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# Couple therapy, family therapy and systemic interventions for adult-focused problems: the current evidence base

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This paper updates previous similar reviews published in JFT in 2000, 2009 and 2014. It presents evidence from meta-analyses, systematic literature reviews and controlled trials for the effectiveness of couple therapy, family therapy, and systemic interventions for adults with a range or 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, psychosis and adjustment to chronic physical illness.

*Keywords: couple therapy research; effectiveness of couple therapy; efficacy of couple therapy; systemic therapy for adult-focused problems.*

## Introduction

This paper summarizes the evidence base for systemic therapy with adult-focused problems, and updates previous reviews (Carr, 2000, 2009, 2014). It is also a companion paper to a review of research on the effectiveness of systemic interventions for child-focused problems (Carr, 2018). The overall effectiveness of systemic therapy is now well established. Lebow (2016) recently edited a special issue of *Family Process* on couple and family therapy research. He concluded that there is now a significant number of well defined empirically supported systemic interventions for specific problems. This work updates previous special issues of the *Journal of Marital and Family Therapy* on systemic therapy research (Pinsof and Wynne, 1995; Sprenkle, 2002, 2012), and complements other important major reviews of the evidence base for couple and family therapy (Baucon *et al*., 2012, 2014; Meis *et al*., 2013; Sexton *et al*., 2013; Stratton 2016; Stratton *et al*., 2015; von

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Sydow *et al*., 2010). While the magnitude and complexity of the evidence base for systemic therapy continues to grow, conclusions about the effectiveness of couple and family therapy have been drawn in review papers dating back to the 1970s (e.g. Gurman and Kniskern, 1978).

Because they statistically synthesize the results of many outcome studies in a relatively unbiased way, meta-analyses provide a particularly important type of evidence to support the effectiveness of family therapy. The first meta-analyses of systemic therapy outcome studies were published in the late 1980s and early 1990s (Hazelrigg *et al*., 1987; Markus *et al*., 1990; Shadish *et al*., 1993). In 2003, Shadish and Baldwin reviewed twenty meta-analyses of systemic interventions for a wide range of problems across the lifespan. The average effect size was 0.65 after therapy, and 0.52 at six to twelve months follow up. These results show that the average treated family fared better after therapy and at follow-up than in excess of 71 per cent of families in control groups and this is equivalent to a success rate of 61–64 per cent. In a recent meta-analysis of thirty-seven studies of systemic therapy for adult psychiatric disorders, Pinquart *et al*. (2016) found very similar results. Systemic therapy showed medium effects in comparison with waiting list control groups after treatment ($g = .51$) and at follow up ($g = .55$). Where systemic therapy was combined with medication, it was more effective than medication alone after treatment ($g = .71$) and at follow up ($g = .87$). There were also lower dropout rates in systemic therapy compared with alternative treatments.

If there is little doubt now about the fact that 'systemic therapy works' the next key question to address is its cost-effectiveness. In a series of twenty-two studies conducted over twenty years, Crane and his team showed that systemic therapy was more cost-effective than individual therapy and systemic therapy led to medical cost offsets (Crane and Christenson, 2014). Medical cost offsets occurred because people who engaged in family therapy, particularly frequent health service users, used fewer medical services after family therapy. The medical cost offset associated with couple and family therapy covered the cost of providing therapy, and in many cases led to overall cost savings. Large US databases involving over 250,000 cases of routine systemic therapy were used for these studies. Cases included families of people diagnosed with schizophrenia, depression, sexual disorders, somatoform disorder, substance misuse, relationship problems and other disorders.

The results of extant 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 are essential if systemic 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, psychosis, 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 practice 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 versions of this review, extensive computer and manual literature searches were conducted for studies of the outcome of systemic interventions with a wide range of problems of childhood and adolescence. For the present review, the search extended from the earliest available year to January 2018. Major databases (e.g. PsycINFO, PubMed), couple and family therapy journals (e.g. *Family Process, Journal of Family Therapy, Journal of Marital and Family Therapy*) and mental health journals were searched, as well as major textbooks on evidence-based systemic practice. Using appropriate Boolean logical operators (e.g. AND, OR) in these searches terms denoting systemic interventions (e.g. couple therapy, sex therapy) were combined with terms denoting specific problem types (e.g. depression, anxiety, marital discord, relationship distress) limited to adults. Where available, meta-analyses and systematic review papers were selected, 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. Where there were so many papers that it would have been impractical within the space constraints of a single article to cite them all, a sample of the most comprehensive and methodologically robust papers representative of older and more recent publications were cited. Thus, the current review paper both incorporates and updates earlier versions of this article (Carr, 2000, 2009, 2014). It was intended that this paper should be

primarily a 'review of the reviews', with a major focus on substantive findings of interest to practising 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

Epidemiological research points to a number of conclusions which justify the development of couple therapy to address relationships distress (Halford and Snyder, 2012; Lebow, 2014; Lebow *et al*., 2012). In Western cultures, by the age of 50 about 85 per cent of people have been married at least once. About a third to a half of couples separate or divorce. About half of all divorces occur in the first seven years of marriage. Of couples that remain married, about 20 per cent experience relationship distress. Compared with distressed or separated couples, those who sustain mutually satisfying relationships have better physical and mental health, live longer, and have better financial prosperity. They also engage in better parenting practices, and their children have better academic achievement and psychological adjustment. Narrative and systematic reviews show that evidence-based couple therapy, which typically involves about twenty sessions over six months, is effective for many couples (Benson and Christensen, 2016; Lebow *et al*., 2012; Snyder and Halford, 2012). About 40 per cent of couples benefit a great deal from couple therapy, and about 30 per cent benefit somewhat. In a review of six meta-analyses of couple therapy, Shadish and Baldwin (2003) found an average effect size 0.84, which indicates that the average treated couple fared better than 80 per cent 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 healthcare 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 couple therapy and concluded that these approaches lead to better outcomes than those of waiting-list control groups (Benson and Christensen, 2016). In a meta-analysis of twenty-three studies, Wood *et al*. (2005) found that for mildly distressed couples, behavioural and emotionally focused approaches were equally effective, but with moderately distressed

couples, emotionally focused couple therapy was more effective than traditional behavioural couple therapy.

*Behavioural couple therapy*

Traditional behavioural couple therapy, cognitive behavioural couple therapy and integrative behavioural couple therapy are three related evidence-based practice models which are subsumed here under the overarching label of behavioural couple therapy.

Traditional behavioural couple therapy 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 traditional behavioural couple therapy is to help partners develop communication and problem-solving skills and behavioural exchange procedures so they can negotiate a fairer relationship. In cognitive behavioural couple therapy, 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*., 2015; Epstein *et al*., 2016). Reviews of over two dozen studies of traditional and cognitive behavioural couple therapy show that they are equally effective in alleviating couple distress (Baucom *et al*, 2015; Byrne *et al*., 2004a). Adapted versions of traditional and cognitive behavioural couple therapy (described below) have been shown to be effective interventions for mental health problems including alcohol problems and depression, and adjustment to physical health problems including cancer and heart disease (Fischer *et al*., 2016).

In integrative behavioural couple therapy, which evolved from traditional behavioural couple therapy, there is a focus on broad relationship themes rather than specific behaviours, because over time, many disparate behaviours become functionally equivalent (Benson and Christensen, 2016; Christensen *et al*., 2015). The same pattern is re-enacted in multiple contexts. This occurs because behaviours that were once reinforcing lose their reinforcement value, and because of the emergence of partner incompatabilities. For example, displays of affection become less arousing, or once endearing attributes, such as impulsivity, become irritating. In integrative behavioural couple therapy, the couple's unique set of incompatabilites are identified and reframed in a formulation. This includes a core theme such as

intimacy, power or control, and the repetitive pattern of destructive and distressing behaviour associated with it. Couples are helped to use this formulation to minimize destructive conflict, and maximize the couple's understanding of, and empathy for, each other's different characteristics. There is 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 traditional behavioural couple therapy. In a major long-term comparative study of the effectiveness of traditional and integrative behavioural couple therapy for severely distressed couples, reviewed in Roddy *et al*. (2016) and Briggs *et al*. (2015), 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 five years follow up, about half of treated couples were clinically recovered and only a quarter had divorced. Results from a randomized controlled trial of a self-help, online version of integrative behavioural couple therapy (OurRelationship.com) indicated that it led to a greater reduction in relationship distress than that shown by couples in a waiting-list control group (Doss *et al*., 2016).

*Emotionally focused couple therapy*

In emotionally focused couple therapy it is assumed that an insecure attachment bond underpins relationship distress and related conflict (Johnson, 2015; Johnson and Brubacher 2016). Partners are anxious that their attachment needs will not be met within their relationship. The primary 'soft' emotions of anxiety and sadness give rise to secondary 'hard' emotions of anger and hostility. The primary emotions are not expressed, whereas the secondary emotions are forcefully and repeatedly expressed. In this way, anxiety about attachment needs not being met fuels a pattern of chronic relationship conflict and distress. 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 initial stage of de-escalating destructive pursuer-distancer interactional patterns; a middle phase of facilitating partners' authentic expression of, and response to, each other's primary emotions and attachment needs; and a closing phase where these more adaptive patterns of attachment behaviour are consolidated. In a narrative review of outcome

and process research on emotionally focused couple therapy, Wiebe and Johnson (2016) drew the following conclusions. About 70 per cent of distressed couples show a reduction in relationship distress following emotionally focused couple therapy. This type of therapy also leads to improved sexual satisfaction. Emotionally focused couple therapy leads to improvement in symptoms and relationship quality in couples where one partner has a diagnosis of depression or post-traumatic stress disorder or where a partner or child is coping with a chronic physical illness, such as cancer. The positive effects of emotionally focused couple therapy on relationship distress arise from expressing and responding to attachment needs in an emotionally meaningful way during therapy. This leads to increases in attachment security within couples' relationships. Greater improvement in emotionally focused couple therapy occurs where the male partner is older, the female partner believes that her male partner still cares about her, one partner has high initial attachment anxiety, and the other is holding back from expressing their softer emotions. Greater therapeutic improvement occurs where there is a depth of emotional experiencing, and affiliative interpersonal responding, especially within the context of blamer-softening events in therapy. In blamer-softening events, a formerly critical partner expresses underlying attachment fears, needs and related softer emotions. Greater improvement occurs where there is a good therapeutic alliance, and couples see therapy as getting to the heart of their issues. Emotionally focused couple therapy changes the way the brain responds to threat. Where a male partner supports a female partner by holding her hand, when exposed to the threat of an experimentally administered electric shock, functional brain scan (fMRI) indicators of female partners' responses to the threat are significantly reduced in couples who have successfully completed emotionally focused couple therapy. An eight-session, group-based preventative version of emotionally focused couple therapy – the Hold Me Tight programme (Johnson, 2008) – leads to increases in relationship satisfaction and trust in clinically non-distressed couples.

*Model integration and common factors in couple therapy*

Benson *et al*. (2012) proposed that five principles are common to evidence-based interventions for relationship distress such as behavioural and emotionally focused 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 (Abbott and Snyder, 2012; Snyder and Balderrama-Durbin, 2012). To address tasks at these six levels, therapists may draw on practices from multiple models of couple therapy, such as behavioural, structural, strategic, social-constructionist, narrative, solution-focused, transgenerational, and psychodynamic. In a comparative trial, Snyder *et al*. (1991) found that, four years after treatment, only 3 per cent of cases who had completed insight-oriented, affective-reconstructive couple therapy were divorced, compared with 38 per cent of those in behavioural couple therapy. Affective-reconstructive couple therapy holds considerable promise as a particularly effective approach to helping distressed couples.

### *Service implications for relationship distress*

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 twenty sessions over at least six months, with the intensity of input matched to couples' needs.

## Psychosexual problems

Hypoactive sexual desire in men and women, orgasmic disorder and vaginismus in women, and erectile disorder and premature ejaculation in men are some of the main psychosexual problems for which couples seek help. International epidemiological surveys show that the overall prevalence of psychosexual problems, which increase with age, ranges from 20 to 30 per cent for men and 40 to 45 per cent for women (Lewis *et al*., 2010). In a UK national probability sample survey of 16 to 74-year-olds, Mitchell *et al*. (2013) found that 42 per cent of men and 51 per cent of women reported sexual problems in the past year; partner-reported sexual problems occurred in 18 per cent of cases; self-reported distress about sex occurred in 11 per cent of cases; and in 25 per cent of cases there was an imbalance in partners' level of interest in sex. Relationship distress typically accompanies clinically significant sexual difficulties (McCarthy and Wald, 2016; Weeks and Gambescia, 2015).

Narrative reviews, systematic reviews, and a major meta-analysis conclude that couples treated with psychosocial interventions show greater improvements than untreated controls (Berner and Günzler, 2012; Frühauf *et al*., 2013; Günzler and Berner, 2012; Linschoten *et al*., 2016; Segraves, 2015). In a meta-analysis of twenty studies, Frühauf *et al*. (2013) found an effect size of 0.58 across all disorders indicating that the average treated couple fared better after therapy than 73 per cent of cases in waiting-list control groups. In this meta-analysis, therapy was particularly effective for women with hypoactive sexual desire and orgasmic disorders. Most studies included in this meta-analysis evaluated interventions that combined elements of 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 (Linschoten *et al*., 2016). In this exercise couples are invited initially 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*

Female orgasmic disorder refers to absent, infrequent, or delayed orgasm, or markedly reduced orgasmic sensations. Reviews by Ter

Kuile *et al*. (2012) and Segraves (2015) of nine controlled trials concluded that directed masturbation (LoPiccolo and Lobitz, 1972) was an effective treatment for primary orgasmic disorder in almost all cases. Similar conclusions have been reached in reviews that included both controlled and uncontrolled trials (Heiman, 2002; Laan *et al*., 2013; Meston, 2006; Meston *et al*., 2004; Pereira *et al*., 2013; Rellini and Clifton, 2011). Directed masturbation may be offered in a range of formats including self-help bibliotherapy, individual and group therapy, and couple therapy. When offered within the context of couple-based sex therapy it involves a graded programme which begins with psychoeducation and is followed by a series of exercises that are practised over a number of weeks by the female with partner support initially, and later with the partner's 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 practising these as a couple and progressing to coitus.

*Vaginismus*

Vaginismus refers to involuntary contraction of musculature in the outer third of the vagina which interferes with or prevents intercourse, and which causes pain and/or distress. In DSM-5 this condition is subsumed within a new broad diagnostic category of genito-pelvic pain/penetration disorder (APA, 2013). This new broad category includes cases that previously would have been diagnosed with vaginismus or dyspareunia (painful intercourse). Currently available evidence suggests that psychosocial interventions are effective for vaginismus, but not dyspareunia. In a narrative review of outcome studies, Segraves (2015) concluded that cognitive behavioural sex therapy was particularly effective for reducing vaginismus. This may be offered on an individual or couple basis. Effective couple-based cognitive behavioural sex therapy programmes for vaginismus include 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. These conclusions are consistent with those of other narrative reviews (Crowley *et al*., 2009; Meston and Bradford, 2007; Pereira *et al*., 2013; Ter Kuile *et al*., 2012).

*Male erectile disorder*

Erectile disorder refers to marked difficulty in obtaining and/or maintaining an erection, or decreased erectile rigidity. Prior to 1998 and the marketing of Sildenafil (Viagra), psychosocial 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 per cent 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 (Segraves, 2015). However, only 40–80 per cent of cases respond to PDE-5 inhibitors. Systematic reviews and meta-analyses show that PDE-5 inhibitors combined with psychosocial interventions, including couple therapy, lead to better outcomes than medication alone (Berner and Günzler, 2012; Melnik *et al*., 2012; Schmidt *et al*., 2014; Segraves, 2015). In cases of erectile disorder that do not respond to medication alone, there is an emerging evidence-based practice of using a multimodal programme involving PDE-5 inhibitors combined with couple therapy (Gambescia and Weeks, 2015).

*Premature ejaculation*

Premature ejaculation is diagnosed when there is marked difficulty in delaying ejaculation beyond a very brief interval during coitus. For premature ejaculation, Masters and Johnson (1970) developed a couple-based sex therapy programme which includes the stop-start and squeeze techniques. In this programme, each time ejaculation is immanent, couples cease intercourse and squeeze the base of the penis to prevent ejaculation. Once the impulse to ejaculate is controlled, intercourse is resumed, until ejaculation is again immanent, and the procedure is repeated. This procedure is practised over a number of weeks during which couples attend therapy sessions to receive psychoeducation, review progress, and fine-tune the homework intervention. Narrative reviews of research on the treatment of premature ejaculation converge on the following conclusions (Althof *et al*., 2014; Bailey and Trost, 2014; Segraves, 2015). For premature ejaculation, the current treatment of choice is multimodal

intervention which includes couple-based sex therapy that involves the stop-start and squeeze techniques combined with selective serotonin reuptake inhibitors (SSRI). Multimodal programmes are more effective than either pharmacological or psychosocial interventions alone. Uncontrolled trials show that most cases benefit from couple-based sex therapy programmes alone, but positive outcomes decline significantly at follow up. Topical creams which contain anaesthetic agents may also be used to increase ejaculatory latency.

*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.

*Service implications for psychosexual problems*

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 ten sessions) over three months, with the intensity of input matched to couples' needs, especially where there is comorbid relationship distress.

## Intimate partner violence

Intimate partner violence refers to physical and sexual violence by an intimate partner. It subsumes cases of 'domestic violence' and 'wife battering'. Distinctions are made between mild-to-moderate situational, and severe characterological intimate partner violence. The former refers to transient, context-dependent aggression, and the latter to a persistent violence (Armenti and Babcock, 2016). Methodologically robust surveys show that intimate partner violence is not exclusively a male-to-female process. Reviews of international epidemiological data show that about 12 per cent of men and women

engage in intimate partner physical violence, and in about 4 per cent of cases severe violence occurs (Esquivel-Santoveña and Dixon, 2012; Langhinrichsen-Rohling *et al*., 2012). Most, but not all, victims of intimate partner violence are female, and the lifetime global prevalence of intimate partner physical or sexual violence against women is 30 per cent (Devries *et al*., 2013). 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 situational intimate partner violence are couple-based; and effective programmes address both violence and substance use which often contributes significantly to violence (Armenti and Babcock, 2016; Barner and Carney, 2011; Karakurt *et al*., 2016; Murphy and Ting, 2010a,b; O'Farrell and Clements, 2012; Stith *et al*., 2012; Stover *et al*., 2009). In a meta-analysis of six studies, Karakurt *et al*. (2016) found that couple therapy was more effective than alternative interventions for mild-to-moderate situational intimate partner violence, with an effect size of 0.84. Karakurt included studies of psychoeducational, behavioural, and solution-focused couple therapy in this meta-analysis. The results indicate that the average case treated with these types of couple therapy fared better after treatment than 80 per cent of those in alternative treatments. Thus, couple therapy is appropriate for treating relatively mild-to-moderate situational intimate partner violence and preventing it from escalating into severe violence. It is not appropriate for severe characterological intimate partner violence. To safely offer couple therapy partners must agree to a no-harm contract, and commit to work together for the duration of treatment which is usually about three to six months.

There is empirical support for behavioural (Fal-Stewart *et al*., 2009), cognitive behavioural (Epstein *et al*., 2015), and solution-focused (Stith *et al*., 2011) couple therapy programmes for intimate partner violence. In behavioural couple therapy for intimate partner violence and alcohol problems, 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 of couples with alcohol and intimate partner violence problems, O'Farrell and Clements (2012) concluded that behavioural

couple therapy halves the rate of intimate partner violence and significantly reduces alcohol problems.

The couples abuse prevention programme is a cognitive behavioural couple therapy programme involving ten ninety-minute conjoint weekly sessions for couples with mild-to-moderate intimate partner violence (Epstein *et al*., 2015). The programme includes a preliminary no-violence contract, psychoeducation, anger management training, cognitive restructuring to modify beliefs, attributions and expectations that contribute to aggression, problem-solving training, and strategies to help couples recover from previous episodes of intimate partner violence. In a randomized controlled trial comparing the cognitive behavioural couples abuse prevention programme with other systemic conjoint couple therapy approaches, both treatments led to a significant decrease in intimate partner violence and improvements in couple functioning and partner wellbeing (Hrapczynski *et al*., 2012; Kahn *et al*., 2015; LaTaillade *et al*., 2006).

Domestic violence focused couple treatment is an eighteen-week solution-focused couple therapy programme (Stith *et al*., 2011). It is facilitated by a team of two co-therapists and may be offered to single couples or in a multicouple group format. For the first six weeks partners are seen separately, with separate therapists 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 for 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. 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 were effective, multi-couple therapy was more effective. Male violence recidivism

rates were 25 per cent for those treated in a multi-couple format, and 43 per cent for those treated in an individual couple format.

This review suggests that in developing services for couples within which intimate partner 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 three to six months of weekly sessions, with a specific focus on violence and alcohol and substance use reduction, should be offered.

## Disorders where anxiety is a central feature

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 per cent, for OCD is 2–3 per cent, and for PTSD is 1–2 per cent in Western Europe, 6–9 per cent in North America and over 10 per cent in countries where there is sectarian violence (Kessler *et al*., 2010). (Lifetime prevalence is the proportion of a population that at some point in their life (up to the time of assessment) have experienced a condition.) Although some people with these disorders respond to serotonin reuptake inhibitors (SSIRs), 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 (Dougherty *et al*., 2015; Golier *et al*., 2015; Kimmel *et al*., 2015). 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 consistently 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 apparently 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 twelve 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 per cent 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.

These conclusions are consistent with those of another recent review (Baucom *et al*., 2015). 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 accommodating to them or engaging in conflict about them, and these processes may lead to significant relationship distress (Thompson-Hollands *et al.*, 2014). The aim of family-inclusive treatment for OCD is to reduce the extent to which family members accommodate to compulsive rituals, and enlist their aid in helping the person with OCD overcome their obsessions and compulsions.

In a meta-analysis of twenty-nine studies of adults or children with OCD, Thompson-Hollands *et al.* (2014) found that family-inclusive treatments were exceptionally effective. There were twelve controlled studies in this meta-analysis and the remainder were single group studies. Family-inclusive treatments led to large effect sizes in analyses examining changes in OCD symptoms and global functioning from pre- to post-treatment, and in post-treatment comparisons of groups treated with systemic therapy and control groups. The post-treatment between groups effect sizes were 1.45 for OCD symptoms and 1.21 for global functioning. Thus, after treatment the average treated case fared better on measures of symptoms than 93 per cent of cases in control groups, and fared better on global functioning than 89 per cent of control group cases. Gains made after treatment were sustained at follow up. Adults and children had similar outcomes. Longer treatments led to greater improvement in OCD symptoms. Individual family, rather than multi-family therapy led to greater improvement. Interventions that specifically aimed to reduce family accommodation to OCD symptoms led to greater improvement in global functioning. These results are consistent with those of other narrative reviews, which concluded that systemic interventions are as effective, or in some instances more effective, than individually based cognitive behaviour therapy for adults with OCD (Baucom *et al.*, 2014; Fisher *et al.*, 2016; Pinquart *et al.*, 2016; Renshaw *et al.*, 2005). 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 nightmares); intense anxiety in response to these memories; ongoing hyperarousal in anticipation of their recurrence; 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). Because they anticipate the recurrence of traumatic memories, people with PTSD experience chronic hyperarousal which may lead to uncontrolled anger, difficulty concentrating, hypervigilance, and sleep difficulties. There may also be feelings of guilt or shame for having survived the trauma, beliefs that the world is unsafe, a loss of trust in others, loss of interest in sex and low mood. Attempts to suppress traumatic memories may lead, paradoxically, to an increase in the frequency and intensity of flashbacks, panic attacks and violent outbursts. However, in chronic cases, suppression of trauma-related memories may lead to amnesia for traumatic memories and emotional numbing. PTSD is associated with significant relationship distress, intimate partner violence and family relationships problems (Birkley *et al*., 2016; Lambert *et al*., 2012; 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 relationship satisfaction.

*Cognitive behavioural couple therapy.* In a narrative review, Monson *et al*. (2015) identified one controlled and three uncontrolled trials which indicated that conjoint couple cognitive behaviour therapy led to significant improvements in PTSD symptoms. In the controlled trial, compared with a waiting-list control group, there was a significant reduction in PTSD symptoms and increased relationship satisfaction and post-traumatic growth for those who engaged in fifteen sessions

of cognitive behavioural couple therapy (Macdonald *et al*., 2016; Monson *et al*., 2012; Wagner *et al*., 2016). Conjoint cognitive behavioural couple therapy involved a preliminary phase of psychoeducation about PTSD and development of couple safety routines for managing anger. In the middle phase, key issues were communication and problem-solving skills training and facilitating 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 intimacy (Monson *et al*., 2015).

*Emotionally focused couple therapy.* In a narrative review, Wiebe and Johnson (2016) identified one controlled and two uncontrolled trials which evaluated the effects of emotionally focused couple therapy on post-traumatic symptoms and relationship distress. In the controlled trial which involved couples in which one partner had post-traumatic symptoms arising from child sexual abuse, Dalton *et al*. (2013) found that compared with waiting-list controls, those who engaged in emotionally focused couple therapy showed a significant reduction in relationship distress, but not trauma symptoms. Two open trials involving 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 increased relationship satisfaction. In these trials, emotionally focused couple therapy involved up to thirty sessions. It progressed through three stages. In the initial 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 response to each other's attachment needs were facilitated. This involved partners expressing and responding to the sense of hurt, betrayal, anxiety, anger and avoidance of closeness associated with prior trauma. In the closing phase, more adaptive patterns of attachment behaviour were consolidated (Johnson, 2015).

*Service implications for disorders where anxiety is a central feature*

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 fifteen to thirty

sessions, depending on client need. In cases that do not respond to systemic therapy, a multimodal programme involving systemic therapy and SSRIs may be appropriate (Dougherty *et al*., 2015; Golier *et al*., 2015; Kimmel *et al*., 2015).

## Disorders where mood disturbance is a central feature

Effective family-based treatments have been developed for major depressive 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 per cent and of bipolar disorder was 2.3 per cent (Kessler *et al*., 2012).

### *Depression*

Major depressive disorder is an episodic condition characterized by low or irritable mood, loss of interest in normal activities, and most of the following symptoms: sleep and appetite disturbance, psychomotor agitation or retardation, fatigue, low self-esteem, inappropriate excessive guilt, pessimism, impaired concentration; and suicidal ideation (American Psychiatric Association, 2013; World Health Organization, 1992). Episodes may last from a few weeks to a number of months and recur periodically over the lifecycle with inter-episode intervals varying from a few months to a number of years. Depressive episodes occur and persist when genetically vulnerable individuals become involved in stressful social systems in which there is limited access to socially supportive relationships, and in which they erode the quality of support available to them through depressive behaviour (Gotlib and Hammen, 2014; Hollon and Sexton, 2012; Whisman and Beach, 2015). Systemic interventions aim to reduce relationship distress 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 (Prendes-Alvarez *et al*., 2015). Also, in the year following treatment, relapse rates following pharmacotherapy are about double those of relapse rates following psychotherapy (Bockting *et al*., 2015).

Narrative reviews and a meta-analysis of controlled trials support six main conclusions about the treatment of depression with systemic therapy (Barbato and D'Avanzo, 2008; Beach and Whisman, 2012;

Stahl *et al*., 2016; Whisman *et al*., 2012; Whisman and Beach, 2015). 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 cognitive behaviour therapy (widely considered to be the treatment of choice) are equally effective. Fourth, for those with relationship distress, couple therapy leads to greater improvements in relationship satisfaction than individual cognitive behaviour therapy. Fifth, for older adults couple and family interventions decrease depressive symptoms. Sixth, a range of couple and family-based interventions effectively alleviate depression. These include systemic couple therapy (Hewson *et al*., 2014; 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; Whisman and Beach, 2015), 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); behavioural family therapy for families of depressed mothers of children with disruptive behaviour disorders (Sanders and McFarland, 2000); and various types of individual family and multifamily therapy for older adults with depression (Stahl *et al*., 2016). All of these approaches to couple and family therapy require about twenty conjoint therapy sessions and focus on both relationship enhancement and mood management. They also involve a staged approach to addressing mood and relationship issues (Beach and Whisman, 2012). In the initial phase, the focus is on psychoeducation, 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 of 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 (Muralidharan *et al*., 2015). The primary treatment for bipolar disorder is pharmacological. It involves initial treatment of acute manic or depressive episodes, and subsequent prevention of further episodes with mood stabilizing medication such as lithium (Keck and McElroy, 2015). The main aim of systemic therapy is to reduce relapse and rehospitalization rates, and increase quality of life. This is achieved 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 has significant positive effects on individuals with bipolar disorder and members of their families (Muralidharan *et al*., 2015; Reinares *et al*., 2016). For individuals with bipolar disorder, these positive effects include improved medication adherence, reduced relapse rate, reduced rehospitalization rate, improved quality of life, and improved family relationships. For family members with bipolar relatives, positive effects include increased knowledge about bipolar disorder and decreased carer burden. Miklowitz's (2008) family focused therapy is a systemic intervention with a particularly strong evidence base. It usually involves twenty-one conjoint family sessions and includes psychoeducation, communication and problem-solving skills training, and relapse prevention.

*Service implications for disorders where mood disturbance is a central feature*

From this review it may be concluded that effective systemic therapy for depression and bipolar disorder usually spans about twenty sessions. Systemic services for these 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 depression and bipolar disorder, services should adopt a chronic care model which includes procedures for re-referral and early intervention when relapses occur.

## Alcohol problems

Harmful alcohol use constitutes a significant mental health problem, particularly in developed countries. In the US, the lifetime prevalence of DSM-5 alcohol use disorder is 29.1 per cent (Grant *et al*., 2015). 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 behavioural couple therapy (McCrady and Epstein, 2015). Wide-ranging narrative reviews by McCrady *et al*. (2016) and 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 (Blonigen *et al*., 2015; Fletcher, 2013; Meis *et al*., 2013; Powers *et al*., 2008; Ruff *et al*., 2010; Templeton *et al*., 2010; Wesley and Chanel, 2016).

### *Community Reinforcement and Family Training*

For helping sober family members promote the engagement of family members with alcohol and drug 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 five controlled trials for families of people with alcohol and drug problems. This approach achieves the goal of helping the person with the alcohol or drug problems engage in treatment by training sober family members in a variety of skills. These include communication skills, and skills for recognizing triggers for alcohol and drug use, positively reinforcing non-alcohol and drug using behaviour, and encouraging sobriety and treatment-seeking in people with alcohol and drug problems. It also helps sober family members

reduce the risk of physical abuse, and 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, McCrady *et al*. (2016) and O'Farrell and Clements (2012) concluded that behavioural couple therapy, in many circumstances, was more effective than other 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 twelve to twenty conjoint sessions of sixty to ninety minutes. It includes alcohol-focused interventions to promote treatment engagement and abstinence, and relationship-focused interventions to increase positive feelings, shared activities, and constructive communication within couples. For the person with the alcohol problem, alcohol-focused interventions may include strategies to promote abstinence such as the use of disulfiram or a sobriety contract, or behavioural strategies to promote controlled drinking, such as self-monitoring and self-management planning. For sober partners, alcohol-focused interventions include training in skills for supporting sobriety and self-care. Relationship-focused interventions include problem-solving and communication skills training and relationship enhancement procedures. Relapse prevention planning is also a central part of behavioural couple therapy for alcohol problems. This type of 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. The evidence base for behavioural couple therapy includes studies of two main treatment protocols developed by McCrady and Epstein (2009) and O' Farrell and Fals-Stewart (2006).

*Social behavioural network therapy*

Social behavioural network therapy, a 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, 2005b). 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).

*Service implications for alcohol problems*

In planning systemic services, this review suggests that therapy for alcohol problems may be offered on an outpatient basis initially over about twelve to twenty 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.

## Psychosis

In ICD-10 (World Health Organization, 1992) and DSM-5 (American Psychiatric Association, 2013) psychosis is an umbrella term that covers a range of conditions including schizophrenia and other schizophrenia spectrum disorders, which share similar symptoms and genetic aetiology with schizophrenia, but vary in duration, severity and the presence of additional mood symptoms. Schizophrenia is characterized by positive symptoms such as delusions and hallucinations; negative symptoms such as diminished affective expression and reduced goal-directed behaviour; and disorganized thinking and behaviour. Although the lifetime prevalence of schizophrenia is under 1 per cent (Saha *et al*., 2005), 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 initial treatment of acute psychotic episodes, and subsequent prevention of further episodes with antipsychotic medication (Abbas and Lieberman, 2015). About 30–40 per cent of medicated clients with schizophrenia relapse within a year, and relapse rates are higher in unsupportive or stressful family environments, characterized by high levels of expressed emotions, notably criticism, hostility or over-involvement (McFarlane, 2016). 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 systematic reviews and meta-analyses involving over 100 studies conducted around the world provide robust support for the effectiveness of psychoeducational family therapy (as one element of a multimodal programme which includes antipsychotic medication) in the treatment of schizophrenia (Claxton *et al*., 2017; Dixon *et al*., 2000; 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; Xia *et al*., 2011). Compared with medication alone, multimodal programmes which include psychoeducational family therapy and antipsychotic medication improve medication adherence and lead to lower relapse and rehospitalization rates, with longer programmes being more effective than shorter ones. For example, in a review of meta-analyses, McFarlene (2016) concluded that psychoeducational family therapy reduced relapse rates by 50–60 per cent compared with routine treatment. The relapse rate with routine treatment is 30–40 per cent, whereas the relapse rate when psychoeducational family therapy is added to routine treatment is about 15 per cent. Systematic reviews and meta-analyses show that family intervention for schizophrenia also has positive effects on the adjustment of non-symptomatic family members. It reduces carer burden and negative expressed emotion (Lobban *et al*., 2013; Ma *et al*., 2017; Sin *et al*., 2017).

Psychoeducational family therapy may take a number of formats (McFarlane, 2016). These include conjoint 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 psychosis 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

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 psychoeducation families learn to understand and manage the condition, along with antipsychotic medication, related stresses, early warning signs of relapse, and how to access relevant mental health services. 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 nine to twelve months. They are usually offered in a phased format, with, for example, three months of weekly sessions, three months of fortnightly sessions, three months of monthly sessions, followed by three monthly reviews and crisis intervention as required.

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

## Chronic physical illness

With chronic illnesses such as heart disease, cancer or chronic pain, systemic interventions are offered as one element of multimodal programmes involving medical care (Hodgson *et al*., 2014; 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 psychoeducation about the chronic illness and its management. They also offer a context within which to enhance support for the person with the chronic illness, and other family members. They provide, in addition, a forum for exploring ways of coping with the condition, and its impact on family relationships. In a meta-analysis of fifty-two randomized controlled trials with a range of conditions including cardiovascular disease, stroke, cancer, and chronic pain conditions such as 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 patients and other family members compared with routine care. 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 better than 61–64 per cent of cases who received 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 exclusively educational interventions. These conclusions are consistent with those of other reviews of studies of systemic interventions for families of individuals with a wide variety of medical conditions (Baucom *et al*., 2012; Campbell and Patterson, 1995; Martire, 2004; Reed and Harding, 2015), and for reviews focusing exclusively on cancer (Badr and Krebs, 2013; Baik and Adams, 2011; Brandão *et al*., 2014; Carroll *et al*., 2016; Hopkinson *et al*., 2012; Li and Loke, 2014; Northouse *et al*., 2010; Wang *et al*., 2017) and HIV/AIDS (Crepas *et al*., 2015; Jiwatram-Negrón and El-Bassel, 2014). These findings suggest that systemic services for people with chronic illnesses deserve development as part of multimodal programmes for people with such conditions.

## Discussion

The evidence base for systemic therapy for adult-focused problems has grown since the previous version of this review (Carr, 2014). Greatest growth has occurred in medical family therapy, and there has been incremental growth in most other areas. The following conclusions may be drawn from this review. First, 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, treatment manuals have been developed for many of these interventions which may be flexibly used in regular treatment settings. Fourth, it is probable that the evidence-based practices described in this paper are somewhat less effective when used in regular treatment settings by busy therapists, who receive limited supervision, and carry large caseloads 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, and receive intensive supervision. Clearly, an important future research priority is to conduct treatment effectiveness trials in which evidence-based practices are evaluated in regular treatment settings. 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). These should be a priority for future research. Sixth, the contribution of common factors (such as the therapeutic alliance) and specific factors (such as techniques specified in protocols) to outcome has rarely been investigated (Davis *et al*., 2012). Future trials should be designed to address this issue. 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 exceptions (Leff *et al*., 2000). More research is required on social-constructionist and narrative approaches to systemic practice, which are widely practised. Eighth, for some adult-focused problems such as psychosis 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 regular clinical settings, 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, there is little evidence on the conditions under which systemic therapy is not effective for the adult-focused mental health problems covered in the paper. Therefore, it is probably appropriate to use evidence-based systemic interventions described in this paper when family members are available and willing to engage in therapy.

The results of this review are consistent with those of reviews that take a narrow definition of systemic therapy and exclude some of the family-based interventions covered in this paper (e.g. Baucon *et al*., 2012; Pinquart *et al*., 2016; Sexton *et al*., 2013; Stratton, 2016; Stratton *et al*., 2015; von Sydow *et al*., 2010). Our conclusions are more optimistic than those of reviewers who have used more

stringent methodological criteria for making decisions about programme effectiveness (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 National Institute for Health and Care Excellence (NICE) and other guidelines for a range of adult mental health problems including OCD (NICE, 2005a), depression (NICE, 2016), bipolar disorder (NICE, 2017), alcohol problems (NICE, 2011a), and schizophrenia (Dixon *et al*., 2010; NICE, 2014). In contrast, the efficacy 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 main limitation of the current paper is that it is not a systematic review. Rather, it is a narrative review, mainly of other reviews and meta-analyses. It is therefore subject to biases, especially positive biases, of both its author and those of the authors of narrative reviews which it covers. It is therefore difficult to state definitively the extent to which author biases affected our conclusions about the degree to which systemic therapy is effective.

## Conclusion

Our findings have clear implications for training and practice. Family therapy training programmes should include coaching in evidence-based practices in their curricula. This position is endorsed in UK and US statements of core competencies for systemic therapists (Northey, 2011; Stratton *et al*., 2011). When planning their own continuing professional development, family therapists should make learning evidence-based practices, relevant to the client group with whom they work, a priority. Experienced therapists 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 (Carr, 2012). To facilitate this, a list of accessible treatment manuals is included at the end of this and the accompanying paper (Carr, 2018).

## Treatment resources

Gurman, A. S., Lebow, J. L. and Snyder, D. K. (eds) (2015) *Clinical handbook of couple therapy* (5th ed.). New York: Guilford.

Snyder, D. and Whisman, M. (eds) (2003) *Treating difficult couples. Helping clients with coexisting mental and relationship disorders*. New York: Guilford.

## Relationship distress

Christensen, A. and Jacobson, N. (2000) *Reconcilable differences*. New York: Guilford. (For clients)

Epstein, N. and Baucom, D. (2002) *Enhanced cognitive-behavioural therapy for couples: a contextual approach*. Washington, DC: American Psychological Association.

Jacobson, N. and Christensen, A. (1998) *Acceptance and change in couple therapy: a therapist's guide to transforming relationships*. New York: Norton.

Johnson, S. (2004) *The practice of emotionally focused couple therapy: creating connection* (2nd ed.). New York: Guilford.

Johnson, S. M. (2008) *Hold me tight: seven conversations for a lifetime of love*. New York: Little Brown. (For clients)

## Psychosexual problems

Binik, Y. and Hall, K. (2014) *Principles and practice of sex therapy* (5th ed.). New York: Guilford.

Hertlin, K., Weeks, G. and Gambescia, N. (2015) *Systemic sex therapy* (2nd ed.). New York: Routledge.

Weeks, G., Gambescia, N. and Hertlin, K. (2016) *A clinician's guide to systemic sex therapy* (2nd ed.). New York: Routledge.

## Intimate partner violence

Stith, S., McCollum, E. and Rosen, K (2011) *Couples therapy for domestic violence. Finding safe solutions*. Washington, DC: American Psychological Association.

## Anxiety disorders

Baucom, D., Stanton, S. and Epstein, N. (2003) Anxiety disorders. In D. Snyder and M. Whisman (eds) *Treating difficult couples. Helping clients with coexisting mental and relationship disorders* (pp. 57–87). New York: Guilford.

## PTSD

Johnson, S. (2002) *Emotionally focused couple therapy with trauma survivors: strengthening attachment bonds*. New York: Guilford.

Monson, C. M. and Fredman, S. J. (2012) *Cognitive-behavioural conjoint therapy for PTSD: harnessing the healing power of relationships*. New York: Guilford Press.

## Mood disorders

Beach, S., Sandeen, E. and O'Leary, K. (1990) *Depression in marriage: a model for aetiology and treatment*. New York: Guilford Press.

Hewison, D., Clulow, C. and Drake, H. (2014) *Couple therapy for depression: a clinician's guide to integrative practice*. Oxford: Oxford University Press.

Jones, E. and Asen, E. (1999) *Systemic couples therapy for depression*. London: Karnac.

Milkowitz, D. (2008) *Bipolar disorder: a family-focused treatment approach* (2nd ed.). New York: Guilford.

## Alcohol problems

Copello, A., Orford, J., Hodgson, R. and Tober, G. (2009) *Social behaviour and network for alcohol problems*. London: Routledge.

McCrady, B. S. and Epstein, E. E. (2009) *Overcoming alcohol problems: a couples-focused program*. New York: Oxford University Press.

McCrady, B. S. and Epstein, E. E. (2009) *Overcoming alcohol problems: workbook for couples*. New York: Oxford University Press. (For clients)

Meyers, R. and Wolfe, B. (2004) *Get your loved one sober: alternatives to nagging, pleading, and threatening*. Centre City, MN: Hazelden. (For clients).

O'Farrell, T. and Fals-Stewart. W. (2006) *Behavioural couples therapy for alcoholism and substance abuse*. New York: Guilford.

Smith, J. and Meyers, R. (2004) *Motivating substance abusers to enter treatment. Working with family members*. New York: Guilford.

## Schizophrenia

Falloon, I., Laporta, M., Fadden, G. and Graham-Hole, V. (1993) *Managing stress in families*. London: Routledge.

Kuipers, E., Leff, J. and Lam, D. (2002) *Family work for schizophrenia* (2nd ed.). London: Gaskell.

Leff, J. (2005) *Advanced family work for schizophrenia*. London: Gaskell.

McFarlane, W. (2004) *Multifamily groups in the treatment of severe psychiatric disorders*. New York: Guilford.

## Chronic physical illness

Hodgson, J., Lamson, A., Mendenhall, T. and Crane, R. (eds) (2014) *Medical family therapy: advanced applications*. New York, NY: Springer.

McDaniel, S., Hepworth, J. and Doherty, W. (2013) *Medical family therapy and integrated care* (2nd ed.). Washington, DC: American Psychological Association.

Rolland, J. (1994) *Families, illness, and disability: an integrative treatment model*. New York: Basic Books.

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