of the following systems-oriented authors (Anderson, Boszormeny-Nagy, de Shazer, Haley, Minuchin, Satir, Selvini-Palazzoli, Stierlin, Watzlawick,, White, Zuk) or specified the intervention by use of at least one of the following terms: systemic, structural, strategic, triadic, Milan, functional, solution focused, narrative, resource/strength oriented, McMaster Model…” (p. 460). Their definition is somewhat confusing, as the first part automatically includes all cognitive/behavioural/ psychodynamic approaches that use a couple or family constellation, whilst the second part excludes them. When the two parts of the definition are fused together, then the term “systemic” as it is used here excludes only cognitive/behavioural/psychodynamic approaches that are not applied in the context of couple or family constellations.

A similar problem is met in the work by Alan Carr, who uses a narrower but even looser definition in order to select studies for his meta-analyses: “…a broad definition of systemic practices has been used, covering family therapy and other family-based
interventions such as parent training or multi-systemic therapy, which engage family members or members of the families’ wider networks in the process of resolving problems for young people from birth up to the age of 18 years” (Carr, 2014a; p. 107).

The term “systemic therapy” (ST) has become more and more commonly used. In the *First International Research Conference in Systems and Family Therapy* held in Heidelberg in 2014, an interesting question was raised a number of times during the two days: what is the meaning and value of using two terms - *systemic* and *family* - to describe what is presumed to be a (somehow) related therapeutic approach? A second question was also explicit: if a given (systemic) specific approach is not manualised, then how do we know that epithets used to identify to the work of different therapists actually refer to similar ways of working?

A third distinction can be added to Pinsof’s suggestion – that of *change context*. The change context in any specific therapy is identified by the client’s formulation of problem and goal: it is both the reason why client and therapist work together and the means to measure the effectiveness of their work. Taken together, theoretical orientation, constellation and change context offer a practical means to conceptualise what any model of therapy claims to be about, relating the desires of the client with the chosen theoretical approach and the constellation in which it applied. Until a single way of categorizing therapy methods is accepted and applied some confusion is inevitable, and will have consequences for the professional discourse.

It might be thought that perhaps the easiest approach would be to use the term “systemic therapy” or “interactional therapy” as a class term for that group of therapies that identify themselves as context and relationship-oriented: this is similar to the definition of systemic therapy offered by Stratton (2011): “Systemic practice
may be with an individual, a couple, a family, a group of families, professional systems and wider contexts. It is mostly offered to couples or families, but always with the larger and smaller systems in mind…” (p.7) At first glance, this might seem reasonable as it is claimed that the core idea underpinning the “systemic perspective” is that human beings exist continuously in a network of relationships, and the way in which these work will have a defining impact on the experience of the individual in general, and in the way that difficulties are managed and eventually solved in particular. However, it as it is difficult to think of any cognitive-behavioural or psychodynamic therapist (or even medically-oriented therapist for that matter) arguing against this idea, then such a classification does not help much. (It can be noted that there is increasing signs of cognitive/behavioural approaches being applied in a systemic way. See for example: Dummet, 2010.)

Following Pinsof’s ideas, we can begin with either constellation or theoretical orientation. If we begin with constellation as the primary identifying tag, then the terms “Family” or “Couple” Therapy would constitute a primary classification, one that may then be further refined by reference to theoretical orientation (behavioural, cognitive etc.). If accepted, systems therapists could also make explicit which theoretical school they follow (solution-focused, narrative etc.), and which constellation is being chosen for any given intervention.

Thinking in this way does however create a possible problem for the primary classification system (systemic) used for example by von Sydow and her colleagues. For example, their 2010 review includes 38 individual RCTs, representing a wide variety of identified treatment approaches, many of which are not standardized (are not manualised). Further, if we examine the included interventions from two different perspectives, the problem becomes clearer. Firstly, if we take the perspective of
defined problem – for example the category of mood disorders/depression in the same review, the following treatment models are identified as being used:

- Systems oriented couples therapy (Friedman, 1975)
- Systemic couples therapy (Jones and Asen, 2000/2002)
- Solution-focused individual therapy (Kneckt & Lindfors, 2008)
- Problem-centred systems family therapy (Miller et al., 2005)
- Family therapy (McMaster model) (Fabbri et al., 2007)
- Multi-family group therapy (Lemmens et al., 2009)

Secondly, if we pick out one sub-set of interventions identified by the same name - in this case, “Systemic Family Therapy” - we find that:

- 11 such are identified: 8 combined with drugs; 3 were Milano model; 1 focused on the use of paradoxes; 1 was combined with MRT (magnetic resonance tomography); 1 was Minuchin based (Structural Family Therapy?)

The interventions were selected out of the set of all available RCTs by creating an operational definition of what the authors designate as “systemic therapies”: however, the actual clinical-practice relations between the selected interventions are unknown (there are doubts as to whether any of them was manualised), and the proposal that they all possess a common theoretical base is obscure and difficult to understand.

If we are to research specific interventions for specific problems, then classification is important in both parts (intervention and problem), otherwise it is difficult to add the research together in order to clarify and strengthen the evidence base. What does it tell us, for example, if we find that a single RCT in Structural Family Therapy
produced good results, as did a single RCT in Family Therapy using the McMaster model? At best, each of the studies (representing as they do separate theoretical orientations), and taken singly, is promising, and deserves to be repeated following accepted research practice.

This is a very real challenge for research, as there are simply too many models to be adequately researched in the near future. At the Heidelberg Conference, in a humoristic but serious example, Peter Stratton pointed out that if we wanted complete evidential knowledge of all interventions, then we would need to examine all types of relational systems multiplied by the number of all possible types of problem multiplied by all possible methods of intervening: this calculation reveals that at least 98,765,432 RTCs would be required! Some possible alternatives being discussed are using identified common factors, or creating an integrated or eclectic perspective which can make use of those models that have a sound evidence base, or creating interactive data banks collecting daily material from as many individual therapists as possible (see, for example: Breunlin et al., 2011; Fraser et al., 2012; Pinsof et al., 2011; Rohrbaugh, 2014; Sexton & Datchi, 2014; Slife & Wendt, 2007; Sprenkle, 2014; Weisz & Gray, 2008).

We shall now briefly examine the question of what constitutes an acceptable evidence base from the perspective offered by Sexton.

Sexton’s criteria for identifying the strength of the evidence base for a given approach
There is no specific agreement that is universally accepted concerning the criteria that shall be used for deciding which specific trials may be used as part of a potential evidence base concerning outcomes, which accounts for some of the different judgements about what studies may be used in systematic reviews and meta-analyses. See for example, Stratton’s (2011) criticism of the Cochrane Collaboration’s systematic review of CFT with depression (Henken et al., 2009). This disagreement is concerned with theoretical and methodological issues that lie outside the scope of this article. However, to complicate things even more, there is no universally accepted set of criteria for defining the strength of an evidence base. One of the more interesting is the one proposed by Sexton et al. (Sexton et al., 2008, 2011; see also Darwiche & De Roten, 2014), in which the authors suggest three minimal levels to be used in defining the weight of the evidence base for any specific intervention: these seven points are the official guidelines suggested by the Division 43 (Family Psychology) Task Force on Evidence-based Treatments in Family Psychology in the USA:

1. **Evidence informed**: when a treatment program uses interventions taken from previous research findings, or adopts the common factors approach.

2. **Promising**: specific interventions that have been studied, and those studies show either preliminary results, evaluation outcomes, or comparison level studies of high quality.

3. **Evidence-based**: specific treatment interventions that have systematic evidence that they work with the clinical problems they are designed to work with.

In discussions of the actual evidence base for specific interventions, four categories are suggested (in ascending order of difficulty):
1. **Absolute efficacy/effectiveness evidence**: the intervention produces reliable improved outcomes when compared to typical improvement rates for given clinical problems.

2. **Relative efficacy/effectiveness**: the intervention produces reliable improved outcomes when compared to an alternative/viable treatment.

3. **Effective models with verified mechanisms**: this suggests that there are model-specific change mechanisms operating within the intervention model.

4. **Effective models with contextual efficacy**: the intervention can be implemented in a range of professional context, and works for a specified range of clients.

Unfortunately, in the reviews presented in this article, there is no such generalised unity of judgement. The level of evidence and the criteria for each form of intervention is often unclear. The article that is most explicit in this regard is that of Sexton et al (2013), where a trained team rated each published article (though not the meta-analyses, for obvious reasons).

**The evolution of couple and family therapy research**

In any scientific domain, the accumulation of knowledge through empirical research changes the world-view of scientists, and the questions that drive research change and become more detailed and sophisticated. Research in family and couples therapy is no exception. From an historical perspective, it can be seen that research began with very broad questions – for example the "Does therapy work" in the sense of is therapy
better than no therapy. Research also tended to focus on broad models – such as structural family therapy, or experiential family therapy.

However, the researchers began to ask different questions as a result of their empirical approach. It was clear that broad models were not specific enough to answer the next set of questions – these were focused around the idea of what specifically were therapists doing that was effective. This question stimulated interest in manual-based therapies, as standardised interventions become immediately easier to measure – for the obvious reason that all therapists are doing approximately the same thing.

Again this approach raised the possibilities for even more specific questions, in particular concerning what in the standardised intervention was the effective component in terms of change and outcome.

As the research material grew, so did the possibility of revisiting the material to do meta-research – research on the research. In other words, asking new questions of old material. One important example concerned the idea of common factors: could it be possible that, whatever the theory or method employed, there are key elements or components of practice that are important for outcome results. Now we believe that there are, and three such factors seem to be well-established in a general sense: establishing an alliance between therapist and client; managing family interactions; and changing family interactions (Sexton & Datchi, 2014).
On a more technical level, whilst RTCs remain the “gold standard” for research into any given intervention, new approaches are being developed that both assess outcome issues and are more relevant for clinical practice. These are based on the idea of *participation research*: the clinician is invited to fill in questionnaires concerning ongoing therapies after each session: such reports are then sent to a central data base, where the work is assessed, and the clinician is then offered feedback concerning her work. This approach is termed, ”participation research through measurement feedback systems” (Sexton & Datchi, 2014).

Two final observations are perhaps worth making: firstly, therapists traditionally appear to be reluctant to examine their own work from a scientific perspective. Until therapists and their employers can be convinced of the value of a scientific approach, then the gap between between clinicians and researchers will persist. Secondly, as the discussion of efficacy and efficiency demonstrate, it is important that researchers continue to develop methods that are more immediately relevant for clinicians in their practice in “the real world” – for example to focus not only on evidence-based practice, but also on practice-based evidence, and in doing so to strengthen the dialogue between science and practice (Sexton & Datchi, 2014; Sprenkle, 2012).

**Research and ideology**

It is explicitly stated in three of the four reviews (Sexton et al. excluded) that there is an ideological purpose that motivates the work of the authors. For Carr, Stratton and von Sydow and her colleagues it is considered of weight to lift the value of what they identify as systemic therapy: Carr and Stratton achieve this by assuming some form of isomorphism between CFT and systems therapy, while Von Sydow and her
colleagues are quite open with their intention to promote systemic therapy as an evidence-based approach in its own right. Interestingly, a somewhat similar approach, though not made so explicit, can be found the reflective article by Weisz & Gray (2008) where they speculate over the best means of seeking to help children in their development. They speak exclusively of cognitive-behaviour approaches, but in a throwaway comment they add, “The illustrative treatments just described are part of a much larger array of interventions”. Later they also add, “…most everyday clinical practice continues to be characterised by interventions that do not rely on behavioural or cognitive-behavioural principles”.

The need to push forward one theoretical orientation or constellation-based approach over another reveals a competitive spirit that may be presumed to be a part of what Imber-Black (2014) calls “the model wars”. This war extends back at least as far as John Watson when he threw down the theoretical and methodological gauntlet in the form of the behaviourist program (Watson, 1913) – or perhaps even earlier as revealed in the internecine struggles in the group that surrounded Freud. This is to a large degree an ideological competition, in which different individuals or groups fight to define what is the “right” way to think. Such struggles are of course common in human culture, and not unknown even in the history of science. Such agendas are more easily handled when they are made explicit, as they are in the three reviews mentioned here: however, one can only hope it time that such competition can be subsumed under the more important goal of serving the client.

Concluding comments
The message contained in the present research literature is quite clear: that family/couple/systemic therapy would seem to be an effective approach to many types of problems, both for children and adults (Heatherington et al., 2015; Meis et al., 2013; Reibstein & Burbach, 2013). In its broadest terms, it is usually better than no treatment, and normally is as good as (when not better than) individual therapy. For a number of problems, it is the model of choice. Generally it does not cost more, and over time is in fact often more cost-effective than other intervention forms (Baldwin et al., 2012; Crane & Christenson, 2012; Sexton & Datchi, 2014; Sprenkle, 2012).

The challenges are identified in many of the articles named here: for example, to apply CFT to a broader range of problems, to see if is effective with them; to increase the sophistication of research to establish not only if CFT interventions are effective in terms of outcome, but also to relate process variables to outcome, to examine the challenge of implementation in the “the real world” (efficacy, effectiveness), to relate individual practice and research, and to see that the world of research and clinical practice.

In order to pursue research, one fundamental and ongoing demand is the need for clarity, both in terms of conceptualisation (theory) and practice (methodology). It is only then that we can test the claims about the practice that we have chosen to pursue. This ties in with the empirical data: as noted above, therapists who are structured, who lead, who are clear about what they are doing and why they do it will generally be more successful than therapists who are not so. This is only half the story of course. The therapist who is clear, and leads, and does so in a sensitive manner, and so obtains a working alliance with her clients will have the best chance of success.
This approach requires of the therapist that she is very clear about the chosen approach (theoretical orientation), with whom it will be applied (constellation) and how (general or systematic intervention), and what the problem context is (change context). If these are clear, then there are no practical or theoretical conflicts between establishing a working alliance between clinical practice and empirical research – providing of course that the employers who control the work context provide the necessary directives and support.
References


*Correspondence: Ingegerd.Wirtberg@psy.lu.se
Bill Petitt, MA., lic. Psychotherapist, privat practise
Marianne Cederblad, Child Psychiatrist, lic. Psychotherapist, Prof. University of Lund
Ingegerd Wirtberg, lic. Psychotherapist, Ass.Prof. University of Lund*