Australian & New Zealand Journal of Family Therapy

Australian and New Zealand Journal of Family Therapy 2016, **37**, 37–55
doi: 10.1002/anzf.1135

How and Why Do Family and Systemic Therapies Work?*

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My reviews of the evidence base for family therapy conducted over the past 15 years have been guided by four key questions. Does systemic therapy work? What sorts of systemic therapy work for specific problems? What processes occur in effective systemic therapy? Is systemic therapy cost-effective? In this paper answers to these questions are given. Systemic interventions are effective for about two out of three cases. Specific models of effective systemic therapy have been developed for most common mental health problems. There are many processes shared by evidence-based models of practice that can be incorporated into the routine practice of research-informed family therapy. Systemic therapy is cost-effective and in many cases leads to medical cost-offsets. Available evidence indicates that family therapy can make a very significant contribution to alleviating suffering and making the world a better place to be.

Keywords: systemic therapy research, family therapy research, couple therapy research

Key Points

1. The evidence indicates that two out of three cases improve with systemic therapy.
2. Specific models of systemic therapy work for most common mental health problems.
3. There are many processes common to evidence-based models of practice that can be incorporated into the routine practice of research-informed family therapy.
4. Systemic therapy is cost-effective and saves health services and governments money!

The ideas in this presentation are based on extensive literature reviews which I published in two books (Carr, 2000a, 2009a) and a major Irish report on psychotherapy effectiveness (Carr, 2007); six JFT papers (Carr, 2000b, 2000c, 2009b, 2009c, 2014a, 2014b); and chapters in three editions of my family therapy textbook (Carr, 2000d, 2006, 2012). In these reviews, I asked four broad questions:

1. Question 1 – Does systemic therapy work?
2. Question 2 – What sort of systemic therapy works for specific problems?
3. Question 3 – What processes occur in effective systemic therapy?
4. Question 4 – Is systemic therapy cost-effective?

What follow are the answers I have found to these important questions.

Question 1 – Does Systemic Therapy Work?

Family therapy, like medicine, was originally founded on case studies. Increasingly, medicine, and in its wake, family therapy, has moved from case studies to stronger

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*This paper was presented as a keynote address at the 36th Annual Australian Association for Family Therapy Conference, Jasper Hotel, Melbourne, Australia, 6–7 November 2015.

forms of scientific evidence as a basis for practice. The founder of evidence-based medicine (EBM), David Sackett (1934–2105), said that EBM is the judicious and compassionate use of the best available scientific evidence to make decisions about patient care (Sackett et al., 2000). Similarly in the family therapy field we can say that evidence-based practice in systemic therapy involves taking account of available scientific evidence about 'what works' on the one hand, and clients' unique problems, needs, rights and preferences on the other, and making balanced compassionate judgements.

Hierarchy of evidence

When we talk about taking account of scientific evidence in the field of systemic therapy, it is important to note that not all evidence is of equal value. Some forms of evidence are more valid than others. There is a hierarchy of evidence that runs from uncontrolled case studies, through single group outcome studies, controlled single case experiments, non-randomised and randomised controlled trials, and narrative reviews of evaluation studies to meta-analyses of controlled trials.

Randomised controlled trials

In this hierarchy randomised controlled trials (RCTs) occupy a very special place, because they attempt to offer an unbiased evaluation of the efficacy or effectiveness of treatments such as family therapy (Arean & Chmura Kraemer, 2013; Schulz, Altman, & Moher, 2010). An RCT is an experimental design used for evaluating the effect of one treatment compared with another, or to a no-treatment control group. Usually similar cases are randomised to treatment and control or comparison conditions, and assessed before and after treatment, and in some trials on a later follow-up occasion. In RCTs the chances of biased results are reduced by randomly assigning cases to groups and by using reliable and valid instruments to assess outcome. In systemic therapy questionnaires or rating scales are commonly used assessment instruments. In RCTs conducting pre- and post-treatment assessments, as well as follow-up evaluations, allows researchers to determine if the treated group improved more than the control or comparison group from pre-treatment to post-treatment, and if improvements that occurred immediately after treatment were maintained when the later follow-up assessment was conducted. In RCTs usually therapists have fairly small caseloads; follow treatment guidelines given in a manual; receive regular supervision; and their therapy practice is monitored to make sure that they are implementing the treatment model with a high degree of fidelity. These procedures are used to make sure that clients in RCTs are getting a 'pure and potent' dose of therapy as defined by the developers of the therapy model.

A couple of classic studies conducted at Kings College London illustrate how useful results from RCTs of systemic therapy are to practicing clinicians. In a five-year follow-up RCT, Ivan Eisler and his team found that for young adolescents with non-chronic anorexia nervosa, family therapy led to greater recovery rates than individual therapy (Eisler et al., 1997). In a two-year follow-up RCT, Julian Leff and his team found that for adults with chronic depression, systemic couple therapy was far more effective than antidepressant medication (Leff et al., 2000). These two RCTs tell us that systemic interventions are more effective than individual therapy for adolescent anorexia, and antidepressants for chronic depression in adults.

Meta-analysis

In the hierarchy of evidence supporting the effectiveness of systemic therapy, meta-analysis is arguably the strongest type of evidence. Meta-analysis is a method for combining the results of many RCTs and making statements about the evidence for systemic therapy based on many studies including hundreds of families (Cooper, Hedges, & Valentine, 2009; Moher et al., 2009). Results of trials are first converted to effect sizes, and then averaged. Since the early 1990s William Shadish has conducted the most influential meta-analyses of couple and family therapy (e.g., Shadish & Baldwin, 2003; Shadish et al., 1993). In a ground-breaking first major meta-analysis of 163 trials of couple and family therapy involving thousands of cases, he concluded that the average treated case fared better after treatment than 73% of cases in control groups, and this is equivalent to a treatment success rate of 65% (Shadish et al., 1993).

Answer to Question 1 – Does systemic therapy work?

In my reviews of the evidence for systemic therapy, I have selected papers that were as high up the hierarchy of evidence as possible. In practical terms this means that my reviews tend to be a review of meta-analyses and narrative reviews with occasional references to illustrative seminal RCTs. These reviews have indicated how effective family and couple therapy alone or in combination with medication is for a range of child and adult-focused problems. They have allowed me to answer the first major question mentioned earlier – Does systemic therapy work? – with a considerable confidence. The evidence indicates that two out of three cases improve with systemic therapy. In comparison only one out of three cases improves without systemic therapy due to the passage of time. A further critical finding is that about one in 10 cases deteriorate with systemic therapy.

What can we tell clients about the effectiveness of systemic therapy?

These research findings have important implications for practice. They let us know what we can tell clients to expect when they attend systemic therapy for help with common child and adult-focused problems. We can say, 'Family therapy helps about two out of three families with problems like yours. You will know after about six to 10 sessions if family therapy is likely to help you. You may wish to give therapy a trial for six to 10 sessions and review progress at that stage.'

I have also reviewed much of the literature of process research in individual therapy (Carr, 2009a). This allows us to add the following to our initial statements to clients about the relevance of research on the effectiveness of family therapy to their situation: 'There are a number of things about your family that make me hopeful that you may benefit from family therapy. You are motivated to come to treatment. You care about each other. You are psychologically minded, and think that the sorts of challenges you face can be improved by understanding your situation better and planning to handle your problems differently.' If relevant you may add, 'You have used therapy to sort out problems before.'

Turning now to the possible consequence of not attending therapy we may say, 'About one out of three families sort out their problems without therapy. You may wish to see if over the next couple of months you can sort out your difficulties yourselves, and if this doesn't work out recontact us.'

You may wish to conclude by letting clients know about the downside of therapy. You may say that 'about one out of 10 families deteriorates with systemic therapy.

This is usually because they have been avoiding talking about challenging issues. When they start to do this in therapy, they feel distress and leave treatment before they have had a chance to sort out the things they have been avoiding. You may wish to "keep the lid" on your problems at the moment, until you are ready to tolerate the distress you may experience when you talk openly about them in family therapy.'

Question 2 – What Sort of Systemic Therapy Works for Specific Problems?

To answer this question searches were conducted for meta-analyses, systematic reviews, and RCTs of the effectiveness of systemic therapy for particular child and adult-focused problems. Both computer and manual searches were conducted. In the computer searches we searched databases such as PsychINFO and MEDLINE using terms to describe child and adult-focused problems such as 'depression' or 'drug use,' combined with terms to describe systemic interventions such as 'family therapy' or 'couple therapy.' In manual searches we searched the tables of contents and, where appropriate, lists of references of major family therapy academic journals, textbooks, and edited handbooks. We also consulted reference lists of relevant practice guidelines, for example, UK NICE guidelines for conditions such as eating disorders and schizophrenia (https://www.nice.org.uk/guidance). In Carr (2009a), the searches cover the period from 1950 to 2008. The searches extend to July 2013 in the two most recent JFT papers (Carr, 2014a, 2014b).

In selecting papers for inclusion in the evidence base a broad definition of systemic therapy was taken. Papers on the following were included: couple and family therapy based on a range of theoretical models (e.g., systemic, cognitive behavioural, psychoeducational, psychodynamic/attachment-based); interventions into broader systems than the family (e.g., multisystemic and multidimensional intervention programs); and interventions into narrower systems than the family (e.g., parent training, and psychoeducational interventions for carers of family members with medical conditions such as diabetes, chronic pan, heart disease, and cancer). Papers on the following were excluded: individual interventions with an individual focus such as supportive home visiting for vulnerable young mothers; and complex multisystemic clinical and educational 'care packages' for families of people with intellectual or developmental disabilities, or disadvantaged families.

Meta-analyses, systematic reviews, and illustrative seminal RCTs of the effectiveness of systemic interventions, and relevant process studies for particular child and adult-focused problems identified in these searches were used to write statements about evidence-based systemic practice. These statements outlined key aspects of practice and cited publications which gave detailed descriptions of interventions.

Answer to Question 2 – What sort of systemic therapy works for specific problems?

We found that there was evidence for the effectiveness of specific systemic interventions with the child and adult-focused problems listed below.

Child and adult-focused problems for which systemic therapy is effective. For both young people and adults there was evidence for the effectiveness of systemic interventions with alcohol and drug problems, mood disorders, anxiety disorders, psychosis, and adjustment to illness and disability.

Drug and alcohol problems—Functional family therapy (Alexander, Waldron, Robbins, & Neeb, 2013; Sexton, 2011, 2015), multidimensional family therapy (Liddle, 2002, 2015), multisystemic therapy (Henggeler et al., 2009; Schoenwald, Henggeler, & Rowland, 2015) and brief strategic family therapy (Szapocznik et al., 2015; Szapocznik, Hervis, & Schwartz, 2002) were effective for adolescent drug problems. Behavioural couple therapy was effective for adults with alcohol problems (McCrady & Epstein, 2015a, 2015b; O'Farrell & Fals-Stewart, 2006).

Depression—Attachment-based family therapy (Diamond, Diamond, & Levy, 2013), family-based cognitive behaviour therapy (Stark, Streusand, Krumholz, & Patel, 2010), family-based interpersonal therapy (Jacobson & Mufson, 2010), and concurrent attendance of adolescents and parents on the Coping with Depression program (Clark & DeBar, 2010) were effective for depression in adolescents. Behavioural couple therapy (Beach, Sandeen, & O'Leary, 1990; Whisman & Beach, 2015), emotionally focused couple therapy (Johnson, 2004, 2015; Johnson & Brubacher, 2015), systemic couple therapy (Jones & Asen, 1999), and conjoint interpersonal therapy (Foley et al., 1989; Weissman, Markowitz, & Klerman, 2000) were effective for depression in adults.

Bipolar disorder—Family-focused therapy (combined with mood stabilizing medication such as lithium carbonate) was effective for adolescents and adults with bipolar disorder (Milkowitz, 2008).

Anxiety disorders—Family involvement in the treatment of anxiety disorders in children and adults was found to be effective (Baucom, Stanton, & Epstein, 2003; Creswell & Cartwright-Hatton, 2007; Drake & Ginsburg, 2012). Specifically, parent- or partner-assisted cognitive behaviour therapy was effective for separation anxiety disorder (Heyne & Sauter, 2013; Kearney & Albano, 2007), panic disorder with agoraphobia (Byrne, Carr, & Clarke, 2004a), post-traumatic stress disorder (Deblinger & Heflinger, 1996; Leenarts et al., 2012; Monson & Fredman, 2015) and obsessive compulsive disorder (Moore, Franklin, Freeman, & March, 2013; Renshaw, Steketee, & Chambless, 2005).

Psychosis—Psychoeducational family therapy was found to help improve adjustment and delay relapse in adolescents and adults with psychosis who were being treated with antipsychotic medication (Kuipers, Leff & Lam, 2002; McFarlane, 2004, 2015).

Physical illness and disability—Psychoeducational family therapy, as an adjunct to medical care, was found to improve adjustment in children and adolescents with asthma and diabetes, and adults with chronic pain, heart disease, and cancer (Brinkley, Cullen, & Carr, 2002; Hood, Rohan, Peterson, & Drotar, 2010; McDaniel, Hepworth, & Doherty, 2013; Rolland, 1994; Ruddy & McDaniel, 2015).

Child-focused problems for which systemic therapy is effective. We found evidence for the effectiveness of systemic interventions for the following problems in young people (but not adults): sleep and feeding problems in infancy, attachment problems in infancy, elimination disorders, aspects of child abuse, disruptive behaviour disorders, and eating disorders.

Sleep and feeding problems in infancy—Family-based behavioural program were found to be effective for sleep (Mindell et al., 2006; Mindell & Owens, 2009) and feeding problems in infancy (Kedesdy & Budd, 1998; Sharp, Jaquess, Morton, & Herzinger, 2010).

Attachment problems in infancy—Mother–child interventions with intensity matched to family vulnerability were found to be effective for attachment problems in infancy (Berlin & Ziv, 2005; Zeanah, Berlin, & Boris, 2011).

Elimination disorders—Family-based urine alarm program were effective for enuresis (Glazener, Evans, & Peto, 2009; Houts, 2010). Family-based behavioural program with paediatric input were effective for encopresis (Buchanan, 1992; McGrath, Mellon, & Murphy, 2000).

Child abuse—Multisystemic therapy (Brunk, Henggeler, & Whelan, 1987; Henggeler et al., 2009) and family-based cognitive behaviour therapy were found to be effective for physical abuse and neglect (Kolko & Swenson, 2002; Rynyon & Deblinger, 2013). Trauma-focused cognitive behaviour therapy involving the child and non-abusing parent was effective for treating survivors of child sexual abuse (Deblinger & Heflinger, 1996; Leenarts et al., 2012).

Disruptive behaviour disorders—There was evidence for the effectiveness of parent management training for childhood oppositional defiant disorder (Michelson et al., 2013) especially if fathers were included (Lundahl, Tollefson, Risser, & Lovejoy, 2008). Parent management training was also effective for attention deficit hyperactivity disorder, especially if it was combined with stimulant medication (Pfiffner & Haack, 2015). A range of systemic interventions were found to be effective for conduct disorder in adolescence. These included interventions effective for adolescent drug use mentioned above (functional family therapy (Sexton, 2015), multidimensional family therapy (Liddle, 2015), and multisystemic therapy (Schoenwald et al., 2015)) as well as multidimensional treatment foster care (Chamberlain, 2003; Smith & Chamberlain, 2010).

Eating disorders—The Maudsley model of family therapy was found to be effective for both anorexia and bulimia nervosa in adolescents (Eisler, Le Grange, & Lock, 2015; Le Grange & Locke, 2007; Lock & Le Grange, 2013). There was also evidence for the effectiveness of family-based behavioural programmes for obesity in young people (Jelalian, Wember, Bungeroth, & Birmaher, 2007; Nowicka & Flodmark, 2008, 2011).

Adult-focused problems for which systemic therapy is effective. We found evidence for the effectiveness of systemic interventions for relationship distress, psychosexual problems, and intimate partner violence in adults.

Relationship distress—Emotionally focused couple therapy (Johnson, 2004, 2015; Johnson & Brubacher, 2015), traditional behavioural couple therapy (Benson & Christensen, 2015; Jacobson & Margolin, 1979), integrative behavioural couple therapy (Christensen, Dimidjian, & Martell, 2015; Jacobson & Christensen, 1998), cognitive behavioural couple therapy (Baucom et al., 2003, 2015; Epstein & Baucom, 2002)

and insight-oriented couple therapy (Snyder & Mitchell, 2008) were all found to be effective in alleviating couple distress.

Psychosexual problems—Couples-based sex therapy using Masters and Johnson procedures and behavioural techniques were found to be effective for psychosexual problems (Segraves, 2015). These procedures when combined with phosphodiesterase type 5 inhibitor medication were effective for erectile dysfunction.

Intimate partner violence—Solution-focused couple therapy (Stith, McCollum, & Rosen, 2011) and behavioural couple therapy (Fals-Stewart, Klostermann, & Clinton-Sherrod, 2009) were found to be effective for intimate partner violence.

Three examples of evidence-based practices. Psychoeducational family therapy for psychosis, functional family therapy for adolescent conduct problems, and emotionally focused couple therapy for relationship distress will be briefly outlined as illustrative examples of evidence-based systemic practices.

Psychoeducational family therapy for psychosis—In a synthesis of a series of meta-analyses, Pfammatter, Junghan, and Brenner (2006) found that relapse and rehospitalisation rates after 1–2 years are lower when people with psychosis receive psychoeducational family therapy in addition to antipsychotic medication. In a review of 50 studies Lobban et al. (2013) found that family intervention for psychosis had a positive effect on the adjustment of non-symptomatic family members in most studies. In psychoeducational family therapy, therapists may work with single families (e.g., Kuipers et al., 2002); multiple families, or parallel relative and patient groups (e.g., McFarlane, 2004).

Psychoeducation based on the stress-vulnerability model is provided to help people with psychosis and their families understand and manage psychotic symptoms, medication, related stresses, and early warning signs of relapse. Families are helped to use communication skills to reduce criticism and conflict, since research shows that exposure to criticism and conflict is associated with relapse. In addition, families are helped to use problem-solving skills to manage stress. Crisis intervention is provided as required. Finally, family therapy offers a forum for families to talk about the sense of loss associated with the onset of psychosis.

Functional family therapy for adolescent conduct problems—In our recent meta-analysis of 14 studies we found that families of adolescents with conduct problems who engaged in functional family therapy fared better than those in untreated control groups and those who engaged in alternative treatments such as cognitive behaviour therapy, other models of family therapy, and individual and group therapy for adolescents (Hartnett, Carr, & Sexton, in press). In our own recent RCT we found significantly higher clinical recovery rates in cases treated with functional family therapy compared with those in a waiting list control group.

Functional family therapy is based on an ecological multifactorial model of risk and protective factors involved in the development of conduct problems. Therapists meet regularly, usually on a weekly basis for about three or four months, with adolescents and their families in conjoint sessions. There are three distinct phases in treatment: engagement, behaviour change, and generalisation. During the engagement

phase therapists develop a therapeutic alliance with family members and reduce blaming and negativity within the family. In the behaviour change phase they help families develop better parenting practices, communication, and problem-solving skills. In the final phase they help families use these skills independently and generalise progress made within therapy to home and community contexts.

Emotionally focused couple therapy for relationship distress—In a review of seven outcome studies our team found emotionally focused couple therapy led to improvement in over 70% of cases (Byrne, Carr, & Clark, 2004b). In a meta-analysis of 23 studies, Wood, Crane, Schaalje, and Law (2005) found that with moderately distressed couples, emotionally focused couple therapy was more effective than behavioural couple therapy. In this approach it is assumed that in distressed couples partners are anxious that their attachment needs will not be met within their relationship, and this anxiety fuels chronic relationship conflict (Johnson, 2004, 2015). 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 attachment needs; and a closing phase where these more adaptive patterns of attachment behaviour are consolidated.

Question 3 – What Processes Occur in Effective ST?

From a review of the effectiveness of specific models and approaches to family therapy with specific problems, certain processes which are shared by evidence-based practices were identified. These relate to the structure of therapy; the role of the therapeutic alliance; the focus of the therapy contract; the value of models and manuals; practices associated with the engagement phase, middle phase and disengagement phase of treatment; and the importance of measurement. These processes may be incorporated into research-informed family therapy practice. The model in my book – *Family Therapy: Concepts Process and Practice* (Carr, 2000d, 2006, 2012) – is an example of a research-informed approach to the practice of family therapy. What follows are some comments on each of the processes listed above.

Structure of therapy

In research-informed family therapy, therapists and families meet regularly. However, meetings are not confined to conjoint family sessions. Therapists may also meet with family subsystems (e.g., with parents alone, or adolescents alone) or with members of the wider system (e.g., with other involved professionals from health, social services, education, or probation agencies, or the extended family). Therapy is relatively brief spanning 3–6 months and involving 6–20 sessions. Therapy typically progresses through three phases: the engagement phase, the middle phase, and the disengagement phase. Therapy sessions are guided by the five-part session model.

These five parts include: (1) planning (alone or with a team or supervisor), (2) meeting with clients, (3) taking a break from the meeting with clients to review progress and plan an end-of-session intervention, (4) reconvening the meeting with clients to provide feedback and an end-of-session intervention, and (5) reviewing the session (alone, or with a team or a supervisor). Clients are often explicitly invited to

do 'homework' between sessions to continue work that occurred in sessions and facilitate problem resolution.

Therapeutic alliances

In research-informed family therapy, therapists prioritise facilitating strong alliances within the treatment system, and reducing negativity. Therapists facilitate alliances between themselves and family members; between family members; and, where appropriate, between family members and members of the wider system (e.g., other involved professionals from health, social services, education, and probation agencies, and the extended family).

Focus of the therapy

In research-informed family therapy, within the therapy contract, and in subsequent therapy sessions, there is an explicit focus on resolving the main presenting problem, rather than on broader goals such as personal growth, or an unfocused exploration of family issues. Therapy goals are usually explicit and relate directly to the main presenting problem. For example, weight restoration in anorexia; reducing drug or alcohol use where substance use is the main problem; improving mood and activity in depression; decreasing panic and avoidance in anxiety disorders; increasing prosocial behaviour in disruptive behaviour disorders; and so forth.

Models and manuals

In research-informed family therapy, treatment is guided by models of how problems develop and are resolved. These are typically multifactorial models. They may specify the role of a wide range of factors that cause and maintain problems, and that contribute to the resolution of presenting problems. Some models point to ways in which family processes inadvertently maintain presenting problems. However, research-informed family therapy invariably highlights the value of the family as a therapeutic resource. That is, a central position is accorded to the critical role of the family in problem resolution. Technical aspects of therapy are guided by the flexible use of guidelines set out in therapy manuals. Manuals outline principles of practice and specific therapeutic techniques that therapists may use during therapy to help families work towards resolution of presenting problems. The principles of practice and specific therapeutic techniques given in therapy manuals are typically informed by multifactorial models of how presenting problems develop and are resolved.

Engagement phase

There is an old Irish saying, *Tús maith, leath na hoibre*. The literal translation is that a good start is half the work. This is particularly apt in research-informed family therapy, where the overall effectiveness of treatment depends to a large extent on initially engaging families in the therapeutic process, and facilitating commitment to therapy goals, while concurrently conducting a thorough assessment and comprehensive formulation of the presenting problem. In the engagement phase, in research-informed family therapy, therapists typically have goals in the domains of content and process. In the content domain they are aiming to assess the presenting problem, the multiple factors involved in its development and potential resolution, and the family's strengths and vulnerabilities. This assessment will lead to the construction of a formulation or

hypothesis about why the problem developed, and possible solutions. This formulation will be informed by relevant theory and research. In the process domain, the main goal in the first phase of treatment is to engage family members in therapy and establish co-operative working alliances with family members.

Across many empirically supported models of family therapy there is a remarkable consistency in strategies that are used to promote engagement. Reframing and psychoeducation are widely used in the engagement phase to help families arrive at a more useful formulation of their presenting problems. Where families conceptualise problems as intrinsic characteristics of the individual, over which they have no control or for which they deserve to be blamed, through psychoeducation and reframing, they are helped to reconceptualise their difficulties in systemic terms as shared challenges that are controllable. That is, family members may start out by viewing the person with the problem as 'bad' and deserving blame or 'sad, sick, or mad' and helpless. Through psychoeducation and reframing they may be helped to see the person with the problem as a good person with a challenging problem or habit that family members can collectively resolve.

This process of conceptualising the problem as quite distinct from the person with the problem, and viewing the person with the problem and rest of the family along with the therapist as the problem-solving team is a distinctive feature of research-informed family therapy. Psychoeducation and reframing may also help clients see that other family members may inadvertently be responding to the person with the problem in ways that make it worse, which is something over which they have control and therefore can change. This may involve, for example, reducing expressed emotion (overinvolvement or criticism), avoiding inadvertent reinforcement of problem behaviour, using more effective discipline practices, communicating more clearly and empathically, or using more systematic approaches to problem-solving.

Middle phase

In the middle phase the aim in research-informed family therapy is to help families achieve therapeutic goals and resolve presenting problems. The specific therapeutic strategies used in the middle phase are usually informed by the therapeutic model and manual, but are also fine-tuned and guided by a formulation or hypothesis developed during the engagement phase. A wide range of therapeutic techniques are used in research-informed family therapy to help families achieve therapeutic goals and resolve presenting problems.

A useful way to classify these many techniques is to distinguish between: (1) those that focus on family behaviour, or what families do; (2) those that focus on family narratives, or what families believe; and (3) those that address broader contextual factors that affect problem-related behaviour patterns and narratives. These broader contextual factors include personal and family history, the wider system that may contain other involved professionals and the extended family, and psychobiological characteristics of family members.

Middle-phase interventions focusing on behaviour

In the middle phase of research-informed family therapy, examples of interventions that aim to disrupt problem-maintaining behaviour patterns include enhancing communication skills, problem-solving skills, and specific problem-relevant skills. These

sorts of problem-relevant skills include, for example, limit setting for conduct problems; exposure for anxiety; and building family support for depression. With families of adolescents with anorexia, drug use, or illness management problems, parents may be invited to 'take over' adolescents' self-care in the problematic area until the presenting problem becomes manageable, and then gradually transfer control of the problem behaviour back to the adolescent.

For example, in anorexia parents may be invited to re-feed adolescents until a safe weight is reached, at which point the adolescent may be returned responsibility for weight maintenance; with drug use parents may closely supervise cessation of drug use, and then return responsibility for being drug-free to the adolescent; and with conditions like diabetes and asthma, parents may take a highly directive role in implementing illness management regimes until the condition is stabilised, at which point adolescents are given responsibility for autonomous illness management.

Middle-phase interventions focusing on beliefs

In the middle phase of research-informed family therapy, examples of interventions that aim to transform narratives that keep families stuck in problem-maintaining behaviour patterns include: reframing, validating multiple perspectives, highlighting strengths and exceptions, and addressing ambivalence about therapeutic change. The process of reframing problems in non-blaming systemic terms that was begun during the engagement phase may be continued in the middle phase of treatment to consolidate a more useful conceptualisation of the presenting problem and its resolution. Validating multiple perspectives involves empathising with family members' differing viewpoints; letting them know that these are understandable; and that expressing them is an important part of finding solutions to presenting problems. Highlighting strengths involves actively pointing out clients' positive characteristics, which may be often overlooked or taken for granted, and exploring the optimistic implications of these strengths for the way family members see themselves and their roles in solving the presenting problem. Common examples of such strengths are motivation, determination, loyalty, compassion, love, resilience, and thoughtfulness.

Highlighting exceptions involves inquiring in detail about exceptional circumstances in which presenting problems were spontaneously dealt with in a constructive way, and elaborating these accounts so that family members can plan to repeat these exceptions in future. Addressing ambivalence about therapeutic change involves inviting family members to explore the pros and cons of problem resolution, and giving ample opportunity for them to express their views on the 'downside' of taking steps to resolve the presenting problems. Often therapeutic change requires considerable effort, and things may get a lot worse before they get better.

Middle-phase interventions focusing on contexts

In the middle phase of research-informed family therapy there are many interventions that aim to address contextual factors (including developmental factors, the wider system, and psychobiological characteristics) that keep families stuck in problem-maintaining behaviour patterns and that subserve problem-maintaining narratives. What follows are some examples. Where unresolved developmental factors are contributing significantly to the presenting problem, therapists may help clients address developmental issues or family-of-origin issues. Where stresses or lack of co-ordination within the wider social system are contributing significantly to the

presenting problem, therapists may hold network meetings with schools, heath, social services, and probation agencies. Where psychobiological characteristics such as vulnerability to mental or physical health problems (e.g., psychosis or diabetes) are contributing significantly to the presenting problem, therapists may offer detailed psychoeducation and interventions to facilitate adherence to medication and illness-management regimes.

In the middle phase of research-informed family therapy the overarching principals for good practice are to keep focused on resolving the presenting problem (and avoid being side-tracked into addressing other issues), matching the intervention to client needs, and letting families know that you are optimistic about recovery and prepared to 'go the distance'.

Disengagement phase

In the disengagement phase the aim in research-informed family therapy is to prepare families to autonomously manage their difficulties in future. To use a sailing analogy, therapists prepare families for fair and foul weather. The key interventions in this therapeutic phase include reviewing lessons learned in therapy, relapse-prevention planning, and fading out sessions.

Measurement

The emphasis on measurement in research-informed family therapy is reflected in the witticism of Grace Hopper, the famous computer scientist: 'One accurate measurement is worth a thousand expert opinions.' Before and after treatment (or at regular intervals) measurements are made to evaluate progress. The most important thing to measure is the presenting problem or symptom, even if just on a 10-point scale. Other constructs that may usefully be measured include family functioning; the therapeutic alliance; and treatment fidelity or adherence to a particular therapy model. Reviews of family therapy measures have been provided by Hamilton and Carr (in press) and Lebow and Stroud (2012). We have found Peter Stratton's brief version of the SCORE (Systemic Clinical outcome in Routine Evaluation) a very useful measure (Hamilton et al., 2015; Stratton, Bland, Janes, & Lask, 2010). It assesses overall family adjustment; family strengths, difficulties and communication; and the severity and impact of the presenting problem.

Question 4 – Is Systemic Therapy Cost-Effective?

In a series of 22 studies conducted over 20 years, Russell Crane has shown that systemic therapy is more cost-effective than individual therapy, and systemic therapy leads to medical cost-offsets (Crane & 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. 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.

A couple of examples illustrate how systemic therapy leads to reduced overall costs for society. For conduct problems, interventions such as functional family therapy, multisystemic therapy, and multidimensional treatment have been shown to be very cost-effective for conduct disorders and substance misuse because they save a lot of

money that would be spent on residential care or detention of juvenile offenders, and costs to society associated with crime and court involvement (Savignac, 2009). For psychosis, psychoeducational family therapy used as part of multimodal treatment involving antipsychotic medication is cost effective, because it reduces the need for hospitalisation (Lucksted et al., 2012).

What can we tell service funders about the cost-effectiveness of systemic therapy?

The main message for service funders is that systemic therapy works. For most common child, adolescent, and adult mental health problems or adjustment problems associated with physical illnesses, two out of three cases improve with systemic therapy. The success rate of about 66% is as good as that of other psychotherapies. However, systemic therapy is more cost-effective than individual therapy. It leads to greater medical cost-offsets. The funds spent on providing systemic therapy are considerably less that the costs of medical consultations, tests, and hospitalisation that would occur if clients did not engage in family therapy.

Concluding Short Answers to the Four Big Questions

At the outset of the address I mentioned that my reviews of the evidence base for family therapy have been guided by four big questions. What follow are the short answers to each of these. The answer to the first question – Does systemic therapy work? – is: Yes it does, for two out of three cases. The answer to the second question – What sort of systemic therapy works for specific problems? – is: Specific models of systemic therapy work for most common mental health problems. The answer to the third question – What processes occur in effective systemic therapy? – is: There are many processes common to evidence-based models of practice that can be incorporated into the routine practice of research informed family therapy. The answer to the fourth question – Is systemic therapy cost-effective? – is: Yes it is! It saves health services and governments money!

It will be helpful to our clients, funders, and profession to let these questions and the answers to them be widely known. Family therapy can make a very significant contribution to alleviating suffering and making the world a better place to be.

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