

The Effectiveness of Family and Relationship Therapy:

**A Review of the
Literature**

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Foreword

This document is a literature review of research into the effectiveness of family therapy, intended as a resource for counsellors and psychotherapists. It was written on behalf of the PACFA Research Committee. However, this does not imply that PACFA or its Member Associations endorses any of the particular treatment approaches described.

The PACFA Research Committee recognises that it is important to counsellors and psychotherapists that they have access to recent research evidence that demonstrates the effectiveness of different therapeutic approaches, to assist them in their practice. This document is one of a series of reviews that has been commissioned by the PACFA Research Committee to support its Member Associations in their work.

The PACFA Research Committee endorses the American Psychological Association's definition of evidence-based practice as 'the integration of the best available research evidence with clinical expertise in the context of patient characteristics, culture and preferences', although we would prefer to use the word client or consumer rather than 'patient'.

The PACFA Research Committee recognises that there is overwhelming research evidence to indicate that, in general, counselling and psychotherapy are effective and that, furthermore, different methods and approaches show broadly equivalent effectiveness. The strength of evidence for effectiveness of any specific counselling and psychotherapy intervention or approach is a function of the number, independence and quality of available effectiveness studies, and the quality of these studies is a function of study design, measurements used and the ecological validity (i.e. its approximation to real life conditions) of the research.

The PACFA Research Committee acknowledges that an absence of evidence for a particular counselling or psychotherapy intervention does not mean that it is ineffective or inappropriate. Rather, the scientific evidence showing equivalence of effect for different counselling and psychotherapy interventions justifies a starting point assumption of effectiveness.

It should be noted that this review is limited in its scope and covers only seven modalities within family therapy. It was beyond the scope of this literature review to determine which groups of clients have been shown to benefit from family therapy. For more details about specific groups responding to family therapy, we recommend you visit the Cochrane Reviews at <http://www.cochrane.org/cochrane-reviews>.

The PACFA Research Committee is committed to supporting our Member Associations and Registrants to develop research protocols that will help the profession to build the evidence-base to support the known effectiveness of counselling and psychotherapy. We hope that you will find this document, and others in this series, useful. We would welcome your feedback.

Dr Sally Hunter
Chair of the PACFA Research Committee, 2012

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Outline of the Literature Review

Aims of this review

This literature review examines the effectiveness of family and relationship therapy and psychotherapy in relation to the following seven of the key modalities.

1. Experiential Family Therapy (EFT)
2. Structural Family Therapy (SFT)
3. Cognitive Behavioural Therapy (CBT)
4. Multi-systemic Therapy (MST)
5. Family Problem Solving
6. Solution Focused Therapy (SFT)
7. Narrative Therapy

It is acknowledged that these modalities represent only a sample of the many forms of family therapy practiced in Australia and elsewhere. They do represent however some of the key approaches.

This review poses the central research question: 'To what extent, if any, is family and relationship therapy and psychotherapy effective?' The review systematically poses this question when examining each of the seven key modalities. The review assumes that the common aim of each of these modalities as they relate to the field of family and relationship therapy is to identify and treat problematic family and intra-personal relationship dynamics, as defined by the client(s). The review also identifies any knowledge gaps pertinent to the research area.

Scope and methodology of this review

This review describes the characteristics of relevant Australian and international studies, their findings and conclusions, and compares and contrasts relevant studies and findings to determine their veracity. The primary focus, where possible, is on literature released in Australia during the past ten years and internationally in the past five years. Where there is a dearth of available robust research outcomes in this time period, the timeframe has been expanded.

The inclusion criteria for this review provide preference to the following types of studies, in order:

1. Randomised control trial studies.

2. Efficacy studies undertaken under controlled clinical conditions and effectiveness studies elicited from everyday practice.
3. Process research that determines effectiveness (i.e. therapeutic alliance, therapist variables and family members' experience and expectation of therapy).

The following exclusion criteria have been applied to studies in this review:

1. Purely descriptive studies.
2. Studies with poor methodology (e.g. ill-defined terms, no outcome measures, etc.).
3. Studies that have not been published in peer reviewed journals.
4. Explorative studies.
5. Studies with sample sizes too small to generalise findings.
6. Anecdotal commentaries.

The first step in identifying research studies was to examine each issue within the specified dates of the five major journals in the study of family therapy; *Australian and New Zealand Journal of Family Therapy*, the *Journal of Marital and Family Therapy*, *Family Process*, the *Journal of Family Therapy* and the *Journal of Family Psychology*. Next, the following databases were searched: *InformaWorld*, *Web of Science*, *Google Scholar*, *APAIS* and *Social Services Abstracts*. Other databases used included *PSYCINFO* and *PSYCH ARTICLES*. Key search terms, including the name of each of the seven modalities were: 'family therapy', 'couple therapy', 'meta-analysis', 'effectiveness', 'evidence-based' and 'what works'. Additional studies were identified by examining the references sections of reviewed articles and textbooks. Despite the exhaustive literature search, it is acknowledged that some studies may have been overlooked, but in sum, the most substantial studies feature in this review. The appendices provide summary tables listing all of the studies included in the review.

Defining 'effective' practice

In the context of this review, 'effectiveness' is determined by the following two key elements:

1. the extent to which a modality achieves its stated desired client/ family outcomes; and,
2. the methodological soundness of evaluation studies that purport to demonstrate such outcomes, as they relate to each modality.

The seven key modalities can be grouped into two major theoretical approaches: traditional and post-modern. The traditional approaches tend to come from a modernist perspective and can be described as a philosophical perspective that considers there to be an objective world of facts and concepts that are real, the truth of which we can access and share with others. The post-modernist approach rejects this view and instead considers that reality or truth is socially constructed and that meaning is negotiated through discourse with others and ourselves (Freedman & Combs, 1996).

Examining the Modalities

1. Experiential Family Therapy

Sigmund Freud laid the foundations of psychodynamic theory in the early twentieth century. While Freud acknowledged the importance of family in human development, he did not advocate working with the family group and preferred to work with individuals.

Nevertheless, subsequent theorists and family therapists have used the principles of psychoanalysis in the development of family therapy.

Today's practice of psychodynamic family therapy is inclined towards integration and eclecticism in recognition of the limitations of any single therapeutic model. A wide range of family therapies have emerged which might be described as psycho-dynamic and there is not scope to address all of them in this review. Therefore, this review focuses on experiential family therapy as an example of psychodynamic family therapy. Another psychodynamic therapy, structural family therapy is discussed as a separate modality.

Experiential Family Therapy, developed by Virginia Satir (Satir, et al. 1991) and Carl Whitaker (Whitaker & Bumberry 1988), is a traditional insight oriented theory which can be loosely described as psychodynamic. Experiential family therapy, however, tends not to be driven by theory but is focused on the potential of the relationship with the therapist to help family members to develop insight into their family relationships. Greater self-awareness, it is argued, can lead to greater levels of choice and improved levels of functioning. The therapist helps family members to analyse their underlying feelings, to communicate honestly and openly with each other, and to develop self-esteem through a focus on positives rather than negatives. The therapist tries to change repetitive communication styles with a focus on genuineness, avoiding secrets and unlocking defensiveness. Experiential family therapy is a flexible way of working and the content of the session varies according to the needs of the family and the individual therapist.

This review identified thirty-six refereed journal articles and books on experiential family therapy, but only three of those make a direct reference to outcomes or effectiveness. This is partly because the goals of experiential family therapy are often difficult to define, for example, goals such as self-actualisation and expressing innermost thoughts. The nature of this approach is not prescriptive and it is dependent on the needs of particular families and the expert decision-making of the therapist. Therefore, it is difficult to generalise about effectiveness independently of the family or the therapist.

One of the few research studies on this approach was undertaken by Thompson et al. (2011). The authors examined a family therapy approach which included experiential activities as a supplement to the usual family therapy offered to high-risk adolescents and their parents. Follow-up interviews with nineteen carers and young people indicated that

they found the activities helpful and increased their motivation to continue with family therapy.

There has been more recent work done on emotionally-focused couples therapy, which is an experiential systemic model based on Gestalt principles. Byrne, Carr and Clark (2004) reviewed thirteen studies on short term behavioural couples therapy (BCT) and seven studies on the longer-term emotionally-focused therapy (EFT), both directed towards couples. They concluded that the outcomes for EFT were positive and in some cases better than BCT, but cautioned that the results need replication.

2. Structural Family Therapy

Structural family therapy (SFT) was developed by Salvador Minuchin during the 1960s. SFT is described as primarily a way of thinking about and operating in three related areas: (a) the family, (b) the presenting problem, and (c) the process of change (Minuchin, Lee, & Simon, 1996). Prominent in family therapy literature, structural family therapy shares with other family system approaches a preference for examining the contextual nature of the problems rather than a focus on issues and solutions. Structural therapists actively strive for organisational changes in the dysfunctional family as their primary goal (Goldenberg & Goldenberg 2008).

Few studies within the prescribed date ranges exclusively using a SFT model were located. As noted by McFarlane et al, (2003), elements of SFT can be found in other family therapy modalities, particularly within psycho-educational family therapies. SFT concepts have been built on and amalgamated into newer therapies. Family-Directed Structural Therapy (FDST) utilises similar definitions of the family unit (McLendon, McLendon and Petr, 2005) and the structural component of Brief Strategic Family Therapy (BSFT) draws on the work of Minuchin (1974).

Despite an exhaustive search into recent research with SFT utilised as the primary modality, the only research that has been undertaken in the last decade was case study research. Thus, given the limitations with this methodology and inability to generalise the findings of these studies to wider populations, no definitive statement will be given as to the effectiveness of SFT.

Carter (2011) provides an example of the type of case study research which has been undertaken on SFT. He undertook single case study research with a young man and his family where the primary diagnosis was schizophrenia. The family was randomly selected to participate in this intervention and sixteen Personality Questionnaires were administered over the fifteen week treatment. Carter reports significant change in the individual from pre-test to post-test. Sim (2007) describes a case study involving an adolescent and their family in Hong Kong, where drug and alcohol use of the young person was identified as the primary issue. A Chinese Self-Report Inventory was administered pre- and post-treatment.

The author tentatively concluded that there was improvement in both individual and family functioning.

Going outside the scope of the specified timeframe, two key studies utilising SFT were located. Szapocznik et al. (1988) undertook a randomised controlled study assigning families in which an adolescent was suspected of, or observed, using drugs. Subjects were randomly assigned to a strategic structural systems engagement (experimental) condition or to an engagement-as-usual (control) condition. The two conditions were operationalised by establishing therapist behaviours that were permitted within each treatment group. The outcome measures of this study were difficult to ascertain and focused on establishing the level of rapport between the therapist and client. The authors of this study noted that this cohort of young people was particularly difficult to engage in treatment. Thus, one of their key findings was that subjects in the experimental condition were engaged at a dramatically higher rate than subjects in the control condition. The authors conceded that, although not intended, the study design was limited by the fact that one therapist administered both the control and experimental intervention, making clear differences in the modalities difficult to discern or attribute to the model of the individual therapist.

Szapocznik et al. (1989) undertook a further randomised control study, assigning participants to one of three interventions: structural family therapy, psychodynamic child therapy, and a recreational control condition. Participants included sixty-nine Hispanic boys (aged 6-12 years), who presented with behavioural and emotional problems. Five outcome measures were utilised in this study, administered pre- and post-intervention and at a one year follow up. The control condition was found to be significantly less effective in retaining cases than the two treatment conditions. Interestingly, the most significant finding in this study that supported the position and intervention of family therapists was the dramatic effect on the family functioning measure with the Family Therapy condition improving, the Child Therapy condition deteriorating, and the Control group remaining the same.

SFT has attracted numerous criticisms in recent years, of which much stems from the use of confrontation and the impact this has on the therapeutic alliance (Hammond & Nichols 2008). Proponents of SFT strenuously deny the use of confrontation is harmful to the therapeutic relationship. Hammond & Nichols (2008) examined the use of empathy in structural family therapy by reviewing twenty-four video tapes of sessions utilising SFT. The Therapist Collaborative Empathy Scale was utilised to measure the use of empathy. This tool relies on observer ratings to measure the extent to which a therapist demonstrates an effort to elicit and accept a client's perspective. The authors of this study suggest that although confrontation and 'forceful interventions' may be a feature of SFT, a collaborative partnership may be a prerequisite for making these interventions effective. The authors acknowledge the limitation of the small sample size of this study and of utilising primary observer rating scales to draw conclusions and note that further study is required to ensure results are accurate.

The Maudsley model of family therapy is an eclectic model of intervention specifically designed for the treatment of children and adolescents with anorexia nervosa. Although this model notes strong influences from both narrative and strategic family therapy it embraced the work of Minuchin's structural work with anorexia (Rhodes, 2003) which is evident in its three clear phases of intervention. The primary focus of the intervention is to empower the family to take control of the re-feeding aspect of intervention over a 6 to 12 month time period (The National Eating Disorders Collaboration, 2010). Developed at the Maudsley Hospital in London, the Maudsely model of family therapy has received empirical support internationally.

Robin et al (1995) conducted a randomised control study comparing the impact of a family systems therapy (FST) (with similar underpinnings to the Maudsely model) to individual therapy (IT) amongst 22 adolescents diagnosed with anorexia nervosa. Each group received an average 15 months therapy with a 12-month follow-up period. Both groups improved significantly over time on body mass index. At post-treatment, 64% in the FST and 64% of IT had achieved target weight. At 12-month follow-up, 82% of the FST and 50% of the IT were at or above target weight.

Authors reported that other measured outcomes, such as measures of family functioning, generally favoured those treated with behavioural family systems therapy.

The support for the model was not as influential when comparing it to another family therapy. Eisler et al., (2007) conducted a randomised control study with a 5 year follow-up period. Families were allocated to either conjoint family therapy or separated family therapy (an early variation of the "Maudsley" model). The authors found that 72.2% of patients in CFT group and 80% of patients in SFT had good outcome further concluding that there were no differences in the long-term outcome between the two treatment groups, though noting the efficacy of family therapy with regard to treating anorexia nervosa.

3. Cognitive Behaviour Therapy (CBT)

Today, cognitive-behavioural therapy (CBT) has become a conventional part of psychotherapy and aims to alter an individual's thoughts and actions by modifying their conscious thought patterns (Goldenberg & Goldenberg, 2008). The distinct influence of this approach has been its determination to employ a rigorous, scientific set of methods that is regularly and consistently scrutinised (Goldenberg & Goldenberg, 2008). This review examines CBT outcomes as they compare to other therapeutic approaches, as well as outcomes from specific forms of cognitive-behavioural family therapy, including behavioural couple therapy (BCT), integrative behavioural couple therapy (IBCT) and behavioural marriage therapy (BMT). The majority of identified studies relevant to these approaches are from the USA and UK and were published between 2004 and 2011.

Behavioural Couple Therapy (BCT)

Two very recent systematic reviews that examine behavioural-couple therapy (BCT) have been published in the USA. The most recent of these examines BCT outcomes as part of a larger review of controlled studies of marital and family therapy (MFT) treatment outcomes for alcoholism (see O'Farrell & Clements, 2011). The review includes mostly randomised studies and some quasi-experimental studies, published between 2002 and mid-2010, which compare MFT to one or more comparison situations (O'Farrell & Clements, 2011). Results of the study were reported at two main stages of change: (a) when a person dependent on alcohol is unwilling to seek help, and (b) when such person has sought help. No specific outcomes of BCT were noted at the first stage of change, but the authors conclude that in the second stage, MFT and BCT are more effective than individual treatment for increasing abstinence and improving relationship function (O'Farrell & Clements, 2011). BCT also appeared efficacious with women, gay and lesbian alcoholics and showed promise in treating male alcoholic veterans with comorbid combat-related post-traumatic stress disorder (PTSD) (O'Farrell & Clements, 2011).

The second systematic review examined outcomes of a specific program of BCT developed by Fals-Stewart, O'Farrell and colleagues (see Ruff et al. 2010). Twenty-three studies, published in peer-reviewed journals that examined this version of BCT, were included in the review. The authors made the general finding that couple-based treatment for substance abuse was consistently more efficacious than individual treatment (Ruff et al. 2010). The authors concluded that the literature demonstrated BCT was linked to positive outcomes for children and reduced intimate partner violence (IPV) (Ruff et al., 2010).

Integrative Behavioural Couple Therapy (IBCT)

In an American study that compared how traditional behavioural couple therapy (TBCT) and integrative behavioural couple therapy (IBCT) affected relationship satisfaction during and after therapy, Christensen et al. (2010) followed up one-hundred and thirty-four distressed married couples for five years after they participated in a clinical trial. In the original trial, couples had been randomly assigned to approximately eight months of either TBCT or IBCT (Christensen et al. 2004). Treatment outcomes were based on participant self-reports every three months during the treatment and for five years after treatment (Christensen et al. 2010). The study concluded that TBCT and IBCT were both effective, but that IBCT produced marginally, but significantly, improved outcomes for the first two years following treatment termination (Christensen et al., 2010). However, after five years of follow-up assessments and no further treatment, these differences between treatments had disappeared (Christensen et al., 2010).

Behavioural Marriage Therapy (BMT)

Shadish and Baldwin (2005) conducted a meta-analysis to examine the outcomes of thirty randomised trials with distressed couples that compared behavioural marital therapy (BMT) with no-treatment control groups. This appears to be the first substantial review conducted

of BMT, since it was first declared to be empirically supported more than a decade ago by Baucom (see Baucom et al. 1998). Shadish and Baldwin concluded that BMT is significantly more effective than no treatment and that despite the trend for BMT studies to be conducted under conditions that are not as clinically representative as other study samples, representativeness did not have a significant relationship to outcome (Shadish & Baldwin, 2005). More notably however, the authors stated that ‘...evidence also suggested that publication bias may exist in this literature whereby small sample studies with small effects are systematically missing compared with other studies.’ (Shadish & Baldwin, 2005, p. 6) Thus, the findings of this review should be interpreted with caution.

Cognitive Behavioural Therapy (CBT) and Multi-Dimensional Family Therapy (MDFT)

A recent American study involved secondary analysis of two randomised control trials using growth mixture modelling (GMM) to examine diversity in treatment response (Henderson et al., 2010). Of these studies, one is of particular interest to this review, as it compared the effectiveness of individually delivered CBT with multi-dimensional family therapy (MDFT) for treating adolescent substance abuse and delinquency (Henderson et al., 2010). The study involved two-hundred and twenty-four primarily male African-American adolescents (aged 12 to 17.5 years), with substance abuse issues not requiring detoxification. Young people were excluded from the study if they were actively suicidal. Participants were randomly assigned to either CBT or MDFT. Treatment outcomes were assessed using baseline, post-treatment and follow-up assessments at six and twelve months after terminating treatment. The secondary analysis of this study concluded that individually delivered CBT produced inferior treatment outcomes for young people with more severe substance abuse and greater psychiatric comorbidity than MDFT (Henderson et al., 2010).

It is perhaps worth noting that in addition to this study, there is a large and growing body of literature related to the effectiveness of interventions or ‘what works’ to reduce recidivism and delinquency in children, adolescents and adults that demonstrates the efficacy of CBT approaches in this regard (see Dowden & Andrews, 2003; McGuire, Kinderman & Hughes, 2002; Sallybanks, 2002; Sexton & Alexander, 2002).

4. Multi-Systemic Therapy (MST)

Multi-Systemic Therapy (MST) is sometimes described as a form of family therapy, however there are key differences from traditional models of intervention. MST is a home-based model of service delivery, which aims to overcome barriers that families and young people may face to services access, with the purpose of increasing the chances that families will adhere to the treatment. It is a holistic intervention, addressing several key systems in which the individual and family are involved, including educational/ vocational systems, peer and wider social groups, and neighbourhoods. In consultation with each family member, the therapist identifies well-defined treatment goals, assigns the tasks required to accomplish these goals, and monitors the progress in regular family sessions at least once a

week. The goals of the treatment are family-driven, rather than therapist-driven, and the treatment is highly individualised.

The goal of MST is to provide an integrative, cost-effective, family-based treatment that results in positive outcomes for adolescents who demonstrate serious antisocial behaviour (Perkins-Dock, 2001). MST focuses on altering the young person's natural settings in the home, school and locality in order to support positive conduct and behaviours (Henggeler et al., 1997). MST is usually provided for three to five months and therapists carry caseloads of four to six families. Therapists are seen as experts, and are available round-the-clock to respond to families and crises (Henggeler et al., 1998). MST draws on a number of family therapy modalities included in this review, such as strategic family therapy, structural family therapy, behavioural parent training and cognitive therapies.

MST has a strong research tradition with research assessing its effectiveness being undertaken since its inception in the 1990s. Research pertaining to the effectiveness of MST has predominately been undertaken with offending adolescents. The results of these outcome studies clearly support the efficacy of MST in treating relatively serious, psychosocial difficulties with juvenile offenders and their multi-problem families. MST has demonstrated decreased criminal activity and incarceration in studies with violent and chronic juvenile offenders (Rowland et al., 2005; Timmons-Mitchell et al., 2006; Ogden & Halliday-Boykins, 2004; Perkins-Dock, 2001). Painter (2009) evaluated a pilot project designed to use MST with youth who were seriously and emotionally disturbed, who had no history of juvenile justice involvement. The author compared MST services with intensive case management and parent skills training. Preliminary results indicated that youth involved in MST improved to a statistically significant degree with lessened symptoms and improved functioning.

Henggeler et al. (2003) undertook another study that moved beyond the scope of offending adolescents and their families, and examined the efficacy of treating adolescents with a serious emotional disturbance and their families with MST. According to several outcome measures, including placement and youth-report outcomes measures, MST was initially more effective than emergency hospitalisation and usual services at decreasing adolescents' symptoms and out-of-home placements and increasing school attendance and family structure. These differences, however, were generally not maintained at one-year follow-up.

Following on from this study, Rowland et al. (2005) conducted a randomised, mixed factorial study examining the effectiveness of MST compared to usual services in thirty-one adolescents with serious emotional disturbance. This study included a six-month follow-up and found that compared to usual services, adolescents in families treated with MST reported significant reductions in externalising symptoms, internalising symptoms, and minor criminal activity. Caregivers reported near significant increases in social support, and

archival records showed that MST youths experienced significantly fewer days in out-of-home placement.

The majority of research has been undertaken in the USA and criticism has been levied at this research as it has predominately been undertaken by researchers affiliated with MST (Littell, 2008). Two notable studies have been undertaken outside of the USA. Curtis, Ronan, Heiblum & Crellin (2009) undertook a one-group pre-test/ post-test study incorporating a 12 month follow-up period. They reported ninety-eight percent of the families in this study successfully completed treatment. Further to this they established that there was a comparable magnitude of reduced re-offending rates of MST participants as seen in the United States, with MST being superior to the treatment as usual control group. A study undertaken in Norway (Ogden & Halliday-Boykins, 2004) also reported positive outcomes with regard to increasing youth social competence and family satisfaction with treatment.

5. Family Problem Solving

Family problem solving has its origins in models of problem solving, which have been used by workers in the human services for many years. This model has been utilised by social workers, psychologists, family support workers and family therapists working with clients in a wide array of settings including child welfare, youth justice, mental health, drug treatment, school welfare, community and hospitals. Typically, the family problem solving model is an eight-step approach, specifically designed for client/s to understand the nature and purpose of the intervention and the roles of the worker and each family member. Briefly, the model encompasses role clarification, problem survey, problem ranking, problem exploration, setting goals, developing a contract, developing tasks/strategies and an on-going review process (Trotter, 2010).

There has been some research on the effectiveness of this approach with families. Wade et al (2006) undertook a study with families where a young person (aged 5 to 16 years) was recovering from traumatic brain injury. Sixteen families were given family problem solving and sixteen control group families received no treatment. The experimental group were offered seven bi-weekly core sessions with family members followed by four individualised sessions using the problem solving model. They used the acronym ABCDE to describe the steps in the model - Aim, Brainstorm, Choose, Do it, Evaluate. Sessions focused on general goals as well as goals relating directly to the brain injury, based on the evidence that brain injury impacts on multiple issues for family members. This study found positive results for the use of family problem solving with families with a young person (aged 5 to 16 years) recovering from brain injury. The young people in the treated families subsequently showed significant reductions in levels of behaviour problems, depression and anxiety.

Ahmadi et al (2010) undertook research in Tehran using a family problem model with married couples studying the effects of family problem-solving on decreasing the couple's dissatisfaction. Four hundred and fifty couples were recruited and participated in the study,

and were randomly assigned to the experimental or control group. Ahmadi (2010) found increased levels of marital satisfaction following around fifteen sessions of family problem solving with maladjusted couples, compared to a matched control group with no treatment. The model included several steps: an introduction to the model, prioritizing issues and increasing optimism, creating solutions evaluating solutions, solving problems and evaluation.

A meta-analysis of thirteen randomised studies of the use of problem solving therapy (PST) for depression concluded that there is no doubt that PST can be an effective treatment for depression, although they also suggest that more research is needed to determine when and in what circumstances it is most effective (Cuijpers, van Straten, and Warmerda, 2007). They defined PST as:

[A] 'psychological intervention in which the following elements had to be included: definition of personal problems, generation of multiple solutions to each problem, selection of the best solution, the working out of a systematic plan for this solution, and evaluation as to whether the solution has resolved the problem.' (Cuijpers et al., 2007:10)

In addition, family problem solving models have been shown to be effective with depressed older adults in methadone maintenance treatment (see Rosen, Morse and Reynolds, 2011). Those undertaking the study have argued that PST is particularly suitable for this group, as it is less cognitively demanding than other therapies. Family problem solving models also appear to be effective in reducing suicidal behavior and depression, as demonstrated in a study with young people in Sri Lanka (Perera & Kathriarachchi, 2011).

In another study, a twelve-session family problem solving intervention was offered to families recruited from a head start program in Canada (Drummond, Fleming, McDonald & Kysela, 2005). They used a model based on three steps: 'evaluate options', 'can anyone help' and 'agree and notice the difference'. They found improvements in the length of time that children in the experimental group engaged in play therapy and further co-operation within the parent / child relationship was also evident. Problem solving also proved to be effective in an Australian study by Trotter (2010) of thirty-one families, most of which had been referred for family work by juvenile justice or child protection agencies. Seventy four percent of the family members reported that they were getting along much better following the family counselling, with only one person saying that things were worse.

Psycho-education family interventions are not commonly applied in current clinical practice though there is a body of literature supporting such intervention. Most notably, psycho-education has generally been applied in the field of mental health, utilised to support and educate family members about their loved one's illness. A complicating factor when investigating the empirical evidence regarding psycho-education is defining what constitutes this intervention as it is often married into other interventions such as the problem solving model. Magilano et al (2005) conducted a one year follow-up study on the implementation and effectiveness of a psycho-educational family intervention in six European countries. Intervention was provided to families for one year by a range of suitably qualified

practitioners. The authors report the psycho-educational intervention was associated with a statistically significant improvement in patients' symptoms and social functioning as well as in family burden and coping strategies. It was not clear, however, if psycho-educational intervention was the only intervention offered over this one year period.

6. Solution Focused Brief Therapy (SFBT)

Solution Focused Brief Therapy (SFBT) was developed by Steve de Shazer, Insoo Kim Berg, and their team at the Brief Family Therapy Center in the mid-1980s. It is described as a brief goal-focused treatment developed from therapies applying a problem-solving approach and systemic family therapy (Gingerich & Eisengart, 2000). The key elements of solution focused therapy include; problem identification and motivation; the miracle question; possibility/hope; scaling/ goal formation; exceptions and coping; confidence/strengths; and feedback. It is centred on assisting clients construct solutions to their problems rather than focusing on the problem itself. It is based on a social constructivist philosophy and on the assumption that the resolution of a client's presenting problem need not involve an understanding of the root cause of the problem. Solution focused family therapy is often used in crisis intervention settings (Greene et al., 1996), child protection services (Berg, 1994; Berg and Kelly, 2000), and school settings (Corcoran, 2006).

Only one meta-analytic study examining the effectiveness of solution-focused brief therapy (SFBT) (see Kim, 2008), could be located for this review, canvassing the period from 1988 to 2005. This meta-analysis included a sample of twenty-two distinctive studies, eleven of which were either published or under review in peer reviewed journals and eleven were unpublished dissertations. Findings from this meta-analysis demonstrated small but positive treatment effects favouring SFBT group on the outcome measures ($d = 0.13$ to 0.26). Only the magnitude of the effect for internalizing behaviour problems was statistically significant at the $p < .05$ level, thereby indicating that the treatment effect for SFBT group is different than the control group.

Two reviews of controlled outcome studies of SFBT were undertaken in 2000 and 2009 respectively. Each of these reviews noted the methodological limitations of the studies examined, but there was a consistent finding for the efficacy of SFBT (Gingerich et al. 2000; Corcoran & Pillai, 2009), with Corcoran & Pillai (2009) reporting about 50 percent of the studies reviewed can be seen to show improvement over alternative conditions or no-treatment control. Three randomised control studies were also located pertaining to the effectiveness of SFBT. Unfortunately, many of the included studies on solution focused interventions were focused on group or individual interventions and did not specifically examine the effectiveness of Solution Focused Therapy within the domain of couples or relationship counselling. An overwhelming number of the studies identified were American and no Australian studies pertaining to SFBT were found.

7. Narrative Therapy

Pioneered by Michael White (Dulwich Centre, Adelaide) and David Epston (Family Therapy Centre, Auckland), narrative therapy is a set of social constructionist intervention techniques that characterise the influence of post-modernism on family therapy practice (Goldenberg & Goldenberg 2008). Narrative therapy, which originates from clinical work with children, is defined as a process that assists people to re-examine the narratives or stories that underpin how they have lived their lives through 're-authoring' or 're-storying' conversations (Goldenberg & Goldenberg 2008; Morgan 2000). As postmodernism considers that reality is structured and reinforced through stories that form people's current and future identities, a key aim of narrative therapy is to increase people's awareness of the dominant, helpful or unhelpful stories that are influencing their lives (Bennett 2008).

Despite a comprehensive search for outcome studies of narrative therapy that fit the inclusion criteria for this review, only two methodologically adequate studies were identified, of which only one is relevant to family therapy. This study, from the UK, is well beyond the preferred time-span for this review, published in 1998, and compares the outcome of White (1984) and White and Epston's (1990) 'externalising' approach to predominantly behavioural approaches for the treatment of children with soiling issues (Silver et al. 1998). The methodology for this study is a retrospective audit of the therapy notes and follow-up of one-hundred and eight children with soiling issues, who attended the Ipswich Child and Family Consultation Service with their families for treatment. Fifty-four families were treated with 'externalising' methods and a further fifty-four families were treated by usual, predominantly behavioural, clinic methods. The audit included one-hundred and sixty-two sets of notes over a four year period and post-treatment follow-up questionnaires, (sent at six months), completed by General Practitioners (GPs) and parents regarding treatment satisfaction. Compared to the group who had received treatment as usual, the results from the externalising group were better and rated as much more helpful by parents at follow-up with GPs reporting that less children from this group returned with soiling issues (Silver et al. 1998). The authors concluded that in the treatment of children who soil, externalising appears to be a viable alternative or addition to behaviour modification (Silver et al. 1998).

Other literature that did not fit the methodological requirements of this review, but was found to be relevant to narrative therapy was not in most cases relevant to family therapy (see Butt 2011; Herzig 2010; Matsuba et al. 2010; Rood 2009; Wever 2009; Young 2010). These studies offered anecdotal evidence about the value and effectiveness of narrative therapy, based on single or a small number of case studies or practice outcomes described by the practitioner. However, one Australian study, which also employs a case study approach, uses hermeneutic analysis of family therapy sessions that included narrative techniques to document a child's narrative understanding of the presenting family problem (Larner, 1996). The author reported that for both parents and children the understanding of the family presenting problems improved using the narrative approach (Larner, 1996).

Similar to the findings of this review, a recent article by Bennett (2008), examines the evidence-base for narrative therapy and its associated effectiveness. Bennett notes that qualitative research has provided the majority of knowledge and that:

[t]he values and practices underlying research on narrative methods stress the importance of experience, individual perspectives, and the voice of the research participant over the voice of the researcher.' (West & Bubenzer 2002, In Bennett 2008, p. 14)

Bennett briefly describes a number of such qualitative studies, which have been described in various articles and textbooks, all of which purport to support the effectiveness of narrative methods. These international studies generally focus on children and use case studies to demonstrate their outcomes (see Besa, 1994; Focht & Beardslee, 1996; Lerner, 1996; Vetere & Dowling, 2005).

Also outside the methodological scope of this review, two exploratory Canadian ethnographic studies have examined the outcomes of narrative therapy from clients' and practitioners' perspectives. The earliest study examined eight families' experiences of narrative therapy from their perspective and found that narrative therapy provided them with a 'richness of...experience' and that '[t]hese clients believe that the therapy helped reduce their problems.' (O'Connor et al., 1997, p. 493) The subsequent, most recent study examined the experiences of a team of eight narrative therapists in using this approach in a large outpatient, paediatrics and child psychiatry clinic in a teaching hospital (O'Connor et al., 2004). Of interest to the post-modern foundations of narrative therapy, the researchers made the following observations in relation to addressing family violence:

'This particular team switched from the post-modern approach where there are many interpretations and stories to a right and wrong approach with violence. Can a postmodern approach that stresses a variety of interpretations be used with family violence? How can narrative be used more effectively when dealing with instances of family violence?' (O'Connor et al. 2004, p. 37)

The study concluded that overall, the therapists found narrative therapy to be helpful with clients in reducing the presenting problem, but that further, longitudinal research, located in a variety of contexts, is required (O'Connor et al. 2004).

Given the inability to generalise findings from these studies to broader populations, no definitive statements can be made about the effectiveness of narrative therapy and it is clear that further research is required to develop an evidence base from which to establish the efficacy and effectiveness of narrative therapy with couples and families.

Concluding Comments

This review has examined the available research outcomes for the effectiveness of seven key modalities in couples and family therapy. While the review set out to focus on research conducted in Australia within the last five years, besides the work of Trotter (2010), virtually

no Australian studies could be located. Those that were located either fell well outside the review's preferred time-span of ten years or did not meet the methodological inclusion criteria, or both. The international studies included in this review are predominantly American, followed by the UK, and the results have largely been published within the past five years. The available research varied considerably across modalities in its quantity and methodological quality. In some areas, such as cognitive-behavioural therapy, there is a vast amount of rigorous research focused on individuals, but limited amounts conducted with couples and families.

This review found that there is evidence to support the effectiveness of a number of approaches with couples and families, including multi-systemic family therapy (MST) and family problem solving. Promising approaches that require further research to support their effectiveness include experiential family therapy, behavioural couples therapy (BCT), behavioural marriage therapy (BMT) and solution focused brief therapy (SFBT), while approaches for which there are no clear outcomes include emotionally focused therapy (EFT), structural family therapy (SFT) and narrative therapy. There are clear gaps in the available literature with a need for more methodologically rigorous research to be conducted with couples and families in general, and specifically, in an Australian context.

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Appendices

Appendix 1 – Table of experiential family therapy studies

	Author / date / location	Methodology / study type	Substantive Focus	Participants	Outcomes/ Measures	Follow up	Conclusion regarding effects of Experiential Family Therapy
1.1	Thompson (2011) <i>USA</i>	Qualitative, in-depth interviews	Understand how families view experiential activities within family therapy.	19 Adolescents (aged 12–17 years) and their parents/caregivers, receiving family therapy combined with experiential activities, recruited from social service agency.	Analysis of interviews with participants.		<ul style="list-style-type: none"> • Most young people and their caregivers found the experiential activities helpful in creating positive family interactions and developing communication skills. • Participants indicated that the activities improved their desire to participate in family therapy sessions and motivation to engage in the treatment. • Limitations of this study mean that results cannot be generalised.
1.2	Byrne, Carr & Clark (2004) <i>Ireland & UK</i>	Systematic review	To review the efficacy of behavioural couples therapy (BCT) and emotionally focused couples therapy (EFT) in alleviating couple distress.	20 Treatment outcome studies – 13 on BCT, 7 on EFT, published 1982–2002.	Study inclusion criteria: 1. Controlled and uncontrolled treatment outcome studies that included reliable and valid pre- and post-treatment assessment instruments. 2. English language.	N/A	<ul style="list-style-type: none"> • EFT leads to short and long-term gains for mild to moderate couple distress. • Addition of a cognitive therapy component to EFT does not enhance its efficacy. EFT may be more effective than problem solving therapy and less effective than integrated systemic therapy, but the two studies supporting this conclusion require replication.

Appendix 2 – Table of structural family therapy studies

	Author / date / location	Methodology / study type	Substantive Focus	Participants	Purpose/ Hypothesis	Outcomes/ Measures	Follow up	Conclusion regarding effects of structural family therapy (SFT)
2.1	Szapocznik, Rio, Murray, Cohen, Scopetta & Rivas-Vazquez, (1989) USA	Follow up of randomised clinical trial.	To build on previous research regarding the effectiveness of three differing interventions: structural family therapy (SFT), psychodynamic child therapy (IPCT), and a recreational control condition	Boys 6-12 years and their families: N= 26 in SFT N= 26 in IPCT N= 17 in the control condition.	An investigation of efficacy of each modality and an exploratory articulation of mechanisms that may account for effectiveness	<ul style="list-style-type: none"> Psychodynamic Child Rating Scale Structural Family Systems Ratings (SFSR) Behavioral, self-report, psychodynamic, and family measures 	1 year	<ul style="list-style-type: none"> The control condition was found to be significantly less effective in retaining cases than the two treatment conditions. Dramatic effect on the family functioning measure with the Family Therapy condition improving, the Child Therapy condition deteriorating, and the Control group remaining the same.
2.2	Szapocznik,, Perez-Vidal, Brickman, Foote, Santisteban & Hervis (1988) USA	Randomised controlled study	Subjects were randomly assigned to a strategic structural systems engagement (experimental) condition or to an engagement-as-usual (control) condition.	Strategic structural engagement (experimental group) n = 56 Engagement as usual (control group) n = 52	To test the efficacy of a procedure for engaging hard-to-reach cases and bringing them to therapy completion.	<ul style="list-style-type: none"> Psychiatric Status Schedule(PSS) Client Oriented Data Acquisition Process (CODAP) 	N/A	<ul style="list-style-type: none"> The subjects in the experimental condition were engaged at a dramatically higher rate than subjects in the control condition. The study design was limited by one therapist administered both the control and experimental intervention, making clear differences in the modalities difficult to discern or attribute to the model of the individual therapist.

Appendix 3 – Table of cognitive-behavioural studies

	Author / date / location	Methodology / study type	Substantive Focus	Participants	Purpose/ Hypothesis	Outcomes/ Measures	Follow up	Conclusion regarding effects of cognitive-behavioural therapy (CBT)
3.1	O'Farrell & Clements (2011) USA	Systematic review	Examine outcome of controlled studies of marital and family therapy (MFT), including behavioural marital therapy (BMT), in alcoholism treatment.	Controlled studies (published 2002-mid-2010) that compare MFT with one or more comparison conditions. Most studies involved randomisation, but some quasi-experimental studies (without random assignment) included.	Updates the earlier review by O'Farrell and Fals-Stewart (2003) on the effectiveness of MFT in alcoholism treatment.	Study inclusion criteria: 1. Evaluate one or more treatment groups, involving spouse and/or other family members of an alcoholic to (a) improve family coping and/or initiate change when the alcoholic unwilling to seek help or (b) aid the alcoholic's recovery once they had sought help. 2. Include comparison group (either wait-list control group, individually based treatment without a family-involved component, or alternative family treatment method. 3. Specific objective outcome data.	N/A	<ul style="list-style-type: none"> Once the client enters treatment, MFT, particularly BCT, is evidently more effective than individual treatment at increasing abstinence and enhancing relationship functioning. New BCT studies showed efficacy with women alcoholics and with gay and lesbian alcoholics. BCT was successfully transported to a community clinic.
3.2	Christensen, Atkins, Baucom & Yi (2010) USA	Follow up of randomised clinical trial.	To follow distressed married couples for 5 years after their participation in a randomised clinical trial (see Christensen et al. 2004).	134 chronically and seriously distressed married couples randomly assigned to approx. 8 months of either traditional behavioural couple therapy (TBCT; Jacobson & Margolin, 1979) or integrative behavioural couple therapy (IBCT; Jacobson & Christensen, 1998).	A key aim: Examine how TBCT and IBCT affected relationship satisfaction during and after therapy.	Marital status and satisfaction were assessed on self-reports using several different methods approximately every 3 months during treatment and every 6 months for 5 years after treatment.	2 years (previous study) and 5 years	<ul style="list-style-type: none"> TBCT and IBCT both produced substantial effect sizes in even seriously and chronically distressed couples. At 2 year follow-up, IBCT produced significantly but not dramatically superior outcomes. At 5 year follow-up, without further intervention, outcomes for the 2 treatments converged.

3.3	Ruff, McComb, Coker & Sprenkle (2010) USA	Systematic review	Provide a substantive and methodological review of Fals-Stewart, O'Farrell, and colleagues' program of research on behavioural couples therapy (BCT).	23 Studies that examined Fals-Stewart, O'Farrell and colleagues' version of BCT.		Study inclusion criteria: 1. Published in peer-reviewed journals 2. Written in English 3. Examined Fals-Stewart, O'Farrell and colleagues' version of BCT 4. Examined primary and/or secondary outcomes of BCT 5. Directly related to the dissemination or cost effectiveness of BCT.	N/A	<ul style="list-style-type: none"> • Couple-based treatment for alcohol and drug abuse was consistently more efficacious than individual treatment. • BCT research demonstrated positive outcomes for children and is associated with decreased intimate partner violence (IPV).
3.4	Henderson, Dakof, Greenbaum & Liddle (2010) USA	Secondary analysis of 2 randomized controlled trials. (Only 1 relevant to this review and included in this table.)	Examine heterogeneity in treatment response in a secondary analysis of a study that compared effectiveness of individually delivered CBT with multidimensional family therapy (MDFT) for adolescent drug abuse and delinquency.	224 Primarily male African-American drug-using adolescents (aged 12-17.5 years) and their families, not requiring inpatient detoxification and not actively suicidal.	Hypotheses: 1. At least 2 classes of change trajectories characterised in part on baseline severity would be identified. 2. MDFT would be more effective than comparison treatments among the classes demonstrating greater baseline substance use and co morbidity.	Secondary analysis using growth mixture modelling (GMM).		<ul style="list-style-type: none"> • Results indicate that for young people with more severe drug use and greater psychiatric co morbidity, MDFT produced superior treatment outcomes to individually delivered CBT (Study 1).

3.5	Shadish & Baldwin (2005) <i>UK</i>	Meta-analysis	Examine outcomes of studies that compare behavioural marital therapy (BMT) with no-treatment control with distressed couples.	30 Randomised experiments of BMT with distressed couples.		Study inclusion criteria: 1. Randomised experiments comparing BMT to control. 2. Interventions aim to reduce marital or psychological distress. 3. Cognitive-behavioural marital therapy (CBMT) studies.	N/A	<ul style="list-style-type: none"> • BMT is significantly more effective than no treatment. • Representativeness not significantly related to outcome (BMT research inclined to be conducted under conditions that are less clinically representative than other samples). • Publication bias may exist in this literature.
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Appendix 4 – Table of Multi-Systemic therapy studies

	Author/ date/ location	Methodology / study type	Substantive Focus	Participants	Purpose/ Hypothesis	Outcomes/ Measures	Follow up	Conclusion regarding effects of Multi-Systemic Therapy
4.1	Curtis Ronan Heiblum Crellin (2009) <i>New Zealand</i>	One-group pre-test/post-test design	Examine the transportability of Multi-systemic Therapy (MST) for the treatment of juvenile offenders in a community	65 young people and their families. Youth ranged in age from 8.6 to 17.0 years ($M = 13.83$, $SD = 1.88$), and 71% ($n = 46$) were male.	<ol style="list-style-type: none"> 1. To evaluate the effectiveness of MST in assisting families to engage and finish treatment. 2. To evaluate the effectiveness of MST in terms of ultimate outcomes including reduced youth offending and recidivism, days in formal out-of-home placements, increased school and/or employment attendance. 3. To evaluate the effectiveness of MST in terms of instrumental outcomes including improved youth psychosocial functioning and family relations. 	<ol style="list-style-type: none"> 1. Outcome data (i.e., details of frequency and severity of offending behavior, days in out of home placements, days absent from school) 2. Consumer Satisfaction Questionnaire 3. Multi-systemic Behavioral Rating Scale 4. Recidivism data 	6 months 12-month	<ul style="list-style-type: none"> • Ninety-eight percent of the families in this study successfully completed treatment. • High staff attrition rates • High client satisfaction

4.2	Timmons-Mitchell, Benderm Kishna & Mitchell (2006) USA	Randomised clinical trial	Evaluating the efficacy of MST vs. treatment as usual (TAU) in the treatment of 93 juvenile adolescents who had appeared before a family court	MST; n = 48 TAU; n = 45 Mean age 15.1 years (SD 1.25)	1. The MST effects on rearrest results achieved in previous clinical trials are replicable in an independent clinical trial conducted in the United States with juvenile offenders 2. The effects of MST on youth functioning	1. Recidivism 2. Child functioning - Child and Adolescent Functional Assessment Scale	6 months 12 months 18 months	<ul style="list-style-type: none"> The hypotheses, that MST would be superior to treatment as usual in (a) reducing rearrest and (b) improving functioning during treatment and at follow-up were partially supported Specifically, MST resulted in decreased recidivism compared with the effects of usual court services
4.3	Rowland, Halliday-Boykins, Henggeler, Cunningham, Lee, Kruesi and Shapiro. (2005) USA	Randomised mixed factorial design (treatment type: MST vs. Usual Service) × 2 (time: Pre-treatment vs. 6-month follow-up).	Examining the effectiveness of MST vs. usual services in 31 adolescents with serious emotional disturbance	MST; n = 15 Usual services; n = 16 Mean age 14.5 years 58% male	The project represents a partial replication of the Henggeler 2003 study, in which MST was used as an alternative for the psychiatric hospitalization of youths in crisis.	1. Child Behaviour Checklist 2. Youth Risk Behavior Survey 3. Substance use - Personal Experience Inventory 4. Criminal activity – Self-Report Delinquency Scale 5. School placement	6 months	<ul style="list-style-type: none"> Compared to usual services, MST condition reported significant reductions in externalizing symptoms, internalizing symptoms, and minor criminal activity; their caregivers reported near significant increases in social support; and archival records showed that MST youths experienced significantly fewer days in out-of-home placement
4.4	Schaeffer & Borduin (2005) USA	Randomised clinical trial	Follow-up study MST vs. individual therapy (IT) assessing long-term criminal activity of 176 adolescents	MST n = 92 IT n = 84		Recidivism data	13.7 years	<ul style="list-style-type: none"> Significantly lower recidivism rates for MST group at follow-up, compared to IT group (50% vs. 81%, respectively) 54% fewer arrests and 57% fewer days of confinement in adult detention facilities for MST group

4.5	Ogden & Halliday-Boykins (2004) Norway	Randomised clinical trial	Examining the effectiveness of MST vs. usual Child Welfare Services (CS) in the treatment of antisocial behaviour in adolescents	100 adolescents recruited MST; n = 60 CS; n = 40 Total sample: Mean age 14.95 years (SD 1.87) 63% male	The favourable outcomes utilising MST obtained in the US would be replicated in Norway for adolescents with serious behaviour problems.	<ol style="list-style-type: none"> 1. Child Behaviour Checklist – assessed by caregiver, adolescent and teacher 2. Self-Report Delinquency Scale 3. Social Competence with Peers Questionnaire - assessed by caregiver, adolescent and teacher 4. Social Skills Ratings 	6 months	<ul style="list-style-type: none"> • MST was more effective than CS at reducing youth internalising and externalising behaviours and out-of-home placements, as well as increasing youth social competence and family satisfaction with treatment • Previous measures of recidivism difficult to obtain in Norway this other, non-equivalent, measures utilised.
4.6	Curtis Ronan Bourdin 2004 USA	Meta-analysis	Evaluate the effectiveness of Multi-Systemic Therapy (MST)	7 primary outcome studies and 4 secondary studies involving a total of 708 participants.		<p>Inclusion of studies in the meta-analysis required</p> <ol style="list-style-type: none"> 1. identification of the treatment approach as MST, including documented adherence to the MST treatment principles 2. random assignment of participants to MST and one or more control groups; 3. a clinical sample in which youths or their parents/caregivers manifested antisocial behavior (defined as social rule violations, acts against others, or both) and/or psychiatric symptoms; 4. use of both pre-treatment and post treatment assessment measures and/or follow-up assessment measures; and 5. use of test statistics suitable for meta-analysis. 		<ul style="list-style-type: none"> • Following treatment, youths and their families treated with MST were functioning better than 70% of youths and families treated alternatively. • Results also showed that the average effect of MST was larger in studies involving graduate student therapists (i.e., efficacy studies; $d = .81$) than in studies with therapists from the community (i.e., effectiveness studies; $d = .26$). • MST demonstrated larger effects on measures of family relations than on measures of individual adjustment or peer relations.

4.7	Henggeler, Rowland Halliday-Boykins, Sheidow, Ward, Randall, Pickrel, Cunningham & Edwards (2003) USA	Randomised clinical trial	1-year follow-up assessing efficacy of home-based MST vs. inpatient hospitalisation followed by usual services in the treatment of 156 children and adolescents approved for emergency psychiatric hospitalisation	Mean age 12.9 years 65% male	Based on the success of MST in treating juvenile offenders at imminent risk of placement, a study was designed to examine whether the model could be adapted to produce comparable outcomes in treating serious emotional disturbance	Adolescent symptomatology: Global Severity of Index of the Brief Symptom Inventory (completed by adolescent); Child Behavior Checklist (completed by caregiver) Adolescent self-esteem: Self-Esteem sub-scale of Family Friends and Self Scale Days in out-of-home placement: Service Utilisation Survey (completed by caregiver) School attendance	12 months	<ul style="list-style-type: none"> • According to placement and youth-report outcomes measures, MST was initially more effective than emergency hospitalisation and usual services at decreasing adolescents' symptoms and out-of-home placements and increasing school attendance and family structure • These differences were generally not maintained at 1-year follow-up • Hospitalisation resulted in a rapid, short-lived decrease in externalising symptoms based on caregiver reports
4.8	Henggeler, Clingempeel, Brondino & Pickrel (2002) USA	Randomised clinical trial	Follow-up study examining four-year outcomes examining MST vs. usual community services in the treatment substance-abusing juvenile offenders	80 of 118 original participants MST; n = 43 Usual services; n = 37		Self-Report Delinquency scale Illicit drug use: Young Adult Self-Report; Addiction Severity Index Youth Risk Behavior Survey Psychiatric symptoms: Substance use Criminal Behaviour Urine and head hair samples	4 years	<ul style="list-style-type: none"> • Significant long-term treatment effects for aggressive criminal activity, but not for property crimes • Biological measures showed significantly higher rates of marijuana abstinence for MST group • No long term treatment effects for psychiatric symptoms

Appendix 5 – Table of family problem-solving studies

	Author / date / location	Methodology / study type	Substantive Focus	Participants	Purpose/ Hypothesis	Outcomes/ Measures	Follow up	Conclusion regarding effects of family problem solving
5.1	Wade, Michaud & Brown (2006) <i>USA</i>	Randomised clinical trial	To describe a family-centered problem-solving intervention (FPS) for paediatric traumatic brain injury (TBI), and to assess the efficacy of the intervention in a randomized clinical trial.	19 families allocated to FPS 18 families allocated to TBI	Families receiving FPS: increased knowledge, improved relationships, and high levels of acceptance of the intervention; caregivers receiving FPS would report fewer behavioural problems associated with the child, less parental psychological distress, and lower levels of parent-child conflict at the post-intervention assessment than would caregivers in the comparison group.	1. Child Behavior Checklist 2. Brief Symptom Inventory 3. Conflict Behavior Questionnaire	N/A	<ul style="list-style-type: none"> • FPS led to significant reductions in child behavior problems • Families in the FPS group did not report greater reductions in parental distress than did families in the UC group • Limited follow up
5.2	Ahmadi, Ashrafi, Kimiaee & Afzali (2010) <i>Iran</i>	Randomised clinical trial.	The effects of family problem-solving on decreasing couples dissatisfaction	80 couples in total 50 couples in experimental group 30 couples in control group	A key aim: To assess the effectiveness of family problem-solving in reducing marital dissatisfaction	ENRICH satisfaction scale	Pre and post intervention	<ul style="list-style-type: none"> • Increased levels of marital satisfaction following around fifteen sessions of family problem solving with maladjusted couples, compared to a matched control group with no treatment

Appendix 6 – Table of Solution Focused Brief Therapy studies

	Author (date)	Methodology / study type	Substantive Focus	Participants	Purpose/ Hypothesis	Outcomes/ Measures	Follow up	Conclusion regarding effects of Solution Focused Brief Therapy (SFBT)
6.1	Corcoran & Pillai (2009) (USA)	Literature review	Review of treatment outcome research involving solution-focused therapy to determine empirically its effectiveness		Follow on from Gingerich et al. (2000) review to examine efficacy of SFT	The review involved experimental or quasi-experimental designs conducted from 1985 to 2006 (10 studies identified)		<ul style="list-style-type: none"> About 50 per cent of the studies can be viewed as showing improvement over alternative conditions or no-treatment control . A call for 'equivocal and more rigorously designed research needs to establish its effectiveness' .
6.2	Kim (2008) USA	Meta-analysis	Evaluate the effectiveness of solution-focused brief therapy (SFBT)	outcome studies from 1988 to 2005		Rated for inclusion (a) randomization of sample; (b) comparisons with other treatments, standard services, or waiting lists; (c) definition of specific problem or population; (d) use of validated and reliable outcome measures; (e) use of treatment manuals or procedures and monitoring of treatment adherence through video or audio review; and (f) large sample size (more than 25 per group).	N/A	<ul style="list-style-type: none"> positive treatment effects favouring SFBT group on the outcome measures (d = 0.13 to 0.26) Concluded that SFBT appears to be effective with internalizing behavior problems such as depression, anxiety, self-concept, and self-esteem but does not appear to be as effective with externalizing behavior problems such as hyperactivity, conduct problems, or aggression or family and relationship problems.
6.3	Corcoran (2006) USA	Non-randomised controlled, quasi experimental study	Examining outcomes for solution-focused therapy (SFT) compared to treatment as usual	139 families began SFT intervention (58% dropped out) 100 families began 'treatment as usual' (73% dropped out)	Treatment engagement would be higher in the SFT group and that the SFT group would show greater improvement according to both parent and child reports.	Conners Parent Rating Scale Feelings, Attitudes, and Behaviors Scale for Children	Not stated	<ul style="list-style-type: none"> Better treatment engagement in SFT group No statistically significant differences between groups on perceptions of child behaviours from either parents or child reports High attrition rate for both experimental and control groups.

6.4	Gingerich & Eisengart (2000) USA	Review of controlled outcome studies of SFBT	Effectiveness of SFBT	15 individual studies	discuss the extent to which SFBT has received empirical support through to 1999	Separated studies into 3 groups well controlled, moderately controlled and poorly controlled studies		<ul style="list-style-type: none"> • All five of the well-controlled studies reported significant benefit from SFBT— four found SFBT to be significantly better than no treatment or standard institutional services. • As these studies did not compare SFBT with another psychotherapeutic intervention, the researchers were not able to conclude that the observed outcomes were due <i>specifically</i> to the SFBT intervention as opposed to general attention effects.
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Appendix 7 – Table of narrative therapy studies

	Author / date / location	Methodology / study type	Substantive Focus	Participants	Outcomes/ Measures	Follow up	Conclusion regarding effects of Narrative Therapy
7.1	Silver, Williams, Worthington & Phillips (1998) UK	Retrospective audit of the therapy notes and follow up of 108 children with soiling issues.	This study aimed to compare the outcome of White (1984) & White & Epston's (1990) 'externalising' approach to the treatment of children with soiling issues, compared to predominantly behavioural approaches used at the Ipswich Child & Family Consultation Service.	108 Children & their families referred for 'faecal soiling', 'encopresis', 'psychological soiling', 'failing toileting', 'constipation with overflow' and 'deliberate soiling'. 54 treated by 'externalising' and 54 treated by usual clinic methods.	Audit and analysis of 162 sets of notes over a 4-year period, including follow-up GP and parental outcome questionnaires regarding treatment satisfaction.	Min. 6 months	<ul style="list-style-type: none"> • Compared to 'treatment as usual' group, results from the externalising group were better and compared positively to standards resulting from previous soiling studies. • Parents rated externalising as much more helpful at follow-up. • To treat children who soil, externalising could be a viable alternative or addition to behaviour modification.