The Evidence Base of Family Therapy and Systemic Practice[1]

Peter Stratton, Emeritus Professor of Family Therapy, University of Leeds, UK.

Abstract

This review describes the research base of family therapy and systemic practice basis of systemic family and couples therapies (FTSP). We report a substantial number of current meta-analyses, systematic reviews, and specifically relevant research studies that all point to a strong positive conclusion about the general effectiveness of the approach. We identify 72 conditions for which SFTC has been researched. These reviews demonstrate efficacy and in many cases effectiveness in the conditions for which significant data have been published. However there are significant areas in which published research does not yet allow conclusions to be drawn.

The research review demonstrates that FTSPs are effective, acceptable to clients, and cost effective for a sufficient range of conditions to give confidence that the wide application in current practice is justified and could usefully be extended.

Keywords: systemic, family therapy, couple therapy, evidence, outcome.

Based on Stratton, P (2016). *The Evidence Base of Family Therapy and Systemic Practice*. Association for Family Therapy, UK.

1.Introduction

Mental illness is the largest single cause of disability in our society and imposes substantial costs on health and social services, and on employment.

Estimates of cost are based on the person diagnosed as ill. But when one person has a mental illness all members of their family suffer, so these figures are a serious underestimate. However, most people with a mental illness are part of a family whose members want to help them. The tragedy is that the current mental health system makes too little provision for helping families work effectively to help a member who is suffering.

As evidenced in this report, most cases of psychological difficulty benefit from being treated with the person in the context of supportive relationships. In some cases trying to help the person without directly influencing the others in their relational network is cumbersome or even impossible.

There is good evidence that Systemic Family and Couples Therapy has a number of benefits beyond its effectiveness with referred conditions, including greater acceptability to clients and families, continued improvement after discharge, cost-effectiveness, and reduced use of health and social services resources.

The advantages of working with the couple or family are becoming recognised and individualist therapies, particularly the cognitive, the behavioural and the psychoanalytic have recently started working with couples and even whole families. But they are extending a model of cure that was developed for treating individuals. Even when they are drawing on techniques that have been developed within systemic therapy, this is not the same as a coherent approach that was developed specifically to work through relationships.

As this review demonstrates, Systemic Family and Couples Therapies (FTSP) provide effective help for people with an extraordinarily wide range of difficulties. Later in this report we list 72 conditions for which there is evidence of the value of FTSP.

This review of the existing evidence base finds substantial evidence for the efficacy and the effectiveness of family interventions. Where economic analyses have been carried out, family therapy is found to be no more costly, and sometimes significantly cheaper, than alternative treatments without loss of efficacy.

2 Review of The Research Evidence

2.1 The Systemic Family Therapy Perspective

We live our lives through our relationships. Research into what matters most to people consistently finds that close relationships, especially family relationships, rank higher than anything else. Our sense of who we are and our sense of wellbeing are intimately associated with our relationships – both to other people and the contexts in which we live. When relationships do not give us what we need, we lose our sense of comfort and confidence about the person that we are.

When relationships go seriously wrong, powerful psychological process come to operate, often not in full awareness. Much psychological distress is a result of these processes. Conditions that get given labels such as depression, anxiety, and conduct disorder, are very often effects of relationship problems. Conversely, when systemic family therapists see someone in psychological distress they look first for ways that existing relationships could be adapted to better help that person.

Relationship problems are usually best treated within those relationships. Often that means working with all members of the family or the household together. The advantages are many:

- Problems are being treated in the context in which they arose
- The other people in the family or group with close relationships are a powerful (and nearly always willing) resource for change.
- Therapeutic gains that have been achieved in collaboration with the family and other relational systems are most likely to continue as the person moves forward in their context of everyday living.

In fact, we find that therapy carried out within relational systems is so effective that it is often not necessary to understand where a problem such as depression came from. More often we need to understand what is preventing the problem from being resolved. But always, resolving it within the web of relationships is what is effective. Working in this way has been shown to have benefits for all family members both at the time and for how they handle future difficulties.

We also find that systemic family therapy is effective with chronic and intractable conditions where it does not make sense to talk of a cure. Here we are about establishing a quality of life through the system of relationships and in a way that recognises and incorporates the condition.

Systemic therapists will often prefer to work with as many as practicable of the people in the close network of relationships, whether a couple, the family members living together or a wider network, for example to include grandparents. Several practical advantages have been demonstrated: Gurman

& Burton (2014) offer reasons why conjoint couples therapy is likely to avoid problems that arise when seeing individuals: "structural constraints on change; therapist side-taking and the therapeutic alliance; inaccurate assessments based on individual client reports; therapeutic focus; and ethical issues relevant to both attending and nonattending partners" (p.470). Similarly Baucom et al (2014) state: "Several investigations indicate that relationship distress and psychopathology are associated and reciprocally influence each other, such that the existence of relationship distress predicts the development of subsequent psychopathology and vice versa. Furthermore, findings indicate that for several disorders, individual psychotherapy is less effective if the client is in a distressed relationship. Finally, even within happy relationships, partners often inadvertently behave in ways that maintain or exacerbate symptoms for the other individual. Thus, within both satisfied and distressed relationships, including the partner in a couple-based intervention provides an opportunity to use the partner and the relationship as a resource rather than a stressor for an individual experiencing some form of psychological distress." (p.445).

2.2 How Systemic Family Therapy Works

Systemic family therapy has developed over some 60 years to the point at which we have a varied repertoire of highly effective methods that a therapist can call on to meet the needs of specific clients and families (Borcsa & Stratton, 2016). These include:

- An awareness of how family processes operate and ability to make these apparent to the family.
- An ability to work with children in relation to their parents and vice-versa.
- Working with families to understand and productively use the influence of their family history and traditions.
- Through both conversation and action, helping family members to recognise options they have not been making use of.
- Collaborative exploration of strengths and resources of family members that they can bring to bear to support each other.

A systemic therapist will create a highly adapted and flexible combination of approaches for each unique client. From this perspective, we should ask 'what are the conditions that optimise the tailoring of therapy – what therapeutic situation opens up the best opportunities for effective work? There will be cases in which having several of the people who are important in the relationships present, creates

opportunities that are very difficult to achieve working with an individual. The work often proceeds by bringing difference in assumptions and beliefs into the open for discussion and accommodation .

The systemic perspective is to always take account of the full range of systems that can be seen as nesting inside each other. Systemic practice may be with an individual, a couple, a family, a group of families, professional systems and other wider contexts. It is this orientation that has led the field to place a high priority on working with all aspects of diversity and to be concerned with issues of power and difference such as the impact of migration, economic hardship, and racism.

A typical family therapy clinic helps families deal with a great variety of physical and psychological difficulties. Carr (2016) suggests that on the basis of the evidence "We can say (to clients), '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.'." (p. 39).

2.3 Overviews and meta-analyses of efficacy and effectiveness.

We start with the form of therapy research that is widely assumed to be the most compelling, the Randomised Control Trial (RCT). Two examples of specific RCTs are described in order to clarify the kinds of implications that can be drawn from them. Then we will be in a position to evaluate the studies that have combined collections of RCTs in meta-analyses and systematic reviews.

Dakof et al (2015) compared multidimensional family therapy (MDFT, Liddle, in press) with a standard group-based treatment of adolescent group therapy A sample of 112 youth who were referred by a juvenile court for offending and substance use. They were randomly assigned to one of the two treatments and extensively tested at baseline and at 6 monthly intervals up to 24 months. During treatment itself both groups achieved similar reductions in delinquency, externalizing symptoms, rearrests, and substance use. But at follow-up, extending to 24 months, only the MDFT treatment group maintained their gains in externalizing symptoms (d _ 0.39), commission of serious crimes (d _ .38), and felony arrests (d _ .96). There were no differences in substance use or arrests for minor misdemeanours, but the authors point out that it is reduction in criminal behaviour that is the major objective of the courts. Strengths of this study are the comparison of a well-defined model of systemic therapy with a realistic standard treatment, measurement of the real life effects that matter to the youths, their families, and the justice system.

Perrino et al (2016) compared treatments for youth identified through delinquency but their main focus was the internalising which relates to later major depression (Wesselhoeft, 2013) and risk of

conduct disorder and delinquent behaviour. 242 youth were randomised into either standard community practice or 'Familias Unidas' which is an intervention of multiparent group sessions drawing on Ecodevelopmental Theory. The intervention was developed for reducing sexual and other risk-taking and was tested here because it works to strengthen parenting and family factors relevant to internalizing symptoms. The main finding was of superiority of the Familias Unidas group with a medium effect size of d=0.48. The team analysed not just the comparison of the two treatments but also " "for whom" (i.e., moderators) and "how" (i.e., mediators) the intervention works". Another impressive aspect is that they achieved 95% participation at the 12 month follow-up.

These two examples may already indicate that trying to draw reliable conclusions by combining a significant number of such studies is a complex task. One route is to identify all of the RCTs that meet rigorous standards and use statistical methods to combine the data. Each RCT is given a weighting according to criteria such as the size of the sample and overall statistical conclusions are drawn. This is a meta-analysis and can give a much more reliable indication of the efficacy of a therapeutic approach than any individual RCT. But it does depend on there being a sufficient number of good quality RCTs and they have to fit the model of a well-defined therapy applied to clients with a clear diagnosis. For a variety of reasons discussed in this report, there may not be enough of such studies to be a basis for a meta-analysis. The option then is to conduct a rigorous systematic review and such reviews are included with meta-analyses in the next section. Clear criteria for the quality of evidence-based treatments in couple and family have been proposed by Sexton et al (2011). This paper is a useful guide to understanding why certain aspects of RCTs are necessary. They should use treatment manuals, apply measures of adherence to the treatment, clearly identify client problems, describe service delivery contexts, and use valid measures of clinical outcome.

Four major approaches to treatment have been widely applied and researched in a variety of contexts and have become called the "big four": Brief strategic family therapy (BSFT/SET); Multisystemic therapy systemic family therapy (MSFT); MultiDimensional Family Therapy (MDFT) and Functional Family Therapy (FFT). All four meet the requirements for evidence-based treatments as specified by the Sexton et al (2011) guidelines.

2.4 Meta-Analyses and systematic studies combining findings on general efficacy.

The earlier meta-analyses were reviewed in the previous editions of this report (Stratton, 2005, 2011). They are now of limited value because most of the therapies on which the original research was based predate current practice. Also the standards of RCTs and of meta-analyses have progressively developed. However, one report which gives a good overview is unique in combining existing meta-analyses. Shadish & Baldwin (2003) identified 140 meta-analyses in psychotherapy and the authors undertook a meta-analysis of 20 meta-analyses of couple and family therapy. The average effect size across all meta-analyses was $d = .65$ after family therapy, and $d = .52$ at six to twelve months' follow-up. These results show that, overall, the average treated family fared better after therapy and at follow-up than more than 71% of families in comparison groups. They conclude that '*marriage and family therapy is now an empirically supported therapy in the plain English sense of the phrase - it clearly works, both in general and for a variety of specific problems.*' (p. 567) More specifically, they conclude: "Marriage and family interventions are clearly efficacious compared to no treatment. Those interventions are at least as efficacious as other modalities such as individual therapy, and may be more effective in at least some cases". (p. 566).

Sydow et al. (2010), analysed 38 RCTs of adult patients diagnosed as suffering from mental disorders, published up to 2008. They state: "A meta-analysis could not be performed due to the high variability of the methodology of the trials we identified. Therefore, we conducted a meta-content analysis". A unique feature of this and their subsequent reviews is that research was selected as investigating therapy that was explicitly systemic, whether with family, couple, individual, group, or multifamily group therapy. As the authors point out, all other reviews have defined their sample in terms of the context of the therapy (child, couple, family etc.). Another exceptional aspect is that as far as possible, all languages of publication were included. They conclude that 34 of the 38 studies show systemic therapy to be efficacious. Results were stable across follow-up periods of up to 5 years. They drew a variety of conclusions:

"1. In 34 of 38 RCT, systemic therapy is either significantly more efficacious than control groups without a psychosocial intervention or systemic therapy is equally or more efficacious than other evidence based interventions (e.g., CBT, family psychoeducation, GT, or antidepressant/neuroleptic medication).

2. Systemic therapy is particularly efficacious (defined by more than three independent RCT with positive outcomes) with adult patients in the treatment of affective disorders, eating disorders, substance use disorders, psychosocial factors related to medical conditions, and schizophrenia.
3. Research on the efficacy of systemic therapy for adult disorders focuses on certain diagnostic groups, while other important disorders are neglected in research (e.g., personality or sexual disorders).
4. We found no indication for adverse effects of systemic therapy.
5. Systemic therapy alone is not always sufficient. In certain severe disorders, a combination with other psychotherapeutic and/or pharmacological interventions is most helpful (e.g.,: schizophrenia; heroin dependence; severe depression).
6. The drop-out rate of systemic therapy is lower than that of any other form of psychotherapy
7. Highly efficacious interventions that evolved in the context of systemic (and Ericksonian) therapy are resource/strengths orientation and positive reframing." (p.477).
"Results of this meta-content analysis show that systemic therapy in its different settings (family, couples, group, multifamily group, IT) is an efficacious approach for the treatment of disorders in adults, particularly for mood disorders, substance disorders, eating disorders, schizophrenia, and psychological factors in physical illness." (Sydow et al, 2010, p.478)

In 2012 the Journal of Marital and Family Therapy published its third research review of couple and family therapy. Sprenkle (2012) reviews each of the 12 papers and groups the findings under broad headings of the issues covered. First he rated the quality of the research out of a maximum score of 12. After reviewing the areas he lists 17 issues for which there is strong evidence of the efficacy of CFT. His review included the RCT by Baldwin et al (2012) which examined the differential efficacy of major approaches and did not find strong evidence of superiority of any particular form of FTSP over any other. "While we may be able to speak with some confidence about a modality effect (systemic treatment is often better than non-systemic treatment), we cannot have the same confidence about the advantages of specific systemic interventions/models". (Sprenkle, 2012, p. 24)

Sprenkle's overall conclusion is that:

"Reading the 12 papers in this issue should leave little doubt that CFT has established itself as a scientific discipline. Couple and family therapy began with a belief in the ''Big Idea''—namely, that ''relationships matter.'' During the early decades of the discipline, this belief was more akin to religious dogma than to an assertion rooted in evidence that could pass muster with skeptical outsiders. During the past three decades, the number of CFT evidence based investigations with good methodology has grown exponentially. We can now assert with considerable confidence that many CFT interventions frequently add value and that relationships do indeed matter when it comes to many interventions." (P. 24)

In 2013 the "Hamburg-Heidelberg group", who had examined adult conditions (Sydow et al, 2010 above) published two reviews of RCTs of therapies for children and adolescents. Sydow et al (2013) offer a 'systematic review' of 47 RCTs which as before, were specifically systemic therapies and published across the world. The RCTs were of treatment of childhood and adolescent externalizing disorders.

This review specifically considers the "big four" therapies, BSFT, FFT, MDFT, and MST which provided the great majority of RCTs in this area. Pointing to different strengths of each one, their specific conclusions are:

"1. We found no indication for adverse effects of systemic (family) therapy.
2. Engagement and retention rates of systemic (family) therapy are superior to other therapy approaches for externalizing disorders.
3. Systemic (family) therapy is an efficacious treatment approach for externalizing and juvenile delinquency: In 42 of 47 RCT, systemic therapy was either significantly more efficacious than control groups without a psychosocial intervention, or systemic therapy was equally as or more efficacious than other evidence-based interventions (e.g., individual and group CBT, family psychoeducation).
4. Systemic therapy is efficacious in multiple domains of functioning (primary and secondary mental symptoms, family outcomes, problems with the justice system, and school performance).
5. The positive effects of systemic (family) therapy are long lasting and can be demonstrated not only 6–12 months posttreatment termination but also for longer follow-up intervals—up to 23 years posttreatment (c5: Sawyer & Borduin, 2011).
6. Some of the latest European trials have less positive results than older U.S. trials.
7. Engagement and retention rates of patients from minority groups are lower than those of majority groups.
8. Treatment programs are adapted more to the needs of boys and men, which are the majority of patients with externalizing disorders, and more efficacious for male index patients
9. Results on cost effectiveness of ST are promising, but, to some extent, inconclusive at this point". (p.608)
A total of 42 of the 47 trials reviewed showed systemic therapy to be efficacious for the treatment of attention deficit hyperactivity disorders, conduct disorders, and substance use disorders. Results were stable across follow-up periods of up to 14 years. There is a sound evidence base for the efficacy of systemic therapy for children and adolescents (and their families) diagnosed with externalizing disorders." (p.576).
We can conclude that FTSP has the benefit of a number of major, carefully developed approaches which originated in systemic therapy and have created quite different programmes of implementation. All of them have good evidence of effectiveness within their area of application and are fully

manualised. We can therefore call on several different examples to demonstrate that when a well-defined approach receives adequate funding for its research, FTSP emerges with proven effectiveness.

On the other side, research on the efficacy of ST for children and adolescents has focused on certain diagnostic groups, while other important disorders like anxiety and adjustment disorders have been neglected (Retzlaff, Beher, Rotthaus, Schweitzer, & Sydow, 2009). The pattern fits the comment by Sprenkle (2012):

"Presumably, there is less money available for research on internalizing problems because they are generally less disruptive to society than the externalizing disorders". (Sprenkle, 2012, p.14).

Retzlaff et al. (2013). This article presents findings for internalizing and mixed disorders using the same methodology as Sydow et al. (2010, 2013). Their overall conclusion is that there is a sound evidence base for the efficacy of Systemic Therapy as a treatment for internalizing disorders of child and adolescent patients

Stratton et al (2015) collated CFT outcome studies published in English in the decade 2000-2009. Grouped into broad diagnostic categories the number of studies ranged from 29 to 2 publications. In descending order the most studied categories were:

Comment [PS1]: If you need to save space, you could say: In descending order, the most studied categories were: … and then delete the last 5 entries in the table

Adult	Substance Misuse
Child/Adolescent	Behavioural Problems
Adult	Psychosis (Schizophrenia)
Adult	Mood Disorders (Depression, Bipolar)
Child/Adolescent	Substance Misuse
Child/Adolescent	Physical Illness (Cancer, Obesity, Epilepsy, HIV, Asthma, Diabetes)
Child/Adolescent	Eating Disorders
Adult	Other Mental Health (Post-Traumatic Stress Disorder, Child Sexual Abuse, Dementia)
Child/Adolescent	Anxiety Disorders (Separation Anxiety, Obsessive Compulsive Disorder, Post-Traumatic Stress Disorder)
Adult	Relationship Problems

From this pattern the authors concluded that: “research is disproportionately available in areas of societal concern such as substance misuse, Child/Adolescent behavioural problems, and adult psychosis. This concentration leaves other areas of good and effective practice without research support and vulnerable to being denied to clients in systems of managed care or state provision.” (p.9).

In terms of claims of effectiveness, “No study reported that the clients deteriorated during therapy, 8% did not make a clear claim; 16 % reported no significant difference with the comparison treatment; and the majority (75 %) claimed that the therapy was effective. Only 18 % claimed clear superiority over the comparison treatment.” (Stratton et al 2015, p.5)

The survey concludes that: “Within the limits of accepted standards of publication, the research supports the belief in the field that many different forms of CFT can be effectively applied in varied contexts for the benefit of people (though not evidencing the full range of diversity of people) struggling with a great variety of difficulties.”

Darwiche et al (2015) conducted a detailed analyses of a small sample of RCTS defined by the treatment package. They used the Sexton et al (2011) criteria to report on 9 treatment approaches at three levels. They allocated approaches to Level I “evidence-informed treatments”; level II “evidence-informed treatments with promising preliminary evidence-based results”; and the strongest: level III “evidence-based treatments”. Three approaches are shown to have several RCTs of high quality that demonstrated strong levels of efficacy: BSFT, FFT, MDFT. Family Focused Grief Therapy (FFGT, Kissane & Bloch, 2002) was found to have a satisfactory level. Level II consisted of just one approach, Systemic Couple Therapy (Jones & Asen, 2000) having only one RCT. Level I contained four studies judged to be promising but not yet able to claim clear evidence of effectiveness: Structural-Strategic Family Therapy (Stanton & Todd, 1982), Milan Systemic Therapy (Bertrando et al., 2006), Leeds Systemic Family Therapy (Pote, Stratton, Cottrell, Shapiro, & Boston, 2003), and Family Systems Therapy (Rohrbaugh, Shoham, Spungen, & Steinglass, 1995).

Pinquart et al (2016) report a meta-analysis of 45 RCTs which met stringent criteria similar to those of the Sydow group in terms of a clear theoretical systemic basis for the therapies. They adjusted the reported ,

“… comparisons of systemic therapy against alternative bona fide treatments (g = .12 at posttest and g = .00 at follow-up) support the conclusion that systemic therapy and other psychotherapies are similarly efficacious. Our overall effect size of g = .51 is similar to the mean effect size of d = .65 reported in meta-analysis of couple and family therapy in general (Shadish & Baldwin, 2003).

The present meta-analysis found empirical support for the assumption that dropout rates would be lower in systemic therapy than in other forms of psychotherapy". (p.251).

They conclude: " systemic therapy is an efficacious treatment approach for eating disorders, mood disorders, obsessivecompulsive disorders, and schizophrenia, and there is initial evidence of positive effects on somatoform disorders. Nonetheless, comparisons with other meta-analyses indicate that systemic therapy may not be the most efficacious treatment for depression and obsessive-compulsive disorders, but RCTs have to compare these treatments directly." .(P.252).

The seven careful and thorough analyses reported in this section and the considered conclusions of the authors amount to a powerful indication that FTSP is consistently effective and superior to a variety of alternatives made available to people who come for treatment.

2.5 Some studies with different approaches.

The reviews of the previous section are based on well-established outcome measures that enable CFT to be compared with other treatments. However, many clients, couples and families attend for treatment for serious problems that do not fit the medically oriented diagnostic definitions of the DSM. Also FTSP, like some other therapies, has objectives that are not specified in terms of measureable problems. It is important therefore to take account of research which has tracked other effects of therapy, and which have had other objectives than evaluating the implications of high quality RCTs.

Crane and Payne (2011) report data from 490000 individuals. Using the simple measure of whether clients returned for further treatment they found that compared with individual or "mixed" psychotherapy, family therapists had the highest rates of success. Only 13% requested further treatment of any kind.

Bachler et al (2016) report a substantial pre-post naturalistic study in which 379 families received a home-based therapy designed for multi-problem families. They reported a medium to large effect size for all parameters (range: .35–1.49). The improvements are not only on possibly diagnosable treatment goals but features of the therapeutic collaboration. Improvements in goal-directed collaboration and treatment expectancy were found to be related to clinical improvement. The authors point to their findings as support for individualisation of treatment and setting of goals by clients in improving self-efficacy and problem solving.

Keiley et al (2015) report on a multi-family group intervention for 115 male adolescents who sexually offend and their families. Data from the adolescents and their male and female caregivers collected at pre-, post-, and 1-year follow-up and found that that "problem behaviors (internalizing, externalizing) decreased over pre- and posttest and the significant decreases in maladaptive emotion regulation predicted those changes." (P.324) They conclude that the multiple-family group intervention is an effective, yet affordable, 8-week treatment.

Such studies are interesting because they focus on effects that are likely to be judged important by therapists, and that are relevant to the relationship between wellbeing and mental health. The ways such effects have been shown to relate coherently to symptoms can be taken as an indication that such changes could be taken seriously when evaluating systemic approaches. For example Guo et al (2013) report on 179 runaway adolescents who were randomly assigned to one of three treatments: to Ecologically-Based Family Therapy, the Community Reinforcement Approach, or brief Motivational Enhancement Therapy (MET, n = 61) with the primary focus on substance abuse.. "Adolescents who received EBFT demonstrated more improvement in family cohesion after treatment than those who received CRA or MET, and more reduction in family conflict during treatment than those who received MET" (p. 299). They conclude that "The greater impact of family therapy on family outcomes suggests that family systems therapies should be offered to families who seek services through runaway shelters". (p. 309).

Hunger et al (2014) report an RCT of 208 participants half of whom received Family Constellation Seminars, using a variety of measures to examine the ways personal social systems were experienced. "The average person in the intervention group showed improved experience in personal social systems, as compared with approximately 73% of the wait-list group after 2 weeks (total score: Cohen's d = .61, p = .000) and 69% of the wait-list group after 4 months (total score: d = .53, p = .000). . No adverse events were reported." (P. 288)

At the start of this section the question posed was 'does systemic family and couple therapy work?' The combined weight of the systematic reviews leave no doubt that there is a well-founded positive answer to this question.

2.6 Reviews of the effectiveness of Family Therapy for specified conditions.

There have been several recent, careful reviews that assess the range of evidence available in relation to specific conditions. The reviews consistently identify certain conditions of children, adolescents and adults as effectively treated by Family Therapy. They are of particular interest because they give a direct indication of the range of conditions that have been researched and within each review the

therapies have been evaluated according to the same criteria. Many conditions were identified in the meta-analyses and other reviews discussed in section 3.2. and the conditions they identified are listed below in date order. First it is worth considering the list compiled by Sprenkle (2012) in his overview of the 12 research articles in the special issue of the Journal of Marital and Family Therapy. Sprenkle concluded that the 12 articles provided evidence of a strong Couple and Family Therapy (CFT) Modality Effect for the following issues:

Adolescent	Conduct Disorder／Delinquency
Adolescent	Getting Substance Abusers into Treatment
Adolescent	Substance Abuse
Adult	Getting Adult Substance Abusers into Treatment
Adult	Substance Abuse
Childhood and adolescent	Anxiety Disorders
Childhood	Oppositional Defiant Disorder
Adolescent	Anorexia Nervosa
Adult	Family Management of Schizophrenia
Adult	Coping for Family Members of Alcoholics Unwilling to Seek Help
Adult	Getting Alcoholics into Treatment
Adult	Alcoholism
Adult	Moderate and Severe Couple Discord
Adult	Depression when Combined with Couple Discord
Adult	Couple Violence Associated with Alcoholism and Drug Abuse
Adult	Situational (not Characterological) Couple Violence
Childhood and adolescent	Type 1 Diabetes

(From Table 2, p.25.).

This is an impressive list to have derived entirely from the articles contained in one issue of The Journal of Marital and Family Therapy (Vol. 38, No. 1).

2.6.1 Family and couple therapy with children and adolescents

Carr (2014a) reports a review of reviews using a broad definition of systemic practices . In this context, systemic interventions include both family therapy and other family-based approaches such as parent training. The evidence supports the effectiveness of systemic interventions either alone or as part of multi-modal programmes for:

- sleep, feeding and attachment problems in infancy
- child abuse and neglect
- conduct problems (including childhood behavioural difficulties, attention deficit hyperactivity disorder, delinquency and drug misuse)
- emotional problems
- (including anxiety, depression, grief, bipolar disorder and self-harm)
- eating disorders (including anorexia, bulimia and obesity)
- somatic problems (including enuresis, encopresis, medically unexplained symptoms and poorly controlled asthma and diabetes) and
- first episode psychosis.

Stratton et al (2015) collated CFT outcome studies published in English in the decade 2000-2009. The frequency of articles in which therapy was rated as effective for the most commonly researched conditions were:

- Child behavioral problems 25 articles out of a total of 29
- Child eating disorder 13 articles out of a total of 16
- Child anxiety and mood 6 articles out of a total of 23
- Adolescent substance misuse 6 articles out of a total of 20.

2.6.2 Family and couple therapy with adults

Carr (2014b). reports a review of reviews with a broad definition of systemic practices. The evidence supports the effectiveness of systemic interventions either alone or as part of multi-modal programmes for:

- relationship distress
- psychosexual
- problems
- intimate partner violence
- anxiety disorders
- mood disorders
- alcohol problems
- schizophrenia
- and adjustment to chronic
- physical illness.

In their review of a decade of outcome studies, Stratton et al, (2015) reported that the frequency of articles in which therapy was rated as effective for the most commonly researched conditions were:

Adult substance abuse 28 out of a total of 29
Adult schizophrenia and psychosis 18 out of a total of 23
Adult—other psychiatric 10 out of a total of 13
Adult mood (depression) 7 out of a total of 20.

It may be helpful to have a comprehensive listing of all of the conditions described above as having evidence of efficacy or effectiveness.

2.6.3. A Final alphabetical Listing of all conditions with evidence for efficacy or effectiveness.

Child and Adolescent conditions N=40

Anorexia	encopresis
anxiety disorders	enuresis
anxiety over abandonment	externalizing symptoms,
Asperger disorder	feeding difficulties
asthma poorly controlled	Grief
attachment dependence	internalizing symptoms
attachment problems in infancy	maladaptive emotion regulation

attention deficit hyperactivity disorder	medically unexplained symptoms
behavioural difficulties	mood disorders
bipolar disorder	Obesity
bulimia	oppositional defiant disorder
commission of serious crimes Conduct disorder	perceived family cohesion
conduct disorders, /conduct problems	psychosis, first episode
Delinquency	rearrests
depression	reduced family conflict
diabetes (Type 1)	self-harm
diabetes when poorly controlled	sleep difficulties
drug misuse	somatic illness, psychological factors in
eating disorders	somatic problems
emotional problems	substance abuse, getting adolescent substance abusers into treatment

Adult conditions N=32

affective disorders	medical conditions, psychosocial factors related to
alcohol problems	mood disorders
alcoholics Getting into treatment	obsessive–compulsive disorders
alcoholics: Coping for family members of unwilling to seek help	personal social systems
Alcoholism	physical and psychological health, improvement of
anxiety disorders	psychological functioning and goal attainment
child abuse	psychosexual problems
child neglect	relational autonomy
chronic physical illness: adjustment to	relationship distress
couple discord	Schizophrenia
Couple violence associated with alcoholism or drug abuse	schizophrenia (adult), Family management of
couple violence: Situational (not characterological)	schizophrenia, psychosocial factors related to
Depression	self-esteem, and self-acceptance
depression when combined with couple discord	somatoform disorders
eating disorders	substance abuse
emotional connectedness increased	substance abusers: Getting adults into treatment

These impressive lists are of conditions for which evidence of effectiveness or at least efficacy of CFT has been published. We can make no claim that CFT for these conditions is definitely more effective than alternative appropriate treatments - the judgement must be that when it is appropriate to work with and through relationships, the relevant systemic approach should be available for clients to choose.

In view of the exceptional range of arenas in which FTSP does have evidence it could well be argued that, where evidence is lacking because research has not been reported, it would be reasonable to extrapolate from comparable areas. Forms of FTSP that have proven effective with similar problems should be proposed with a presumption of value until proved otherwise.

2.7 Wider perspectives

2.7.1 User acceptability and dropout

Because clients' needs, contexts and resources vary so substantially, it is not likely that one or even a few forms of psychotherapy will be optimal for everyone. Providers therefore rightly emphasise the need for patient choice. We have little data about expectations of systemic family and couples therapies, and are likely to find major differences in expectation among different cultural groups. Chenail et al (2012) did undertake a qualitative meta-synthesis of 49 articles to develop an "inductive grounded formal theory of CFT client experience/evaluation/preferences". This article is a detailed and informative account of this qualitative methodology and also richly informative about client reactions. "(a) that family members appreciate being actively and fairly involved throughout therapy so it is important to ask for feedback early and often and (b) that family members appreciate what each other contributes to therapy so it is important to encourage and celebrate such contributions." (P. 259)

Overall these authors conclude that the factors that impact clients' perceptions are:

- Clients' commitment to change, motivation
- Clients' recognition of therapists' efforts to provide opportunities to change
- Clients' appreciation of the relationship or alliance they have with their therapists
- Clients' preconceptions and expectations for their therapy's helpfulness

Parra-Cardona et al (2016) compared two culturally adapted versions of Parent Management Training. "Participants exposed to the culturally enhanced intervention, which included culture-specific sessions, also reported high satisfaction with components exclusively focused on cultural issues that directly impact their parenting practices (e.g., immigration challenges, biculturalism)". (P. 321-322).

Sheridan et al. (2010) interviewed 15 parents of adolescents after participating in family therapy. They report that parents valued the therapeutic process and relationship, and the contribution the therapist made to both. Important factors in parental experience of family therapy were: Supportive therapeutic climate; therapist's qualities (such as sensitivity); and noticing positive results which motivates parents to continue with therapy. The supportive therapeutic environment seemed to help parents go through the family therapy experience.

One indication of acceptability is whether clients drop out of therapy early. As reported above, MDFT clients stay in treatment longer than clients in outpatient and residential comparison treatments. 95% of clients in intensive outpatient MDFT stayed in treatment for 90 days as compared to 59% in residential. Hamilton et al. (2011) studied data from 434,317 patients whose therapy had been funded by CIGNA Behavioral Health. Individual therapy had lower dropouts than family therapy. But much of the family therapy was provided by other professionals with limited systemic training. Fully trained marital and family therapists had the lowest rates of dropout. These findings suggest that it is not family therapy as such that keeps clients engaged but family therapy as provided by well trained and experienced therapists.

2.7.2 Cost-effectiveness

It is extremely difficult to accurately gauge the cost of different treatments and yet this is a crucial factor in provision, especially at times of economic constraint. Where studies have been reported, and taking account of the costs of treatment up to two years after the completion of therapy, family therapy has been found to be no more costly, and often substantially less costly than other therapies. In some cases, as for Multisystemic therapy, systemic therapy has been considered more advantageous than treatment as usual because of the low success rate of the alternative. Multidimensional therapy was much more advantageous because the comparison, although almost as effective in the short term, was an extremely expensive residential provision.

Crane and his co-workers continue to provide substantive cost-benefit comparisons. For example, using large-scale data from real-world practice, Crane et al. (2005) analysed the relative costs of different treatments. After establishing from the published evidence that family therapy is an effective

treatment for adolescent conduct disorder, they find that family therapy in the clinic required 32% less care costs than those seen individually (n= 164 and 3086 respectively) while those receiving in-home family therapy (n=503) were least costly, averaging at most 15% of the costs of any in-office treatment.

Crane &. Christenson (2012) provide a useful summary of the main findings from 19 of their studies. The summaries cover the medical offset effect which found reductions in use of health care (with associated costs) not just for the patient but for members of their family. In one study the biggest reduction in health care use (a decrease of 58%) was found in those who reported an improvement in general family functioning after treatment.

Crane et al (2013) examined claims data for 164,667 individuals diagnosed with depression. First they found a saving because the family therapy required fewer sessions on average: "The average number of sessions utilized per patient for family therapy was 5.10 (SD = 5.75), 7.86 for individual therapy (SD = 10.21), and 13.02 for mixed therapy (SD = 13.04). The mean cost using raw data was $248.65 (SD = 313.04) for family therapy only, $391.31 (SD = 566.72) for individual therapy only, and $631.69 (SD = 686.48) for mixed therapy." P.462.

2.7.3 What do Systemic Family and Couples Therapists do?

By now it will be apparent that there is a very wide range of ways of implementing therapy under the broad remit of systemics. Meanwhile the increasing evidence for common factors in effective therapies, and the now widespread willingness to incorporate whatever might be useful for the client by therapists is resulting in a blurring of boundaries. And research reports are not always as helpful as they should be. Stratton et al (2015) found remarkably few of the 225 outcome studies that they reviewed provided a clear specification of the therapy used. The issue becomes acute when planning training or specifying the requirements for accreditation of courses.

A much more detailed account has been created by the competency framework analysis commissioned by the UK agency Skills for Health (Pilling et al, 2010). This analysis worked from manuals that had been the basis for successful outcomes in RCTs and extracted the competences they specified. The lists were reviewed by an expert committee and concluded with a list of five Domains of: Generic Therapeutic Competences; •Basic Systemic Competences; Specific Systemic Techniques; Problem Specific Competences/Specific Adaptations; Metacompetences, which break down to 30 broad headings of systemic competences in addition to a further 10 generic competences shared with other therapies. Each of the headings is unpacked into a listing of specific aspects of that competence (Stratton et al, 2011) generating a complete list of some 240 forms of practice. The interactive map of

competences is available at https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks/Systemic_Therapy

3 Conclusions

This report has had the advantage of being able to bring together a substantial number of rigorous reviews. The message from these sources is consistently that systemic family and couple therapy is effective in a variety of forms and contexts, for whatever conditions and circumstances have been researched.

Despite the many positive findings compiled in this report, and the very substantial number of conditions for which FTSP can make a useful contribution to treatment, there are many areas of everyday systemic practice that have not been researched.

3.1 Future research needs

Relevance to practice. One theme running through this report has been the ways that available research does not correspond to the patterns of work of therapists. Stratton et al, (2015) after reviewing 225 reports of outcome studies conclude that a combination of funding and journal publication strategies mean that some conditions are less likely to receive research funding as research is concentrated in areas of societal concern, and that negative findings are unlikely to be published.

Appropriate measures. A number of authors point to the need for more consistency in the measure used. Sanderson et al (2009) reviewed 274 outcome studies and reported that a total of 480 different outcome instruments were employed. Stratton et al (2015) found "great diversity in the outcome measures employed and most studies used more than one type of outcome measure" (p.7). Only 58 % of the studies gathered measures from more than one person in the family with only 25% of the studies using a family system measure. This lack of consistency makes it difficult to directly compare and combine different research outcomes. It would be useful if there could be some consensus on measures that are appropriate in family therapy. Apart from consistency in choice of measures by researchers we also need instruments that are meaningful to therapists. Hamilton and Carr (2016) concluded that five of the measures they reviewed are suitable for clinical use in family therapy: The McMaster Family Assessment Device (FAD); Circumplex Model Family Adaptability and Cohesion Evaluation Scales (FACES-IV); Beavers Systems Model Self-Report Family Inventory (SFI); Family Assessment Measure III (FAM III); and the Systemic Clinical Outcome Routine Evaluation (SCORE). With one new system currently under-going validation, the Systemic Therapy Inventory of Change (STIC).

What therapy was the research investigating? Many reviewers have commented on the limited information in published studies about the precise nature of the therapy being examined. Clearly this information is crucial in making judgements about what may be responsible for positive outcomes. One potential solution is the use of manuals. Practitioners may be resistant to the idea of using a manual in case its prescriptive nature interferes with the flexibility of therapy. In fact, manuals can be highly adaptable (e.g. Pote et al, 2003) without losing their capacity to be informative about the process of the therapy undertaken (Stratton, 2013).

Process and progress. There has been something of a division between quantitative research into outcomes and qualitative research into process. But in fact, knowing an outcome is quite uninformative if we do not know the therapeutic processes that led to that outcome. Reciprocally, knowing that certain processes occurred during therapy is not very interesting if we have no reason to suppose that they had an influence on the effects of the therapy or the future functioning of the client. The potential for an integration of process research with outcome measurement is enhanced by recent substantial developments in qualitative methodologies that are specifically designed within a systemic framework. Just one example is Simon and Chard's (2014) collation of Innovations in Reflexive Practice Research.

Transportability. Therapy conducted in controlled research conditions by specialists who are often the originators of the particular approach needs to be followed by trials in more realistic field conditions. Are the methods still effective when transported to less specialist locations with no input from the originators? When considering the transportability of treatments developed and tested in the US to other countries, the quality of comparison treatment becomes crucial..

A systemic therapy should be a comparator when researching other therapies.

The many positive findings reported in this review provide a strong justification for including Systemic Family Therapy in future comparison outcome trials, and for conducting more coherent and rigorous outcome research on Family Therapy. There are positive developments. Further substantial RCTS are currently under way, for example into adolescent self harming (SHIFT project), and a comparison of manualised family therapy treatments for eating disorders, while others are being planned. As the existing evidence base of systemic family and couples therapy becomes recognised, we can hope that research in the forms and on the scale that is necessary, will be funded.

"It is innovation that pushes any system, family therapy included, to remain exciting and viable in the difficult world of practice. It is innovation from research and clinical practice that will engender the excitement and advancement of family therapy practice." (Sexton and Datchi, 2014, p.429).

3.2 Why Family Therapy is an essential provision.

It works and it makes immediate emotional and cultural sense to clients.

In summary, reasons to ensure and expand the provision of Family Therapy include:

- It has proven effectiveness for those conditions for which it has been properly researched.
- There is very substantial supportive evidence for its effectiveness from diverse research and clinical experience.
- Trained family therapists draw on a good range of approaches with clear theoretical rationales. Current models of family therapy pay explicit attention to issues of culture, ethnicity, gender, discrimination and wider physical and societal contexts.
- Properly trained family therapists have transferable skills in relation to team working, consultation, organisation etc.
- Family therapists can support other professionals in their work with families.

As Crane & Payne (2011) say: ***"As a number of family therapy approaches have been shown to be effective … at least offering this approach to patients seems warranted where it is appropriate. There should be at least short-term cost benefits and reasonable outcomes as measured by success and recidivism rates. In addition, including family therapy as a treatment modality in health care systems does not seem to increase health care costs …. Now may be the time to begin to educate policy makers and begin to offer this form of care to families who desire to receive it".*** (p. 285).

References

Bachler, E., Frühmann, A., Bachler, H., Aas, B., Strunk, G. and Nickel, M. (2016), Differential effects of the working alliance in family therapeutic home-based treatment of multi-problem families. *J. Fam. Ther*., 38: 120–148. doi:10.1111/1467-6427.12063

Baldwin, S. A., Christian, S., Berkeljon, A., Shadish, W.R. (2012). The effects of family therapies for adolescent delinquency and substance abuse: A meta-analysis. *Journal of Marital and Family Therapy*, *38*(1), 281-304.

Baucom, D. H., Belus, J. M., Adelman, C. B., Fischer, M. S. and Paprocki, C. (2014), Couple-Based Interventions for Psychopathology: A Renewed Direction for the Field. *Fam. Proc*., 53: 445–461. doi:10.1111/famp.12075

Bertrando, P., Cecchin, G., Clerici, M., Beltz, J., Milesi, A., & Cazzullo, C. L. (2006). Expressed emotion and Milan systemic intervention: A pilot study on families of people with a diagnosis of schizophrenia. *Journal of Family Therapy*, 28, 81–102. doi:10.1111/j.1467-6427.2006.00339.x.

Borcsa M., Stratton P. (Eds.) (2016): *Origins and Originality in Family Therapy and Systemic Practice*, Springer

Carr, A. (2014a). The evidence-base for family therapy and systemic interventions for child focused problems. Journal of Family Therapy, 36, 107–157.

Carr, A. (2014b). The evidence-base for couple therapy, family therapy and systemic interventions for adult-focused problems. Journal of Family Therapy, 36, 158–194.

Carr, A. (2016) How and Why Do Family and Systemic Therapies Work? Australian and New Zealand Journal of Family Therapy 2016, 37, 37–55 doi: 10.1002/anzf.1135

Chenail, R. J., St. George, S., Wulff, D., Duffy, M., Wilson Scott, K., & Tomm, K. (2012). Clients' relational conceptions of conjoint couple and family therapy quality: A grounded formal theory. *Journal of Marital and Family Therapy*, 38(1), 241–264.

Crane, D.R. (2008) The cost effectiveness of family therapy: A summary and progress report. *Journal of Family Therapy*, 30: 399-410.

Crane, D. R. & Payne, S. H. (2011) Individual versus family therapy in managed care: Comparing the costs of treatment by the mental health professions.Journal of Marital and Family Therapy.doi: 10.1111/j.1752-0606.2009.00170.x

Crane, D. R. & Christenson, J. D. (2012). A Summary Report of the Cost-Effectiveness of the Profession and Practice of Marriage and Family Therapy. Contemporary Family Therapy. 34, 204-216. doi: 10.1007/s10591-012-9187-5

Crane, D.R., Christenson, J.D., Dobbs, S.M., Moore, A.M., Pedal, F.F.C., Ballard, J., Marshall, E.S. (2013). Costs of treating depression with individual versus family therapy. *Journal of Marital and Family Therapy*, 39 (4), 457-469. doi: 10.1111/j.1752-0606.2012.00326.x

Dakof, G. A.; Henderson, C. E.2; Rowe, C. L. ; Boustani, M; Greenbaum, P. E.; Wang, W; Hawes, S; Linares, C; Liddle, H. A. (2015) A Randomized Clinical Trial of Family Therapy in Juvenile Drug Court. Journal of Family Psychology. 29(2):232-241,

Darwiche, J. and de Roten, Y. (2015), Couple and Family Treatments: Study Quality and Level of Evidence. *Fam. Proc*., 54: 138–159. doi:10.1111/famp.12106

Guo, X. and Slesnick, N. (2013). Family versus individual therapy: Impact on discrepancies between parents' and adolescents' perceptions over time. *Journal of Marital and Family Therapy*, 39, 182–194. doi: 10.1111/j.1752-0606.2012.00301.x

Gurman, A. S. and Burton, M. (2014). Individual therapy for couple problems: Perspectives and pitfalls. *Journal of Marital and Family Therapy*, 38, 470–483. doi: 10.1111/jmft.12061

Hamilton E., Carr A. (2016): Systematic Review of Self-Report Family Assessment Measures. *Family Process*, 55, 1, 16-30.

Hamilton, S., Moore, A. M., Crane, D. R., & Payne, S. H. (2011). Psychotherapy dropouts: Differences by modality, license, and DSM-IV diagnosis. *Journal of Marital and Family Therapy*, 37(3), 333–343.

Hunger, C., Bornhäuser, A., Link, L., Schweitzer, J. and Weinhold, J. (2014), Improving Experience in Personal Social Systems through Family Constellation Seminars: Results of a Randomized Controlled Trial. *Fam. Proc*., 53: 288–306. doi:10.1111/famp.12051

Jones, E., & Asen, E. (2000). *Systemic couple therapy and depression*. London & New York: Karnac Books.

Keiley, M. K., Zaremba-Morgan, A., Datubo-Brown, C., Pyle, R. and Cox, M. (2015). Multiple-family group intervention for incarcerated male adolescents who sexually offend and their families: Change in maladaptive emotion regulation predicts adaptive change in adolescent behaviors. Journal of Marital and Family Therapy, 41, 324–339. doi: 10.1111/jmft.12078

Kissane, D. W., & Bloch, S. (2002). Family focused grief therapy. A model of family-centred care during palliative care and bereavement. Buckingham & Philadelphia: Open University Press.

Liddle, H. A. (in press) Multidimensional Family Therapy: Evidence Base for Transdiagnostic Treatment Outcomes, Change Mechanisms and Implementation in Community Settings. *Family Process.*

Liddle, H., Rigter, H. (2013). How developmental research and contextual theory drive clinical work with adolescents with addiction. *Harvard Review of Psychiatry, 21*(4), 200-204. doi: 10.1097/HRP.0b013e31829aaa6b

Moore, A. M., Hamilton, S., Crane, D. R., & Fawcett, D. (2011). The Influence of Professional License Type on the Outcome of Family Therapy. The American *Journal of Family Therapy*, 39(2), 149–161.

Parra-Cardona, J. R., López-Zerón, G., Domenech Rodríguez, M. M., Escobar-Chew, A. R., Whitehead, M. R., Sullivan, C. M. and Bernal, G. (2016), A Balancing Act: Integrating Evidence-Based Knowledge and Cultural Relevance in a Program of Prevention Parenting Research with Latino/a Immigrants. *Fam. Proc*., 55: 321–337. doi:10.1111/famp.12190

Perrino, T., Pantin, H., Huang, S., Brincks, A., Brown, C. H. and Prado, G. (2016), Reducing the Risk of Internalizing Symptoms among High-risk Hispanic Youth through a Family Intervention: A Randomized Controlled Trial. Fam. Proc., 55: 91–106. doi:10.1111/famp.12132

Pilling, S., Roth, A. D. & Stratton, P. (2010) The competences required to deliver effective systemic therapies. www.ucl.ac.uk/CORE

Pinquart, M. Oslejsek, B & Teubert, D (2016) Efficacy of systemic therapy on adults with mental disorders: A meta-analysis, *Psychotherapy Research*, 26:2, 241-257, DOI: 10.1080/10503307.2014.935830

Pote, H., Stratton, P., Cottrell, D., Shapiro, D., & Boston, P. (2003). Systemic family therapy can be manualized:Research process and findings. *Journal of Family Therapy*, 25, 236–262. doi:10.1111/1467-6427.00247.

Retzlaff, R., Beher, S., Rotthaus, W., Schweitzer, J., & Sydow, K.. (2009). Systemische Therapie mit Erwachsenen, Kindern und Jugendlichen. Zum aktuellen Stand der Wirksamkeitsforschung. *Familiendynamik*, 34, 284–295.

Retzlaff, R., Sydow, K. v., Beher, S., Haun, M. W., & Schweitzer, J. (2013). The efficacy of systemic therapy for internalizing and other disorders of childhood and adolescence: A systematic review of 38 randomized trials. *Family Process*, doi: 10.1111/famp.12041

Rohrbaugh, M., Shoham, V., Spungen, C., & Steinglass, P. (1995). Family systems therapy in practice: A systemic couples therapy for problem drinking. In B. Bongar & L. Beutler (Eds.), *Comprehensive textbook of psychotherapy: Theory and practice* (pp. 228–253). New York: Oxford University Press.

Sanderson, J., Kosutic, I., Garcia, M., Melendez, T., Donoghue, J., Perumbilly, S., et al. (2009). The measurement of outcome variables in Couple an Family Therapy research. The American *Journal of Family Therapy*, 37, 239–257.

Sawyer, A. M., & Borduin, C. M. (2011). Effects of multisystemic therapy through midlife: A 21.9-year follow-up to a randomized clinical trial with serious and violent offenders. *Journal of Consulting and Clinical Psychology*, 79(5), 643–652.

Sexton, T. L., & Alexander, J. F. (2003). Functional Family Therapy: A mature clinical model. In T. Sexton, G.Weeks, & M. Robbins (Eds.), *Handbook of family therapy*. New York: Brunner/Routledge.

Sexton, T. L., Coop Gordon, K., Gurman, A., Lebow, J., Holtzworth-Munroe, A., & Johnson, S. (2011). Guidelines for classifying evidence-based treatments in couple and family therapy. Family Process, 50, 377–392. doi:10.1111/j.1545-5300.2011.01363.x.

Sexton, T. L. and Datchi, C. (2014), The Development and Evolution of Family Therapy Research: Its Impact on Practice, Current Status, and Future Directions. Family Process, 53: 415–433. doi: 10.1111/famp.12084

Shadish, W.R., & Baldwin, S.A. (2003). Meta-analysis of MFT interventions. Journal of Marital and Family Therapy, 29, 547–570.

Sheridan, M., Peterson, B. D., & Rosen, K. H. (2010). The Experiences of Parents of Adolescents in Family Therapy: A Qualitative Investigation. *Journal of Marital and Family Therapy*, *36*(2), 144–157.

Simon, G and Chard, A (2014) *Systemic Inquiry: Innovations in systemic practice research*. Farnhill, Everything is Connected Press.

Sprenkle, D. H. (2012), Intervention Research in Couple and Family Therapy: A Methodological and Substantive Review and an Introduction to the Special Issue. Journal of Marital and Family Therapy, 38: 3–29. doi: 10.1111/j.1752-0606.2011.00271.x

Stanton, M. D., & Todd, T. C. (1982). *The family therapy of drug abuse and addiction.* New York: Guilford Press.

Stouwe, Van der T., Asscher, J. J., Stams, G. J. J. M., Dekovic, M., & van der Laan, P. H. (2014). The effectiveness of multisystemic therapy (MST): A meta-analysis. *Clinical Psychology Review*, 34, 468–481.

Stratton P. (2005): Family Therapy in Focus. *Journal of Family Therapy*, 27, 423-425. Doi 10.1111/j.1467.-6427.2005.0331

Stratton P. (2011): The Evidence Base of Systemic Family and Couples Therapy. www.aft.org.uk

Stratton, P., Reibstein, J., Lask, J., Singh, R., & Asen, E. (2011) Competences and occupational standards for systemic family and couples therapy. *Journal of Family Therapy.* 33: 123–143

Stratton, P. (2013) Manuals: a secure base for playful therapy? *Human Systems: The Journal of Therapy, Consultation and Training.* 24. 176-187

Stratton, P., Silver, E. Nascimento, N. McDonnell L. Powell, G and Nowotny, E. (2015). Couples and Family Therapy in the Previous Decade – What does the evidence tell us? *Contemporary Family Therapy*. 27. 1-12. doi: 10.1007/s10591-014-9314-6

Sydow, K., Beher, S., Schweitzer, J., & Retzlaff, R. (2010). The Efficacy of Systemic Therapy With Adult Patients: A Meta-Content Analysis of 38 Randomized Controlled Trials. *Family process*, *49*(4), 457–485.

Sydow K. et al.(2013): The Efficacy of Systemic Therapy for Childhood and Adolescent Externalizing Disorders: A Systemic Review of 47 RCTs. *Family Process,* 576-618

Szapocznik, J., Schwartz, S. J., Muir, J. A., & Brown, C. H. (2012). Brief Strategic Family Therapy: An intervention to reduce adolescent risk behavior. Couple and Family Psychology: Research and Practice, 1(2), 134–145. doi:10.1037/a0029002.

Wesselhoeft, R., Sorensen, M. J., Heiervang, E. R., & Bilenberg, N. (2013). Subthreshold depression in children and adolescents—A systematic review. Journal of Affective Disorders, 151, 7–22.