JANUARY/FEBRUARY 2022

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FAMILY THERAPY MAGAZINE
THE AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY

Effectiveness of Couple and Family Interventions:

A Decade Review

FAMILY THERAPY MAGAZINE

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> **The evidence base for couple and family interventions has flourished since the first JMFT efficacy and effectiveness special issue was published.**

FEATURES

The articles in this issue are based on the January 2022 issue of the *Journal of Marital and Family Therapy*.

DEPARTMENTS

ALSO IN THIS ISSUE

Perspectives

Read the JMFT January 2022 issue online at https://onlinelibrary.wiley.com/journal/17520606

A Message from the President

Farewell 2021 … Hello 2022!

It's that time of year again, to glance into the rearview mirror at what lies behind and to look to what lies ahead. As you look in the rearview mirror of your past year, what do you see? We've all been enduring a worldwide pandemic—that is still ongoing—and it has shaped each of us, our systems, our lives, our worldview. What do you see there, looking back over the last few years? Now, face forward. When you look ahead, across the horizon for the year(s) before you, what do you envision? Will the world reset itself? Will humans reach deep into their best selves and shape the environments around them for good? Are you a part of that? Systems, like cells, are shaped by their environments. You and I and everyone around us wherever our geographical or social location finds us, have been and are being shaped by our environments. Are we paying attention to what this means for us as humans, as families, as an Association, as communities across the planet?

The view behind and before is the process that the AAMFT Board of Directors engages with throughout our work. Informed by our history, envisioning our vibrant future; considering the meta and micro, we chart a course for our future. In 2021, your board worked diligently in areas of Strategic Planning, DEI implementation and integration throughout governance units across the full Association, overseeing decisions for the future work environment(s) necessary for a changed workplace, and striving to ensure that AAMFT is the best it can possibly be.

Cells are shaped by their environments, as I noted earlier, yet the reverse may also highlight why we belong to this Association: we understand as systemic thinkers, that *systems shape environment(s)*. One of my favorite quotes is from 2001 Nobel Peace Prize recipient and UN Secretary-General, Kofi Annan: "If tolerance, respect, and equity permeate family life, they will translate into values that shape societies, nations, and the world." I love this statement because for me, it sums up the power of systemic thinking and interventions. In a classroom, at a workshop, or even quietly in a room with an individual, a couple, a family, or a workgroup, we are inviting the consideration of Other—their experience, their stories, their rightful due dignity; families shaping the greater systems around them.

One of the ways various systems have been impacted over the past years—and perhaps you've heard it voiced yourself—is regarding capacity. Many people are speaking of the edges of their capacities, their humble limitations to being overwhelmed with nearly two years of continual change and loss. This is especially critical when one considers that we are in the early storm-surge of a mental health tsunami fast approaching. What do we need amid this limitation of capacity as we glance at that proverbial rearview mirror and look ahead to our future?

Ironically, this takes me to service. Giving to others, using different parts of ourselves to serve in a different manner, can be the very wellspring of lifegiving in difficult times. As part of a helping profession, it may be challenging to think of serving in any other manner than the high demand arena in which you are already working. And yet, we may encourage depressed or anxious clients to consider serving at a soup kitchen, assist at a food bank, or lend a hand to someone else. We do this because serving others puts into perspective what we have, who we are; we do this to help those with illness that demands their self-focus to survive, to simply focus on others instead.

What about us? What about systemic thinkers and clinicians who are already feeling overwhelmed and the edges of their capacities? Can service be lifegiving? What about service right within our own Association, alongside other dedicated members?

AAMFT has many arenas in which service is possible: Geographical Interest Networks, Topical Interest Networks, Leadership Mentoring, the Family Team (see Engage & Network tab), COAMFTE, the AAMFT Elections Council and the AAMFT Board of Directors (see About AAMFT, Call for Nominations on the website). Dedicated stewards of the Association and faithful members are always welcome and needed across all these areas. Yet you may be thinking you are at your own personal

capacity. I will openly share that serving as President during the first worldwide pandemic in over 100 years was never my envisioned future! Yet even amid all that has been transpiring—including social justice issues that defy Annan's quote—serving amongst other members has been and is lifegiving.

The year 2022 lies before us with unknown challenges and possibilities. Our Association is strong and healthy. Medicare inclusion is the closest it's ever been. MFTs are doing tremendous good throughout the world. We have hopes for seeing one another face-to-face in the future; we have access to one another through virtual means that is affordable and inclusive. Perhaps it is time for you, the reader, to consider if service in AAMFT might expand your capacities and give life to you even during all that is transpiring. Perhaps this is the year to step up.

I see that our Association—that protects and promotes the profession and the practice of marriage and family therapy—brings positive change to communities across the globe by ensuring the ability for us to have the professions and practices we engage in every day. Service in the Association may be what grants you more capacity; you, too, may find it lifegiving.

In closing, I leave you with another applicable Kofi Annon quote that for me speaks to the reason to serve and support: "To live is to choose. But to choose well, you must know who you are and what you stand for, where you want to go and why you want to get there."

Happy 2022, my fellow AAMFT Members!

Sincerely,
SHELLEY A. HANSON, MA

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Ready to serve in AAMFT? Check out the links on our website, www.aamft.org, by clicking on the tabs ENGAGE and Network, ADVANCE the Profession, or About AAMFT – Call for Nominations, to see areas of service where you can engage!

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Family Therapy Magazine (ISSN 1538-9448) is published bimonthly (January, March, May, July, September, November) by the American Association for Marriage and Family Therapy, Inc., 112 South Alfred Street, Alexandria, VA 22314-3061. Printed in the USA. Periodical mailing from Alexandria and additional entry points.

The articles published in the *Family Therapy Magazine* are not necessarily the views of the association and are not to be interpreted as official AAMFT policy.

Manuscripts may be submitted electronically to FTM@aamft.org. Concise articles (1800 words or less) are preferred. Authors should allow at least two months for a decision.

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Advertising materials are due approximately eight weeks before the month of publication. Please call (703) 253-0447 or write to marketing@aamft.org for exact deadline dates and all advertising questions. All advertising must be prepaid.

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LETTERS TO THE EDITOR

We encourage members' feedback on issues appearing in the Family Therapy Magazine. Letters should not exceed 250 words in length, and may be edited for grammar, style and clarity. We do not guarantee publication of every letter that is submitted. Letters may be sent to FTM@aamft.org or to Editor, Family Therapy Magazine, 112 South Alfred Street, Alexandria, VA 22314-3061.

NOTEWORTHY

GLOBAL PERSPECTIVES

Family-based Intervention for Chinese Families with Children with ADHD

AAMFT Professional Member Joyce L. C. Ma, PhD, reviewed the clinical utility of family-based treatment (FBT), comprised of multiple family therapy (MFT) and structural family therapy (SFT), in helping Hong Kong Chinese families with children with attention deficit hyperactivity disorder (ADHD). Ma identifies the psychosocial service needs of these families and examines the contributions of the adapted MFT and SFT in responding to the psychosocial service needs of these families. Critical issues for clinical practice and research are discussed. Some key points are that empirical and anecdotal evidence supports the clinical utility of family-based treatment in helping these families and that engagement of fathers is critical in helping families with children with ADHD, as well as noting that family therapists are in the best position to offer FBT for families with children with ADHD.

Read the full study. Ma, J. L. C. (2021). Family-based intervention for Chinese families of children with attention deficit hyperactivity disorder (ADHD) in Hong Kong, China. *Australian and New Zealand Journal of Family Therapy, 42*, 402-413. https://doi.org/10.1002/anzf.1468

on the web **Journal of Marital and Family Therapy** Access JMFT at www.aamft.org/jmft // Click 'Proceed to the Wiley-Blackwell website'

correction

Correction to the November/December 2021 issue: "Navigating Client Generated Prejudice" was authored by DeAnna Harris-McKoy, PhD, Racine R. Henry, PhD, and Taimyr Strachan-Louidor, PhD.

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Congratulations!

AAMFT Member Melissa Tran Receives Dr. Robert L. Jesse Award

Melissa Tran, MA, LMFT, an AAMFT Professional Member holding the Clinical Fellow designation, at the Orlando VA Healthcare System, won the Under Secretary for Health Dr. Robert L. Jesse Award for Excellence in InnoVAtion for her InnoVAtion Perinatal Reproductive Education and Planning Resources (PREPARe). PREPARe provides a holistic prenatal and postnatal support program involving nutrition, mental health and women's health. Support groups and classes are available for those who are expecting or recently postpartum. Offerings range from yoga, hypnosis and childbirth, lactation counseling, parenting styles, infant loss, infertility, post-partum depression, effective communication and how your health affects your child including nutrition and food safety. This award recognizes and honors VA employees who have demonstrated excellence and enabled the discovery and spread of healthcare innovation that exceeds expectations, restores hope, and builds trust. Inspired by her own experience with motherhood, Tran developed the program to help other new parents navigate pregnancy and its related conditions. Tran often felt lost during her pregnancy and postpartum period, so she made it her mission to make sure that perinatal services, education, and support are readily available across VHA.

Congratulations, Melissa, on this outstanding achievement!

Introduction to the special issue on the efficacy and effectiveness of couple and family interventions: Evidence base update 2010-2019
Andrea K. Wittenborn, PhD and Kendal Holtrop, PhD (Special Issue Editors)
January 2022 *Journal of Marital and Family Therapy*

Evidence Base Update on the Efficacy and Effectiveness of Couple and Family Interventions, 2010-2019

Andrea K. Wittenborn, PhD Kendal Holtrop, PhD

Since 1995, the *Journal of Marital and Family Therapy* (JMFT) has published decade reviews to provide clinicians and other stakeholders an update on the evidence base for couple and family interventions for mental and behavioral disorders and health conditions (Pinsof & Wynne, 1995; Sprenkle, 2003; Sprenkle, 2012; Wittenborn & Holtrop, 2022). The most recent JMFT decade review was published in January 2022 (Wittenborn & Holtrop, 2022). This exciting issue reviewed the empirical evidence published from 2010 to 2019 on couple and family interventions for a range of mental and behavioral disorders and health conditions relevant to our work as couple and family therapists. The JMFT special issue includes 11 articles that review the evidence base on couple and family interventions for common mental and behavioral disorders and one article focused on high mortality health conditions; the final article (Dwanyen, Holtrop, & Parra-Cardona, 2022) describes the past decade of intervention research on racially and ethnically diverse populations. Findings from these reviews add to the cumulative body of evidence that has consistently shown the positive short- and long-term effects of couple and family interventions (e.g., Carr, 2019a; 2019b). The authors of each article in the special issue reviewed the empirical evidence published in the past decade, in combination with the cumulative body of literature, and constructed categories of the interventions they identified. The interventions were grouped into categories based on mechanism of action, underlying theory, or other meaningful characteristics. The authors then used a set of criteria (Southam-Gerow & Prinstein, 2014) to classify the level of evidence that existed for each intervention category into one of five levels of evidence.

Level 1: Well-Established Interventions require two or more rigorous studies, led by two or more independent research teams in independent settings, showing the intervention to be either: (a) statistically superior to another intervention, or (b) equivalent or not significantly different from an already established intervention in a study with adequate statistical power. The studies were required to meet the following methodological criteria: (a) a randomized controlled trial (RCT) design, (b) use of intervention manual or equivalent, (c) clear inclusion criteria applied to the target population, (d) psychometrically sound assessment of outcomes, and (e) appropriate data analyses. **Level 2: Probably Efficacious Interventions** must show either: (a) two or more rigorous studies demonstrating significantly better outcomes than a waitlist control group, or (b) at least one study meeting Level 1 criteria; they must also meet the same methodological criteria as Level 1. **Level 3: Possibly Efficacious Interventions** are supported by either: (a) at least one rigorous study showing the intervention to be superior to a waitlist or no treatment control group with the same five methodological criteria as Level 1 and Level 2, or (b) at least two studies showing the intervention to be efficacious but without meeting the RCT method requirement. **Level 4: Experimental Interventions** have positive findings from at least one study but are not rigorous enough to meet the Level 3 criteria. Finally, **Level 5: Treatments of Questionable Efficacy**, have been tested against a comparison group and found inferior.

Brief overview of JMFT special issue

The special issue articles report evidence-based classifications on interventions for the following conditions: (1) infant and early childhood mental health (Kaminski, Robinson, Hutchins, Newsome, & Barry, 2022), (2) disruptive behavior problems (Sheidow, McCart, & Drazdowski, 2022), (3) attention-deficit/hyperactivity disorder (Babinski & Sibley, 2022), (4) anxiety disorders (Goger & Weersing, 2022), (5) mood disorders (Wittenborn et al., 2022), (6) suicidal ideation and behavior (Frey, Hunt, Russon, & Diamond, 2022), (7) substance use disorders (Hogue, Schumm, MacLean, & Bobek, 2022), (8) traumatic event exposure (McWey, 2022), (9) violence (Stith et al., 2022), (10) couple relationship education (Markman, Hawkins, Stanley, Halford, & Rhoades 2022), (11) couple relationship distress (Doss, Roddy, Wiebe, & Johnson, 2022), and (12) health conditions (Lamson et al., 2022). Table 1 summarizes the classifications of couple and family interventions for each condition. The classification summary is designed to guide clinical decision-making by compiling the most efficacious practices for each condition. Detailed descriptions of the intervention categories listed in Table 1 can be located in the special issue article associated with each condition.

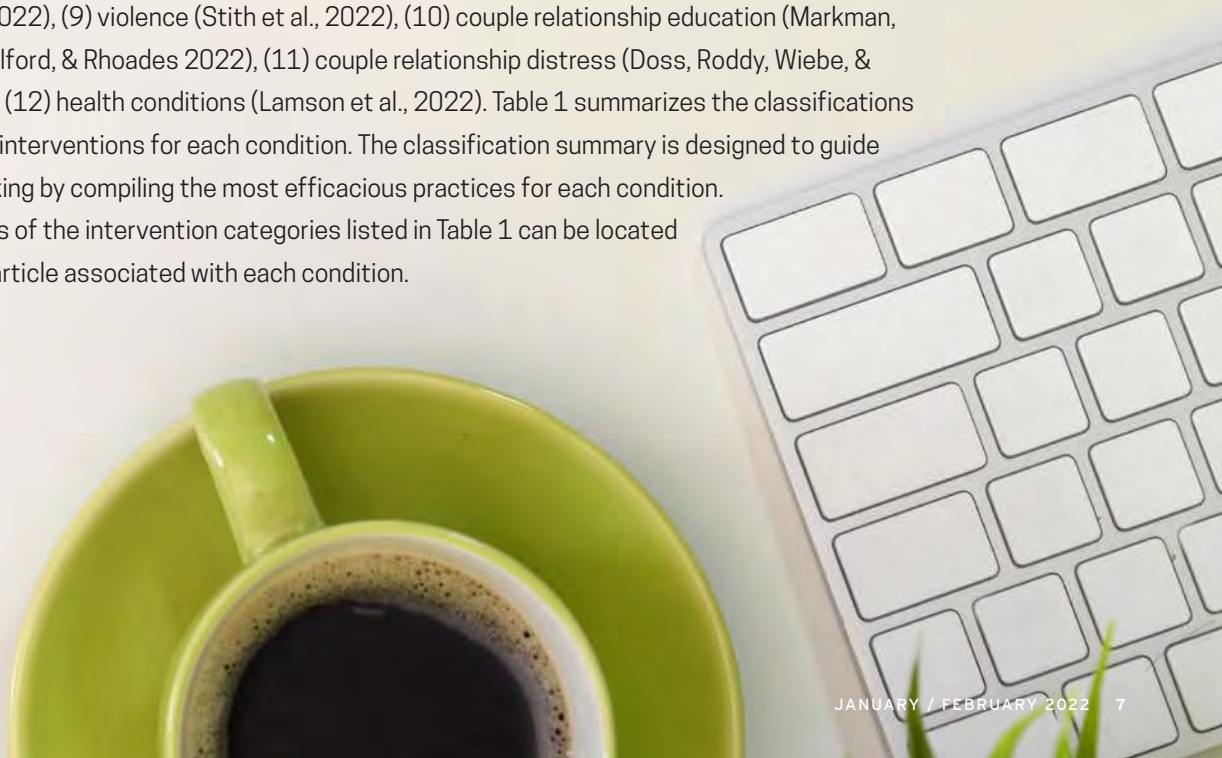

Table 1 Classification Summary of Couple and Family Interventions for Mental and Behavioral Disorders and Health Conditions Reviewed in the JMFT Special Issue

Infant and Early Childhood Mental Health[a]

Level 2: Probably Efficacious	• Behavioral interventions to support parents of toddlers • Interventions to support adolescent mothers • Tiered interventions to provide support based on assessed risk • Home visiting interventions to provide individualized parent support
Level 3: Possibly Efficacious	• Couple interventions to support the transition to parenthood • Parent-infant psychotherapy
Level 4: Experimental	• Parent-focused psychotherapy • Interventions to enhance parent-infant relationships • Interventions to support breastfeeding by improving mother-infant interactions

Disruptive Behaviors

Level 1: Well-Established	• Behavior therapy [parent groups] for child disruptive behaviors • Behavior therapy [family] for child disruptive behaviors • Behavior therapy, cognitive-behavior therapy, & family therapy [combination of family, parent individual, child individual] for adolescent juvenile justice involvement
Level 2: Probably Efficacious	• Behavior therapy [family groups] for child disruptive behaviors • Behavior therapy [parent individual] for child disruptive behaviors • Behavior therapy [family via internet] for child disruptive behaviors • Behavior therapy [parent self-directed & parent coaching] for child disruptive behaviors • Behavior therapy [parent groups & child groups] for child disruptive behaviors • Behavior therapy [child individual with parent participation] for child disruptive behaviors • Behavior therapy and family therapy [family groups] for child disruptive behaviors • Behavior therapy and cognitive-behavior therapy [both parents group & both parents individual] for child disruptive behaviors • Emotion-focused therapy [parent groups] for child disruptive behaviors • Behavior therapy, cognitive-behavior therapy, & family therapy [combination of family, parent individual, child individual] for adolescent disruptive behaviors • Behavior therapy, cognitive-behavior therapy, & family therapy [family] for adolescent juvenile justice involvement
Level 3: Possibly Efficacious	• Behavior therapy [parent groups, family, child groups, child individual] for child disruptive behaviors • Behavior therapy + cognitive-behavior therapy [parent groups] for child disruptive behaviors • Behavior therapy [parent self-directed] for adolescent disruptive behaviors • Behavior therapy and family therapy [parent groups & family] for adolescent disruptive behaviors • Behavior therapy and cognitive-behavior therapy [family] for adolescent disruptive behaviors • Behavior therapy, cognitive-behavior therapy, & family therapy [family] for adolescent disruptive behaviors • Behavior therapy, cognitive-behavior therapy, and family therapy [parent individual] for adolescent disruptive behaviors

Depression

Level 1: Well-Established	• Cognitive and/or behavioral couple and family interventions
Level 2: Probably Efficacious	• Attachment-based couple and family interventions
Level 3: Possibly Efficacious	• Family psychoeducation
Level 4: Experimental	• Integrative approach to couple therapy in a naturalistic setting • Play-based family interventions

Bipolar

Level 1: Well-Established	• Family psychoeducation

Anxiety

Level 1: Well-Established	• Family-based interventions for youth
Level 4: Experimental	• Family-based interventions for adults

Substance Use

Level 1: Well-Established	• Systemic family therapy (as standalone treatment) • Behavioral family therapy (as multicomponent treatment) • Behavioral couple therapy (as multicomponent treatment)
Level 2: Probably Efficacious	• Behavioral family therapy (as standalone treatment) • Behavioral couple therapy (as standalone treatment)

Attention-Deficit/Hyperactivity Disorder

Level 1: Well-Established	• Integrated parent-child treatments • Parent-directed treatments • Youth treatments with adjunctive parent involvement

Suicide Ideation and Behavior

Level 1: Well-Established	• Dialectical behavior therapy + family training for youth • Systemic principles for youth
Level 2: Probably Efficacious	• Cognitive-behavior therapy + parent training for youth • Cognitive-behavior therapy + systemic principles for youth • Psychoeducation for youth
Level 4: Experimental	• Cognitive-behavior therapy + systemic principles [emergency] for youth • Cognitive-behavior therapy-family [emergency] for youth

Traumatic Event Exposure

Level 1: Well-Established	• Systemic youth-caregiver interventions • Systemic group interventions • Systemic couple interventions
Level 2: Probably Efficacious	• Systemic youth interventions

Intimate Partner Violence

Level 2: Probably Efficacious	• Relationship education approaches
Level 3: Possibly Efficacious	• Programs based on cognitive behavioral approaches
Level 4: Experimental	• Naturalistic couple therapy

Child Maltreatment

Level 1: Well-Established	• Parenting programs utilizing in-vivo coaching
Level 3: Possibly Efficacious	• Parent education programs • Family therapy

Couple Relationship Education

Level 1: Well-Established	• Couple relationship education interventions

Couple Relationship Distress

Level 1: Well-Established	• Behavioral Couple Therapy • Integrative Behavioral Couple Therapy • Emotionally Focused Therapy • Cognitive Behavioral Couple Therapy • Marriage Check-up
Level 2: Probably Efficacious	• OurRelationship
Level 3: Possibly Efficacious	• Gottman Method • Psychodynamic • Systemic-constructivist • Hold Me Tight

Health

Level 2: Probably Efficacious	• 1 intervention for congenital deformations/anomalies and chromosomal abnormalities; [0-4] • 3 interventions for cancer/malignant neoplasms [25+] • 1 intervention for Alzheimer's [25+] • 2 interventions for type 2 diabetes [25+]
Level 3: Possibly Efficacious	• 1 intervention for congenital deformations/anomalies and chromosomal abnormalities; [0-4] • 2 interventions for heart disease [25+] • 6 interventions for cancer [25+] • 1 intervention for respiratory disease [25+] • 10 interventions for stroke [25+] • 2 interventions for Alzheimer's [25+] • 4 interventions for type 2 diabetes [25+] • 1 intervention for kidney disease [25+] • 2 interventions for obesity [0-24]
Level 4: Experimental	• 1 intervention for congenital deformations/anomalies and chromosomal abnormalities; [0-4] • 9 interventions for cancer/malignant neoplasms [5-12, 25+] • 3 interventions for heart disease [25+] • 1 intervention for respiratory disease [25+] • 9 interventions for stroke [25+] • 2 interventions for kidney disease [25+] • 9 interventions for obesity [0-24, 25+]
Level 5: Questionable Efficacy	• 6 interventions for cancer [5-12, 25+] • 1 intervention for accidents/unintentional injuries [25+] • 1 intervention for obesity [0-24]

Note. *The intervention categories were developed by the authors of each article to best represent the research on that condition and, therefore, the categories are not consistent across conditions. For health interventions, brackets were used to indicate age categories (e.g., [0-24] indicates 0 to 24 years of age).*

[a] *Two intervention categories for IECMH could not be classified (i.e., curriculum-based INTs for at-risk parents and families, INTs to promote positive parenting through shared reading and play).*

Source: *Wittenborn, A. K., & Holtrop, K. (2022). Introduction to the special issue on the efficacy and effectiveness of couple and family interventions: Evidence base update 2010-2019. Journal of Marital and Family Therapy, 48(1). https://doi.org/10.1111/jmft.12576*

Conclusion

Couple and family interventions are based on the well-established science that close relationships are involved in the development, maintenance, and treatment of mental and behavioral disorders. The evidence base for couple and family interventions has flourished since the first JMFT efficacy and effectiveness special issue was published (Pinsof & Wynne, 1995). **When implemented in the community, these efficacious interventions can make a significant difference in the lives of couples and families.** We encourage future research on couple and family interventions for diverse racial and ethnic groups, gender and sexual identities, ages, and mental health conditions to strive toward mental health equity for diverse and marginalized populations. Together, we can commit to continued research and clinical practice efforts to ensure that all families can receive the most efficacious and culturally appropriate care.

Andrea K. Wittenborn, PhD, is an AAMFT Professional Member holding the Clinical Fellow and Approved Supervisor designations, a professor in the Department of Human Development and Family Studies at Michigan State University, and the program director of the Couple and Family Therapy doctoral program. She also holds an appointment in the College of Medicine's Division of Psychiatry and Behavioral Medicine. Her research evaluates the process and outcomes of couple interventions for depression, including methods for personalizing care. Her research has been continuously funded since 2008 by federal agencies such as the National Institute of Mental Health, private foundations, and intramural awards. Wittenborn is a member of the AAMFT Board of Directors and *Journal of Marital and Family Therapy* Advisory Board. She has also served as a Governor-appointed member of the Michigan Board of Marriage and Family Therapy and mentor for the AAMFT Minority Fellowship Program and AAMFT Leadership Certificate Program. Wittenborn is a licensed marriage and family therapist and has won several awards for excellence in research and mentoring graduate students.

Kendal Holtrop, PhD, is an AAMFT Professional Member holding the Clinical Fellow and Approved Supervisor designations and is an associate professor in the Department of Human Development and Family Studies at Michigan State University. She is also currently serving as the acting program director of the Couple and Family Therapy (CFT) doctoral program. Her program of research focuses on parenting and parenting interventions, with the goal of addressing mental health disparities by expanding the reach of evidence-based parenting interventions among underserved populations. Holtrop has recently completed grants from the National Institutes of Health (NIH) to determine the functional components of the evidence-based GenerationPMTO parenting intervention and from the Michigan Health Endowment Fund to develop and pilot test an online parenting intervention. Holtrop is an editorial board member for the *Journal of Marital and Family Therapy*, an advisory editor for *Family Process*, and a mentor for the AAMFT Minority Fellowship Program. She also serves as a Governor-appointed member of the Michigan Board of Marriage and Family Therapy. Holtrop is a licensed marriage and family therapist.

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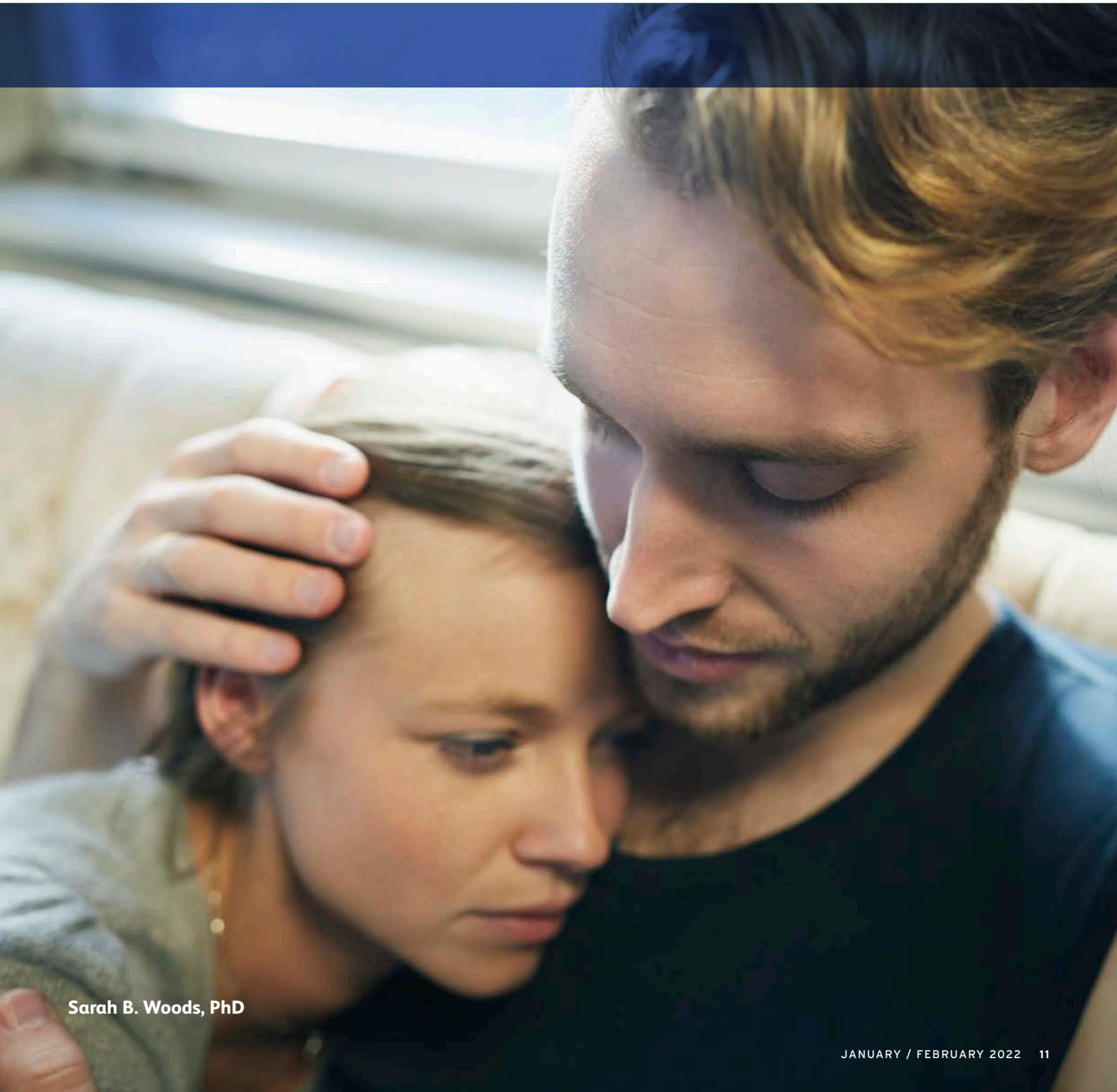
Evidence in Support of Couple and Family Interventions for Depressive and Bipolar Disorders: What Does the Research Say?



Sarah B. Woods, PhD

Couple and family interventions for depressive and bipolar disorders: Evidence base update (2010-2019)
Andrea K. Wittenborn, PhD, Sarah B. Woods, PhD, Jacob B. Priest, PhD, Preston C. Morgan, PhD, Chi-Fang Tseng, MS, Patricia Huerta, PhD, and Caitlin Edwards, MA
January 2022 *Journal of Marital and Family Therapy*

Among those who experience depressive or bipolar disorders, too few get the treatment they need to experience relief. When people do seek treatment, it's commonly in the form of medication, individual therapy, or both. Online searches for treatment options describe symptoms, the process of diagnosis, and effective types of psychotherapy—especially individual and group modalities. Far fewer results guide prospective clients toward couples or family therapy as treatment options—despite the reciprocal relationship between the quality of our close relationships and our mood.

For example, we know that stressful family relationships contribute to the development and maintenance of depression and mania. Family strain may also reduce treatment response: persons with comorbid depression and relationship stress are less likely to achieve symptom relief following therapy than those without relationship distress (Denton et al., 2010). Conversely, depressive and bipolar disorders can create a great deal of stress for families: at the onset of symptoms, for example, or as families work to try and support their family member experiencing mood changes.

Though many individually-oriented therapies help clients experiencing depression or mania to achieve symptom remission, relapse or recurrent episodes are common. Failure to reach or sustain symptom remission is associated with worse disability and even mortality. Especially concerning is the increased risk of suicide linked to persistent depressive and bipolar disorders. Given these high-risk outcomes of failing to adequately treat depression and bipolar disorder, researchers and clinicians have long sought to understand how to improve the success rates of available therapies. Recently, some have suggested that the occasionally poor outcomes of psychotherapy may be due to the common approach of treating these diseases via working with the individual, alone (e.g., Holmes et al., 2018). In other words, given the impact of close relationships on the course of depressive and bipolar disorders, targeting clients' relationships may be a key mechanism to promoting symptom improvement.

Given the impact of close relationships on the course of depressive and bipolar disorders, **targeting clients' relationships** may be a key mechanism to promoting symptom improvement.

But, what is the evidence to support couple and family therapy approaches for depressive and bipolar disorders? Though science, and clinical experience, certainly support the impact of depression and mania on family relationships (and vice versa), establishing research support for *intervening* in these relationships to improve mood is critical. This type of evidence base—specifying which types of couples and family therapy approaches have research to support their effectiveness—can be leveraged to advocate for the increased use of systemic approaches in treating depression and bipolar disorder. It is important that advocating for improved funding for relational therapies, as well as policy recognition of the value of relational therapists, is not tied solely to their value in treating couple and family distress—but, that it also reflects the evidence of the utility of these approaches for common, debilitating mental illnesses.

Earlier research examining the effectiveness of systemic therapies for mood focused mainly on couple-based approaches for depression, and family therapy for bipolar disorders among children and adolescents. In general, summaries of this research suggested that couple interventions that focus on strengthening the couple relationship are helpful for depression, whether or not the couple is distressed (Beach & Whisman, 2012). Moreover,

while the benefits of couples therapy for depression equaled the benefits of individual therapy, couples approaches had the added benefit of improving couple relationship functioning (Barbato & D'Avanzo, 2008). In addition, the growing number of studies testing family interventions for bipolar disorders have shown that family therapy is helpful for maintaining improvements made in treatment, via teaching family members how to support the therapeutic process (Mansfield, Dealy, & Keitner, 2012). However, these earlier summaries of the state of research in this area are now dated and are limited in scope—what is needed is an evaluation of the most recent research support for couples *and* family therapy, for depressive *and* bipolar disorders, for adult *and* pediatric patients.

A new systematic review of couple and family interventions for depressive and bipolar disorders is now available that provides this evidence base. Wittenborn et al. (2021) recently collected clinical trial studies (i.e., research testing a specific intervention versus treatment-as-usual, another type of therapy, or patients on a waitlist) from 2010-2019 testing either couples or family therapy for adults or children diagnosed with a depressive disorder (Major Depressive Disorder, Dysthymic Disorder) or a bipolar disorder (Bipolar I, Bipolar II). Their searches of published research resulted in almost 32,000 studies—one-third on couple interventions, and the remainder testing family interventions.

The research team reviewed each of these studies to ensure they were appropriate, excluding case studies (descriptions of treatment with individual patients) and studies that did not, in fact, test a relational intervention, for example. The result was a collection of 6 clinical trial studies that had tested couple therapy for depression, 13 studies testing family therapy for depression, and 5 studies that tested family therapy for bipolar disorder (zero studies were found that tested couple interventions for bipolar disorders).

Couple therapy for depressive disorders. The authors highlight that the couple therapy approach with the strongest evidence for treating depressive disorders is cognitive and/or behavioral interventions. The results of this systematic review also highlighted an attachment-based couple intervention—specifically, Emotionally Focused Therapy (EFT)—is at least as effective as treatment-as-usual (e.g., group therapy, community-based couple therapy, medication management) at improving depression.

Family therapy for depressive disorders. The research evidence was strongest in support of cognitive and/or behavioral family interventions for depressive disorders, including specific models of therapy such as Family-Focused Treatment for Childhood Depression, Parent-Adolescent-CBT, Family-Based Interpersonal Psychotherapy, and Parent-Child Interaction Therapy. In addition, studies testing attachment-based family therapy interventions—especially tests of Attachment-Based Family Therapy by the model's author—supported the effectiveness of this approach for improving depression among adolescents. Lastly, research is beginning to support psychoeducational family interventions for depression—specifically, family sessions with the patient and their family members focused on learning about the course and impact of Major Depressive Disorder appear to improve mood when offered in combination with usual care (e.g., group therapy, psychopharmacological treatment, etc.). The psychoeducational interventions described in this review were, at times, provided in multi-family groups, which may be a modality that is helpful to test further in the future: meeting together with other families

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experiencing depression may provide validation and decrease isolation.

Family therapy for bipolar disorders. Psychoeducational family interventions (often offered in combination with medication management) had the strongest research support for treating bipolar disorders among youth—especially the Family-Focused Therapy approach. Families receiving this type of treatment received information on bipolar disorder characteristics and suicidality management, as well as communication enhancement and problem-solving skills training.

In all 24 of the studies included in this new systematic review, participants enrolled in couple and family interventions experienced symptom improvement at least similar to (if not better than) those enrolled in a comparison treatment, and significantly more symptom improvement than participants on a waitlist for therapy. In other words, *research supports the use of relational interventions for treating depressive and bipolar disorders!*

As Wittenborn et al. (2021) suggest, understanding *how* these interventions lead to improvements will be an important next step in order to optimize systemic therapies and maximize therapy outcomes. Increasing the availability of training in these approaches may be a key part of advocating for the increased use of couple and family interventions for depressive and bipolar disorders, as well as testing *for whom* these interventions are most effective. Understanding who benefits the most from these types of couple and family interventions aids therapists in appropriately targeting care and would support efforts to increase access to evidence-based relational therapies for the general public. This also requires that future studies establish the effectiveness of these approaches with minoritized couples and families, who are least likely to be represented in current research and may benefit from intervention adaptations to account for their life experiences (e.g., structural racism, anti-gay bias, transnational relationships).

What do the results of this research review mean for practicing therapists? First, for therapists working with couples experiencing depressive symptoms, targeting the depression as well as relationship distress by using a behavioral approach (e.g., Integrative Behavioral Couple Therapy) or EFT may be especially effective. Second, therapists working with young people with depression may find it helpful to select from these research-supported interventions based on the age of their client. For young children (ages 3-6), Parent-Child Interaction Therapy, and teaching parents how to coach their child in recognizing and regulating emotion, may be especially helpful. For therapy with preadolescents ages 7 to 13 years, using either Family-Focused Treatment for Childhood Depression or Family-Based Interpersonal Therapy may benefit the child and their family by mobilizing the family's strengths and improving the family's coping with stressors that trigger depressive symptoms. Adolescents

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(13-18 years) with depressive symptoms, including suicidality, may benefit from an Attachment-Based Family Therapy approach, with a focus on strengthening family relationships and addressing family conflicts associated with the adolescent's depression. Finally, therapists working with youth experiencing bipolar disorders may want to especially consider using a psychoeducational intervention, such as Family-Focused Therapy or Individual-Family Psychoeducational Psychotherapy to improve mood monitoring and active listening.

Overall, though more research in this area is needed, couple and family therapists working with clients experiencing depressive or bipolar disorders have several evidence-based treatment options to choose from. Wittenborn et al.'s (2021) recent systematic review of this research will be helpful for family therapists wanting to promote the research support for relational interventions with these mental illnesses—with clients and larger systems.

Sarah B. Woods, PhD, LMFT, is an AAMFT Professional Member holding the Clinical Fellow and Approved Supervisor designations. She is an assistant professor and director of Behavioral Health at UT Southwestern Medical Center where she teaches in the Department of Family and Community Medicine. Woods recently co-edited the book *Case Studies in Couple and Family Therapy: Through the Lens of Early Career Professionals* (Routledge).

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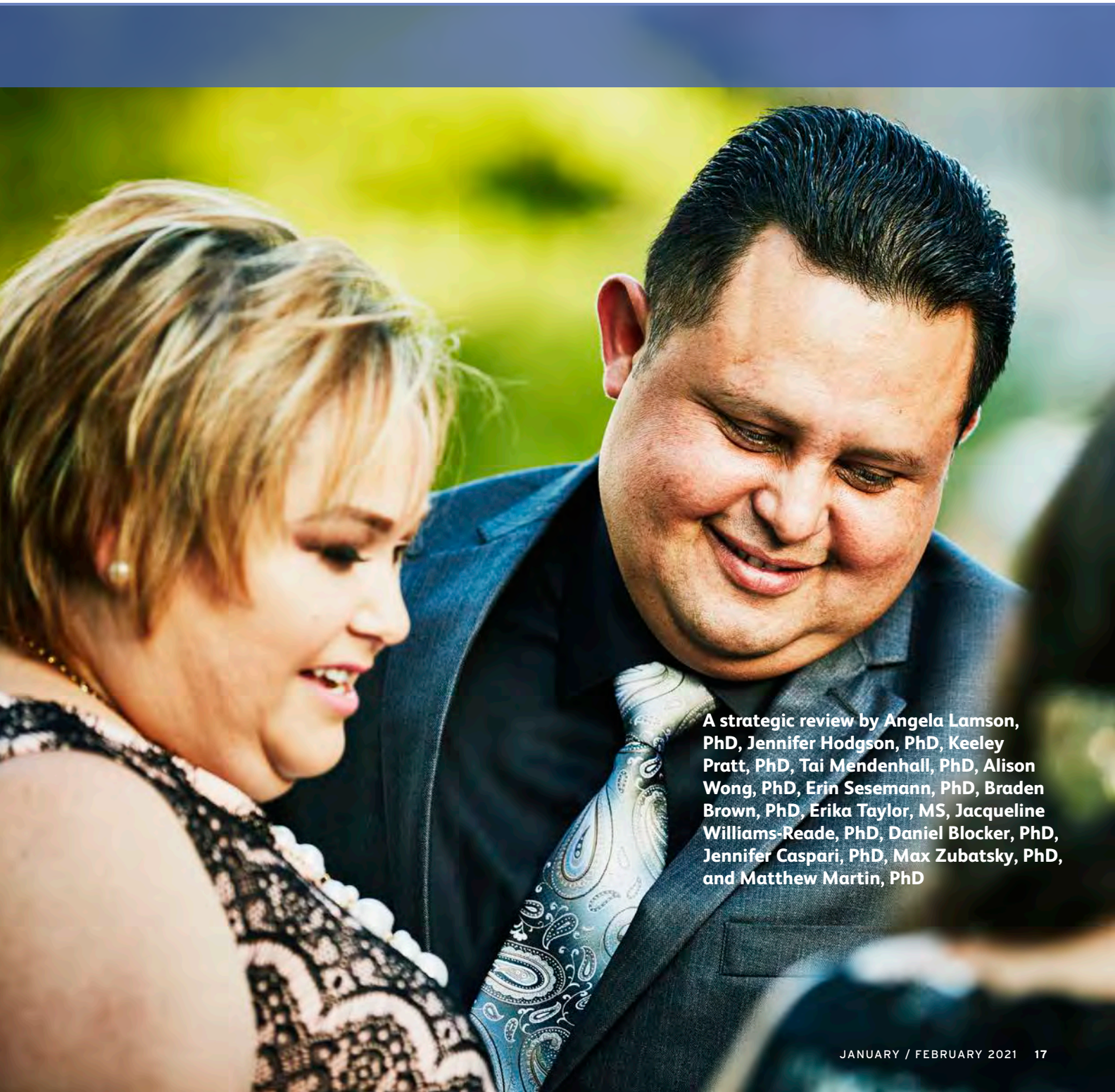
Couple and Family Interventions for High Mortality Health Conditions



A strategic review by Angela Lamson, PhD, Jennifer Hodgson, PhD, Keeley Pratt, PhD, Tai Mendenhall, PhD, Alison Wong, PhD, Erin Sesemann, PhD, Braden Brown, PhD, Erika Taylor, MS, Jacqueline Williams-Reade, PhD, Daniel Blocker, PhD, Jennifer Caspari, PhD, Max Zubatsky, PhD, and Matthew Martin, PhD

Couple and family interventions for high mortality health conditions: A strategic review (2010-2019)
Angela Lamson, PhD, Jennifer Hodgson, PhD, Keeley Pratt, PhD, Tai Mendenhall, PhD, Alison Wong, PhD, Erin Sesemann, PhD, Braden Brown, PhD, Erika Taylor, MS, Jacqueline Williams-Reade, PhD, Daniel Blocker, PhD, Jennifer Caspari, PhD, Max Zubatsky, PhD, and Matthew Martin, PhD
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AAMFT Publications Director Kimberlee Bryce talked with authors of the strategic review to learn more about the study and its findings.

What inspired you all to evaluate family interventions related to medical conditions with the highest mortality rates?

Lamson: As MedFTs, we see health, wellness, illness, trauma, and death in the context of families as they interface with larger systems such as healthcare, schools, and military systems. A group of 13 MedFTs came together with the task of identifying and evaluating the empirical evidence of couple and family interventions in relation to health. Health, as you imagine, encompasses so many conditions. Therefore, we contemplated many places to begin with our search and decided upon the conditions with the highest mortality in the United States.

After all, the earliest practice and research in the field of marriage and family therapy introduced interventions conducted with families experiencing complex health conditions. Our article captures an evaluation of efficacy for couple and family interventions with a focus on the most prevalent health conditions that lead to mortality in the United States.

Hodgson: We needed to be creative in our search strategies, looking beyond traditional ways in which we define and operationalize family, health, and health outcomes. Historically, much of the literature and protocols that were implemented with families only measured individual outcomes. To truly engage in relational and systemic research, you need to know that the researchers took care to study the biopsychosocial and spiritual outcomes with the family as the unit of measurement.

This was such an expansive survey—which age groups and health conditions did you decide to include in your evaluation, and why?

Lamson: Age Groups (Health Conditions)

- Infants and children 0-4 years (chromosomal abnormalities, accidents, assault/homicide),
- Children 5-14 years (accidents, cancer, intentional self-harm/ suicide),
- Adolescents 15-24 years (accidents/unintentional injuries, intentional self-harm/ suicide, assault/homicide), and
- Adults over 25 years (heart disease, cancer, accidents, chronic lower respiratory diseases, stroke, Alzheimer's disease, diabetes, influenza/pneumonia, nephritis/nephrosis, intentional self-harm/suicide)

We needed to start somewhere. We wanted to make sure we were capturing the lifespan and so we selected the top three conditions for infants, children, and adolescents, as well as the top 10 conditions for adults 25 and older. We could have chosen the World Health Organization's lists to have a more global perspective on health, however that would have been incredibly complex because a different list of health conditions are listed for every nation in the world. We strategically evaluated the empirical evidence of couple and family interventions for conditions with the highest mortality in the United States, we chose to rely on the list of conditions according to the Centers for Disease Control and Prevention (CDC).

We also chose to include obesity in our review even though it was not in the top three mortality conditions for children or the ten mortality conditions for adults; we chose obesity for those 5 years of age and older because the CDC and National Institutes of Health (NIH) have consistently listed obesity as a leading precursor to preventable death.

While suicide and/or homicide were present in all age groups, we did not include these in our search because we were aware another JMFT Special Issue article would be covering these topics specifically.

What were some of the key interventions that appeared to be most effective among the various age groups?

Age 0-4

Taylor: Congenital malformations, deformations, and chromosomal anomalies

– Nearly 3000 articles (n = 2937) were assessed for eligibility

(i.e., couple and family intervention articles focused on children with a chromosomal anomaly aged 0-4). Of those reviewed, only three met full inclusion criteria. One included a probably efficacious intervention (i.e., Congenital Heart disease Intervention Program [CHIP-School] with high family inclusion; McCusker et al., 2012). A second CHIP intervention was labeled possibly efficacious with moderate family inclusion (McCusker et al., 2010), and one intervention was deemed experimental with moderate family inclusion (i.e., Enhanced Pilot-Early Start Denver Model [P-ESDM]; Vismara et al., 2019). It is likely that the CHIP program would be considered a well-established intervention if this search allowed for articles to be captured for children beyond the 0–4 age group.

Age 5-14

Cancer/Malignant neoplasms

While several studies stated that family approaches were utilized, the interventions were often individually focused and behavioral in nature, and thus did not adequately capture family interventions.

Accidents

Consistent with younger age groups, no couple or family intervention study emerged from the strategic review for those aged 15-24.

Age 25 and older

Heart disease

Overall, the CBT models, particularly the couples-CBT intervention, offered a promising option for positively influencing health behaviors and relational satisfaction.

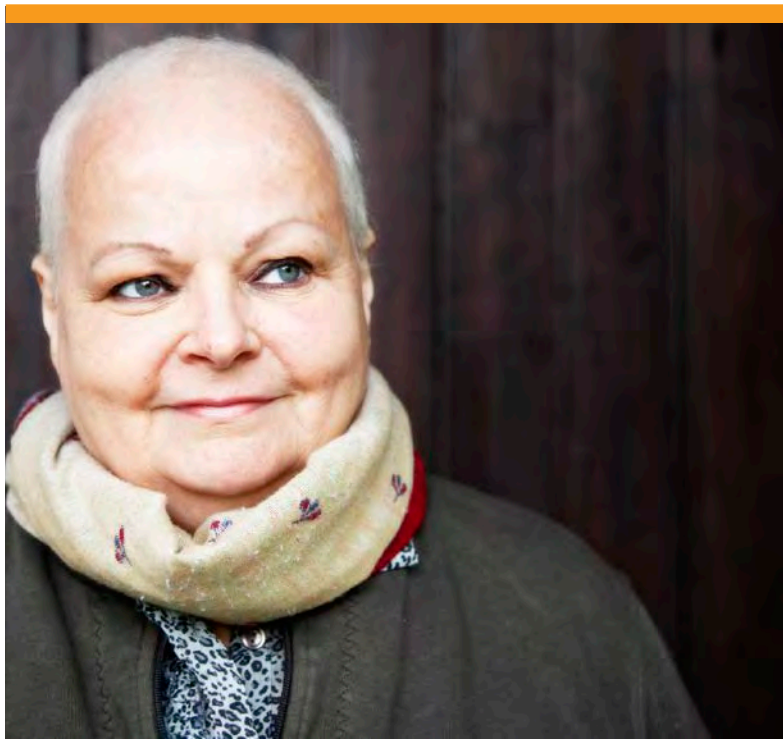
***Wong:* Cancer**

Of all the CDC's top 10 health conditions that lead to mortality (2019), couple and family therapy interventions for cancer offered the most promising efficacy. Three interventions published across four articles were indicated as probably efficacious: FOCUS, Family Focused Grief Therapy (Kissane et al., 2016), and Intimacy Enhancing Therapy.

Overall, studies found that the inclusion of the couple or family in the intervention resulted in improvements in psychosocial functioning for all participants."

With obesity being such a common problem in the U.S., and the resulting heath issues a major concern for so many families, were there any take-aways that might be of particular interest to clinicians in helping their clients with these challenges?

Pratt (on clinical recommendations): The biggest take away is that despite the volume of research focused on family-based weight management interventions, there are very few family therapy interventions addressing existing dynamics for families with obesity. The most evidence for clinical



Of all the CDC's top 10 health conditions that lead to mortality (2019), couple and family therapy **interventions for cancer offered the most promising efficacy**. Three interventions published across four articles were indicated as probably efficacious.

intervention is around behaviorally-based interventions focused on changing individual or dyad (parent-child, spouse) behavior, patterns, and/or routines around eating and activity. Given current evidence, MFTs should prioritize collaboration with professionals with skills around nutrition (registered dietitians) and physical activity specialists, and referrals to these professionals as indicated. In their own practice, MFTs should (a) identify concrete eating and/or activity behaviors to address, and existing family dynamics that may interfere with behavior change, (b) assess and find way to encourage family support for individual member's behavior change, (c) note existing strengths of the family that can be extended to modifying health behaviors and routines, and (d) the cultural and intergenerational context of eating and activity behaviors for the family.

Pratt (on research recommendations): There is a need for multi-tier, family-based approaches to weight management intervention. In light of the scarcity of intervention work in pediatric and adult weight management meeting high family inclusion criteria, future research should focus on: (a) manualizing family therapy approaches with patients and their family members in weight management; (b) assessment of family dynamics consistent with the family therapy approach used in interventions, such as family functioning, chaos, and stress; (c) establishing family-level outcomes that associate with weight loss and behavior change in weight management; and (d) determining family-level outcomes that are sensitive to change over time and mediators or moderators of change in family-level outcomes.

You mention in the article, in relation to research implications, that the review is clearly missing well-established couple and family interventions. What recommendations do you have for MFTs as a way to advance future couple and family intervention research gaps?

Lamson and Pratt:
1. Theory should ground the development and implementation of any couple and family intervention.

2. Researchers seeking to advance the empirical base for couple and family interventions in the context of health conditions should work to integrate behavioral and systemic theories into their designs to address both individual behaviors and the interpersonal dynamics affecting behavior change.

3. MFTs can work toward advancements in intervention science applied to health conditions. Specifically, more early-stage interventions need to be developed and rigorously tested.

4. There continues to be a lack of attention devoted to the contextual details of intervention populations. We must ensure we are including more than just the identified patient or participant in a study. We need to include a partner, parent, sibling or other relational support person into research studies. Furthermore, we must be more aware of how we are attending to representation of our sample in comparison to the population. Often studies that we reviewed provided frequencies in a demographic table but were not intentional about representation by race, sexual orientation, gender identities, ability, etc. Most researchers did not attend to demographic differences in their intervention or analyses and therefore results were generalized for all participants in the sample rather than identifying how social location influences or is influenced by family measures, interventions, or outcomes.

Pratt: To advance research in this area, MFTs should take a staged approach to development, testing, and implementation of family interventions with health conditions. First, given the strong foundation for behaviorally-based theories in family interventions for health conditions, additional development and testing of behavioral plus family therapy interventions are needed. This research is likely best served as pilot or early-stage intervention studies to (a) establish and test the integration of theories, (b) clearly outline the targeted outcomes and interventive components to get to those outcomes, (c) explore acceptability to families, and (d) determine feasibility of implementing the approach in different settings and with diverse families.

Across the spectrum of studies, what did you learn about their inclusivity, cultural awareness and diversity? Is there a trend showing movement toward inclusivity or did you find this to be somewhat in need of improvement?

Lamson: Among the articles reviewed, only 22 specifically mentioned samples that included Black participants and only 19 included samples with Hispanic participants. Even though 13.4% of the U.S. identifies as Black and 18.5% identify as Hispanic (U.S. Census, 2019), only 11 studies had

We chose obesity for those 5 years of age and older because the CDC and National Institutes of Health (NIH) have consistently listed obesity as a **leading precursor to preventable death.**

samples with at least 13.4% participants identifying as Black and only six had samples with at least 18.5% participants identifying as Hispanic. Further, of the articles that included more than one race or ethnicity in the sample, only two tested the efficacy of the intervention with participants of color. Even more apparent are the gaps in representation of other social locations. In fact, there are clear omissions of additional identifying factors by the CDC (2019) (e.g., gender identity, sexual orientation, ability; Institute of Medicine, 2011) which likely influence the lack of representation in health interventions and subsequently contribute to health disparities.

Some of the studies demonstrated that attention is increasing regarding diversity and intersectionality. However, clinicians are encouraged to implement the findings carefully because not all researchers included in this review addressed or approached their studies from a position of cultural awareness and humility, as witnessed in the lack of representation for diversity in their samples and analyses.

Were there any components in this evaluation that were surprising to you all, or something you hadn't expected?

Some of the things that were most striking to us were the diversity and equity concerns listed in the previous response.

Also, out of the 87 articles that were in our review, only 4 named an interventionist (as part of the research team) that was trained in family therapy. This told us that there is more we need to do to advocate for MFTs to work in healthcare. We need to do more to train MFTs in how to initiate or join research teams that incorporate couple and family therapy in context of high mortality health conditions. We hope that by the next 10-year review on couple and family therapy interventions with health that we see more publications that include MFTs as part of the research team.

Do you all have any recommendations related to clinical training as a result of what you learned during this evaluation?

Lamson:

1. Intervention and implementation science training is necessary in MFT/MedFT programs.

2. Knowledge about the biopsychosocial-spiritual framework must extend beyond readings about the original model, moving toward assessments and interventions that recognize the ways physical health can exacerbate psychosocial health and vice versa in couple and family relationships

3. Trainers should teach about efficacious interventions as part of their courses or supervision and ask trainees to apply theory and understand the efficacy of intervention research in relation to the diverse populations they serve and their health conditions

4. Recognize the importance of identifying as a scientist–practitioner who can discern how their clinical theories may translate to culturally indicated couple and family interventions, and also forward thinking in what data they need to track to enhance clinical fidelity and evidence-based research

5. Emphasis should be given to teaching MFTs about ways to secure external federal, foundation, and local funding.

Out of the 87 articles in our review, **only 4 named an interventionist** (as part of the research team) that was trained in family therapy. This told us that there is more we need to do to advocate for MFTs to work in healthcare.

Mendenhall: We should train students to be comfortable working in the comparatively messy worlds of interdisciplinary and collaborative clinics, hospitals, and community sites—understanding medical language(s) and terminology(ies), coordinating the care and contributions that we collectively offer, rubbing shoulders with our biomedical colleagues—and working together in teams.

Are there any "next steps" for you all as the authors? Anything related to your practice or research that you can implement/improve/further study from this evaluation?

Lamson: Determining ways to include, not just an identified patient, but other family members, in both our treatment and our evaluation of treatment. Furthermore, we need to construct well designed dyadic and family research with important considerations in our sampling, assessment, and analyses of findings.

- More early-stage interventions need to be developed and rigorously tested.
- Developmentally, the field of MFT appears to be at the stage where the rigorous assessment of early-stage implementation (Aarons et al., 2011) acceptability, appropriateness, feasibility, and adoption of couple and

family interventions is needed, prior to applying more advanced experimental designs (i.e., RCTs).

- We must be accountable to representation in our science and practice.

Martin: Many agencies and clinics have limited resources, including limited time with families struggling with a chronic disease, injury, or other medical ailment. That is why evidence-based practice is essential in healthcare today! This article can help our clients receive the right care at the right time. This article can also advance the development of practice standards for specific clinical cases. I plan to use this review many times in the years to come.

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Angela Lamson, PhD, East Carolina University, is an AAMFT Professional Member holding the Clinical Fellow and Approved Supervisor designations.

Jennifer Hodgson, PhD, East Carolina University, is an AAMFT Professional Member holding the Clinical Fellow and Approved Supervisor designations.

Keeley Pratt, PhD, The Ohio State University, is an AAMFT Professional Member holding the Clinical Fellow and Approved Supervisor designations

Tai Mendenhall, PhD, University of Minnesota, is an AAMFT Professional Member holding the Clinical Fellow and Approved Supervisor designations.

Alison Wong, PhD, is with Fuller School of Psychology and Marriage and Family Therapy.

Erin Sesemann PhD, Vidant Health, is an AAMFT Professional Member holding the Clinical Fellow and Approved Supervisor designations.

Braden Brown, PhD, is with Indiana University–Purdue University Indianapolis.

Erika Taylor, MS, East Carolina University, is an AAMFT Professional Member holding the Clinical Fellow designation.

Jacqueline Williams-Reade, PhD, Loma Linda University, is an AAMFT Professional Member holding the Clinical Fellow and Approved Supervisor designations.

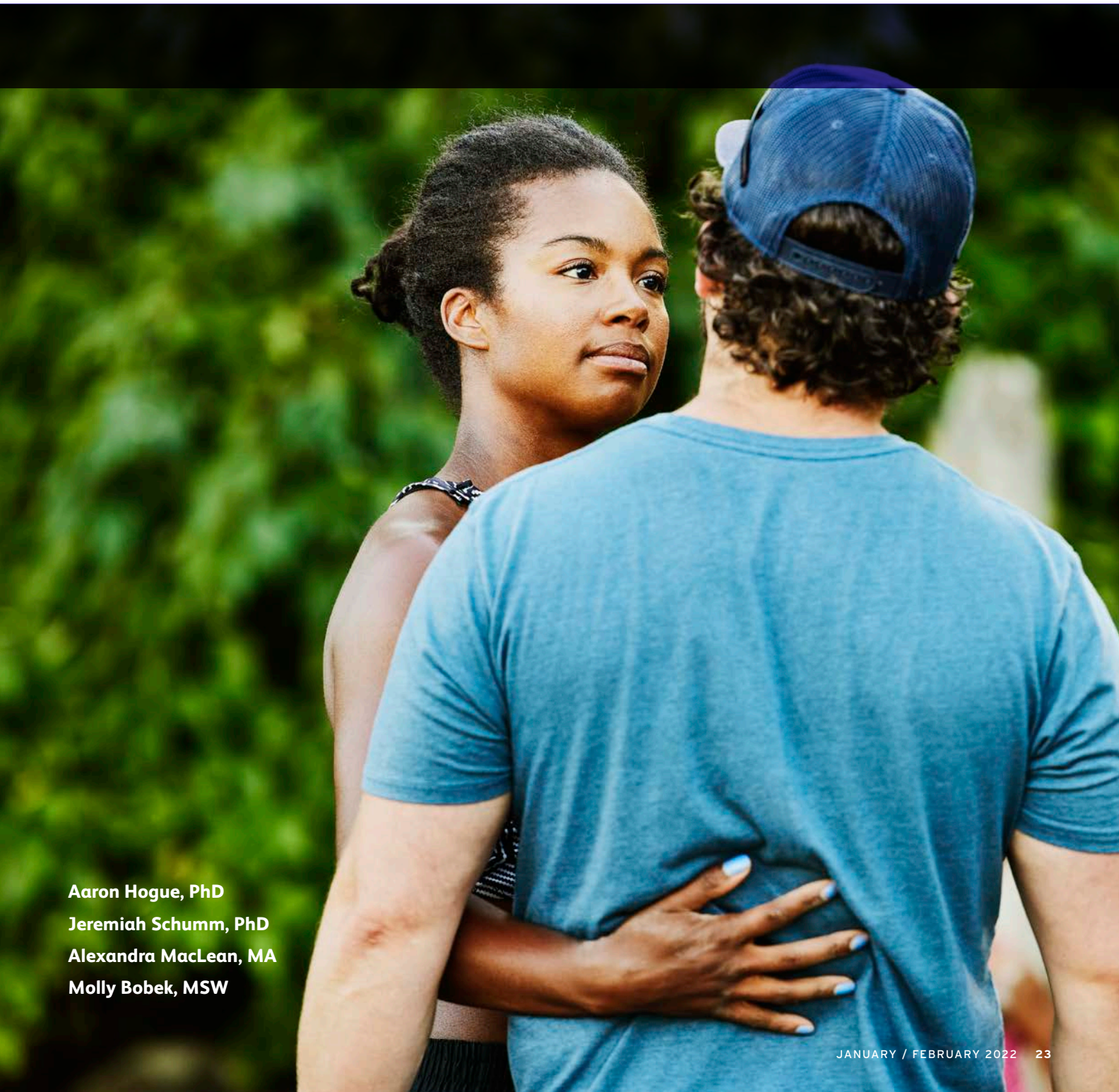
Daniel Blocker, Pomona Valley Hospital Medical Center, is an AAMFT Professional Member holding the Clinical Fellow designation.

Jennifer Caspari, PhD, University of Nebraska, is an AAMFT Professional Member holding the Clinical Fellow and Approved Supervisor designations.

Max Zubatsky, PhD, Saint Louis University, is an AAMFT Professional Member holding the Clinical Fellow designation.

Matthew Martin, PhD, is with Arizona State University.

Couple and Family Therapy for Substance Use Disorders



Aaron Hogue, PhD
Jeremiah Schumm, PhD
Alexandra MacLean, MA
Molly Bobek, MSW

Couple and family therapy for substance use disorders: Evidence-based update 2010-2019
Aaron Hogue, PhD, Jeremiah A. Schumm, PhD, Alexandra MacLean, MA, and Molly Bobek, MSW
January 2022 *Journal of Marital and Family Therapy*

Substance use disorders (SUDs) occur when an individual continues to use alcohol or other drugs despite experiencing problems related to their use (American Psychiatric Association, 2013). SUDs can contribute to a variety of couple- and family-related problems. These problems can in turn contribute to SUDs. Fortunately, there are couple- and family-based interventions for adults and adolescents with SUDs. We reviewed the past decade of research to provide an up-to-date picture of effective couple and family treatment for SUDs.

In a prior review, behavioral couples therapy (BCT) and community reinforcement and family training (CRAFT) was found to improve functioning and treatment engagement, respectively (O'Farrell & Clements, 2012). BCT has two main components. The first is interventions to build support for abstinence. This can be accomplished by helping the client's partner learn skills for managing alcohol-related situations. Another strategy is to use a couple recovery contract to support abstinence. The second is relationship-focused interventions. These include strategies to increase positive behaviors between partners and promote shared mutually enjoyable activities. Couples also learn communication skills to improve the relationship. Unlike BCT, where the person with the SUD and a partner participate, CRAFT is made for concerned significant others (CSOs) of individuals with SUDs who are not ready to get help. CRAFT teaches CSOs communication skills to improve chances that their loved one agrees to enter treatment. It also teaches CSOs self-care and reconnection with their own values to improve their own lives. In examining the evidence for family-based interventions for adolescents, Rowe (2012) identified several effective treatments, including multidimensional family therapy, multisystemic therapy, ecologically based family therapy, functional family therapy, and brief strategic family therapy. These treatments were found to reduce substance use. They also showed impact in reducing mental health difficulties. These reviews concluded that family treatments were effective for treating adults and adolescents with SUDs.

The current update focused on the past decade of research involving couple and family treatments for SUDs. The therapies that were reviewed included interventions that aimed to improve couple and/or family relationships. These interventions focus on changing aspects of the couple or family relationship such as attachment, cohesion and conflict, communication, and shared values. We excluded interventions that include family members in sessions, but are not focused on improving the relationship, such as multisystemic therapy (which focuses on contingency management and drug refusal; Randall, Cunningham, & Henggeler, 2018), network therapy (which focuses on relapse prevention and building sobriety supports; Keller & Galanter, 1999), and varieties of the community reinforcement approach (for which relational interventions are a minor focus; see Godley, Smith, Meyers, & Godley, 2016). We also excluded interventions to improve coping and self-care among CSOs of persons with SUDs, such as Al-Anon. We excluded CRAFT because it focuses on CSO self-care and strategies to encourage those with SUDs to enter treatment (Archer, Harwood, Stevelink, Rafferty, & Greenberg 2020; Kirby et al., 2017). Included studies also had to meet criteria stipulated by Southam-Gerow and Prinstein (2014) for adequate methodological rigor.

We conducted a systematic literature search covering various addictive substances and treatment orientations (e.g., couple/s therapy, relationship

These interventions focus on **changing aspects** of the couple or family relationship such as attachment, cohesion and conflict, communication, and shared values.

therapy, marital therapy, family therapy, family training). From an overall pool of 227 records, 30 articles were independently reviewed by two authors to determine if they met criteria defined in the Study Inclusion Criteria section. A total of 13 studies met the criteria—seven targeting adolescents (ages 13-21) and six targeting adults. These studies were organized by age of target client (adolescent, adult), intervention conditions, sample characteristics, primary outcome measures and assessment periods, and results.

Interventions were categorized along two dimensions (Hogue, Henderson, Becker, & Knight, 2018). First, our review distinguished behavioral versus systemic approaches. The behavioral approach focuses on teaching communication, coping, and problem-solving skills. It includes comprehensive interventions to improve relationship quality between adult partners (i.e., couple therapy) or other family members (i.e., family therapy), as well as discrete protocols focused on parenting skills or a singular aspect of family functioning (e.g., communication training). Hallmarks of the behavioral approach include reliance on standardized protocol content and a fundamentally didactic (i.e., teaching) therapeutic style. The systemic approach differs from the behavioral approach in two primary ways. Regarding intervention focus, it directly targets both intrafamilial relational processes (e.g., roles, attachments, cohesion, conflict) and relational processes between family members and key extrafamilial systems (e.g., school, peer, child welfare, justice) with which families interact. Regarding intervention content, it features one core set of treatment techniques that clearly distinguish it from the behavioral approach (see Hogue et al., 2019): relational reframing. Relational reframing techniques involve therapist efforts to transform symptom-focused and/or individual-focused descriptions of problems into a new understanding of those problems

The behavioral approach focuses on teaching communication, coping, and problem-solving skills. It includes comprehensive interventions to **improve relationship quality** between adult partners or other family members

Given the strength of the research supporting couple and family interventions for SUD across the lifespan, it is critical to include **couple and family interventions** as a standard of care for SUDs.

as being fundamentally relational. This is used to motivate clients to pursue changes in relationships as the primary solution. Hallmarks of the systemic approach include reliance on emergent session content and a fundamentally egalitarian therapeutic style. Second, studies were organized by standalone versus multicomponent models. Multicomponent models refer to intervention packages that contain more than one intervention component (e.g., combining couple and individual therapy for SUDs).

We found four broad categories: systemic family therapy (including the "brand name" models multidimensional family therapy, brief strategic family therapy, and functional family therapy), behavioral couple therapy, behavioral family therapy, and multicomponent treatments. Review results indicated that systemic family therapy is well established as efficacious. Behavioral family therapy and behavioral couple therapy were each deemed as probably efficacious standalone treatments. Behavioral family therapy plus other approaches, as well as behavioral couple therapy plus other approaches, were both deemed well-established multicomponent treatments.

Couple and family-based therapies are shown to be superior to bona fide individual- and group-based therapies. Therefore, SUD treatment programs and practitioners should routinely offer couple and family therapies as a standard-of-care option. Couple and family therapists should develop familiarity with these treatment approaches to treat SUD. There is probably not a "bad" choice when selecting an empirically-supported couple or family-based treatment protocol. However, selection of a specific protocol can be guided by fit to the program or practitioner and/or by client preferences. If the goal is to provide family-based therapy as a standalone option, evidence suggests that systemic family therapy is well established and should be considered a first-line option. Given the number of high-quality studies conducted with adolescents, systemic family therapy is especially recommended as a standalone intervention for this population. A major challenge in the implementation of the reviewed couple and family-based treatments is training of therapists in manualized protocols. Certainly, significant barriers exist to training in systemic family therapy for providers. These concerns have prompted innovative methods for training in core elements of family therapy (Hogue et al., 2017, 2019) as a way to make systemic family therapy more accessible to providers and families. A core elements approach (Chorpita, Daleiden, & Weisz, 2005) organizes evidence-based treatments at a more fundamental level than what manuals offer by focusing on discrete treatment techniques that constitute the core practices of manualized models for a given disorder.

A related innovation is identifying interventions that work across age groups (adolescent versus adult) and relationship types (couple versus family). These can be derived from core elements proven effective for multiple family members across the lifespan. To delineate core relational interventions for SUD that are suitable for adolescents/caregivers and couples, it is necessary to identify processes that impact the development of SUD across the lifespan treatment (see McGoldrick, Preto, & Carter, 2015). Previous research on distilling manualized family therapies for adolescent SUD yielded a set of four core intervention strategies: adolescent engagement, relational emphasis, inviting change in meaning (reframing), and inviting change in family interactions (Hogue et al., 2019). Juxtaposing these core interventions with the core techniques of BCT (e.g., increasing positive activities, teaching communication), a promising common denominator for transdevelopmental intervention can be distilled: relationship improvement in the context of SU and the family life cycle. Moreover, specific treatment techniques included within numerous evidence-based couple and family therapy treatment protocols can be identified: multiparticipant engagement, development of multiple perspectives, psychoeducation on SUD and relationships, coaching in the landscape of action, coaching in the landscape of meaning, and family contract building. Transdevelopmental practices may prove especially valuable in the context of non-traditional family structures, aspiring to a psychosocial kinship model for relational therapy (Pattison, Defrancisco, Wood, Frazier, & Crowder, 1975). They may also help to ameliorate effects of stigma in families (see Livingston & Boyd, 2010) by decreasing focus on one "problematic" member and loosening often-rigid roles for others.

Given the strength of the research supporting couple and family interventions for SUD across the lifespan, it is critical to include couple and family interventions as a standard of care for SUDs. The most recent National Survey of Substance

Abuse Treatment Services (Substance Abuse and Mental Health Services Administration, 2019) does not contain any of the evidence-based couple or family interventions described in the current review. Transforming SUD services to be oriented toward relationships and their ecologies, rather than individuals, is an enormous task. Most practitioners work within the context of a profoundly individual approach, granting supremacy to the notion of individualism, self-reliance, and the generally autonomous self (Rasheed, 2010). A paradigm shift toward relational interventions would invite movement toward systemic conceptualizations of SUD problems and solutions. It would also provide more fluid and flexible roles for target clients and CSOs while recasting "alone" to "together" in SUD treatment. A large-scale shift of SUD services would require re-alignment of billing/reimbursement, documentation, and services offered. The potential benefit of this transformation would be an SUD healthcare network positioned to deliver the most effective treatments for those with SUDs and their families.

Aaron Hogue, PhD, of Partnership to End Addiction, is vice president, Research and Clinical Science/Family and Adolescent Clinical Technology and Science (FACTS). He is a clinical psychologist focused on evidence-based practices for adolescent substance use and related behavioral problems, behavioral treatment implementation science, and adolescent developmental psychopathology.

Jeremiah Schumm, PhD, is with Wright State University. He is board-certified in Clinical Psychology. His internship was completed at the Boston Consortium for Clinical Psychology, where he completed rotations in the National Center for Posttraumatic Stress Disorder (PTSD), Substance Abuse Treatment Services (Jamaica Plain Campus) and Causeway Street Outpatient Clinic. Prior to joining Wright State, Schumm was associate director of the Trauma Recovery Center at the Cincinnati VA Medical Center and associate professor of Clinical Psychiatry at the University of Cincinnati.

Alexandra MacLean, MA, of Partnership to End Addiction, manages National Families Support Technology Assistance Center on behalf of the Partnership, working to advance positive family-driven partnerships between service providers and families to provide family support across the lifespan. The center of excellence seeks to improve resources, training, and technical assistance for families, caregivers, professionals, and organizations.

Molly Bobek, LCSW, of Partnership to End Addiction, is associate vice president, Family and Adolescent Clinical Technology and Science (FACTS). She supports the clinical components of the FACTS team's research projects aiming to support the adoption and sustainability of evidence-based family therapy approaches, develop novel approaches to training and consultation, and better equip and support the community-based workforce treating adolescent substance use and other externalizing problems. Bobek is also on the faculty at the Ackerman Institute for the Family and maintains a private practice working with families and individuals.

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Couple- and Family-based Psychosocial Interventions for Infant and Early Childhood Mental Health

Kimberly Newsome, MPH
Jennifer W. Kaminski, PhD
Lara R. Robinson, PhD
Helena Hutchins, MPH
Caroline Barry, MPH

Evidence base review of couple- and family-based psychosocial interventions to promote infant and early childhood mental health, 2010-2019

Jennifer W. Kaminski, PhD, Lara R. Robinson, MPH, Helena J. Hutchins, MPH, Kimberly B. Newsome, MPH, and Caroline M. Barry, MPH

January 2022 *Journal of Marital and Family Therapy*

Most mental and behavioral problems have roots in childhood (Caspi, Moffitt, Newman, & Silva 1996; National Academies of Sciences, Engineering, and Medicine [NASEM], 2019). Positive mental health in infants and young children is tied to nurturing and responsive early relationships (Lyons-Ruth et al., 2017; Robinson et al., 2017), and these early relationships lay the foundation for lifelong physical and mental health (NASEM, 2016; NASEM, 2019). Our evidence review was inspired by these fundamentals, along with the knowledge that interventions in a child's first five years are critical in supporting later health and success.

As public health researchers, we think about the population-level burden of infant and early childhood mental health problems and the potential of evidence-based prevention and treatment interventions that can support early relationships to foster lifelong health and wellbeing. We conducted this systematic review to provide information not only for individual couple- and family-based psychosocial intervention providers, but also for decision-makers at the local, state, and federal level to have the evidence they need to inform systemic healthcare decisions. While other systematic reviews have summarized the evidence for the impact of family-based interventions in different populations and ages of children (Estrada & Pinsof, 1995, Kaminski & Claussen, 2017; Kaslow, Broth, Smith, & Collins, 2012; Northey, Wells, Silverman, & Bailey, 2003), our paper is the first application of Southam-Gerow and Prinstein's (2014) Evidence Base Update criteria to couple- and family-based psychosocial interventions to promote infant and early childhood mental health.

How did we summarize the evidence?

We conducted this systematic review using search terms related to couple or family-based interventions (e.g., couple therapy) and infant and early childhood mental health (e.g., attachment) in peer-reviewed publications. Our broad search terms identified more than 40,000 potentially relevant titles. After looking carefully at these titles and abstracts, we identified 695 articles that merited retrieval for further review. Next, we completed a full-text review of the 695 articles to identify the studies that tested interventions fitting our inclusion criteria:

- The intervention began prior to or at child age 3 years, and the outcomes were measured prior to age 5 years.
- Participants were either married or cohabitating couples, parent-child dyads, families (e.g., parent-parent-child triads), or parents.
- The intervention focused on changing the knowledge, attitudes, emotions, behaviors, and/or relationships among participants.
- The study reported on emotional, behavioral, functional, or relational outcomes in infants and young children.

Studies were excluded if the interventions focused only on populations with identified issues such as children who have experienced maltreatment or other trauma, and children with developmental disabilities. Populations and corresponding interventions for those issues are worthy of a separate review beyond the scope of our current effort.

After carefully reading all 695 articles, we identified 39 studies published between 2010 and 2019 (the requested date range for this review) that met all of these criteria. When classifying the level of evidence, we also included any eligible study published between 2000 and 2009 that would change the classification. For the included studies, we then carefully summarized two important areas for each study: 1) the design of the study, including whether participants were randomly assigned to intervention and control groups; and 2) whether the families who received the intervention evidenced improvement in infant and early childhood mental health outcomes compared to families who did not.

Finally, we grouped the interventions into categories of similar approaches, instead of presenting results for each individual study or specific packaged program. We determined the intervention approaches could be sorted into 11 categories that facilitate the use of the results in clinical and public health decision-making, based on the intervention's theoretical underpinnings, population served, and standardization. As you can see from the approaches listed here, some of the approaches were broad and some specific:

As public health researchers, we think about the population-level burden of infant and early childhood mental health problems and the potential of **evidence-based prevention and treatment interventions that can support early relationships** to foster lifelong health and wellbeing.

Infant and Early Childhood Mental Health Treatments
- Parent-focused Psychotherapy
- Parent-Infant Psychotherapy

Focused Preventive Interventions
- Couple Interventions to Support the Transition to Parenthood
- Interventions to Support Adolescent Mothers
- Interventions to Support Breastfeeding by Improving Mother-Infant Interactions
- Interventions to Enhance Parent-Infant Relationships
- Interventions to Promote Positive Parenting through Shared Reading and Play
- Behavioral Interventions to Support Parents of Toddlers

Broader-Scope Preventive Interventions
- Curriculum-Based Interventions for At-Risk Parents and Families
- Tiered Interventions to Provide Support Based on Assessed Risk
- Home Visiting Interventions to Provide Individualized Support to Families at Risk

What did the evidence show?

We applied the Evidence Base Update criteria to classify the 11 different intervention approaches (using data from 39 individual studies) into five rankings: *Well-established*, *Probably Efficacious*, *Possibly Efficacious*, *Experimental*, or *Unclassifiable* (meaning insufficient evidence in this time period to classify under these criteria).

No intervention approaches in our review of this time period met criteria to be considered *Well-Established*, which requires at least two independent randomized trials showing treatment superiority.

Four intervention approaches were classified as *Probably Efficacious*, the criteria for which is met when an intervention has been shown to be superior to a no-treatment control group in at least two randomized-controlled studies, or when it has been shown to be superior to another intervention or equivalent to a well-established intervention in one study or in multiple randomized-controlled studies:
- Interventions to Support Adolescent Mothers
- Behavioral Interventions to Support Parents of Toddlers
- Tiered Interventions to Provide Support Based on Assessed Risk
- Home Visiting Interventions to Provide Individualized Support to Parents

Intervention approaches with at least one randomized-controlled study showing superiority over a wait-list/no-treatment control group, or two or more non-randomized but otherwise methodologically strong studies were deemed *Possibly Efficacious*. Two intervention categories, Couple Interventions to Support the Transition

The highest level of evidence documented here was the *Probably Efficacious* classification, suggesting that the four intervention approaches meeting this classification have the **greatest potential for impact** on infant and early childhood mental health.

to Parenthood and Parent-Infant Psychotherapy met these criteria.

The Experimental classification included some studies with rigorous design but not enough evidence of improvement in outcomes. Three intervention groups met this criterion: Parent-focused Psychotherapy, Interventions to Enhance Parent-Infant Relationships, and Interventions to Support Breastfeeding by Improving Mother-Infant Interactions.

Two intervention approaches (Interventions to Promote Positive Parenting through Shared Reading and Play and Curriculum-based Interventions for At-risk Parents and Families) have yet to document evidence of superiority versus a comparison group on infant and early childhood mental health outcomes in either randomized or non-randomized studies during the period of this review. These approaches have also not shown inferiority to a comparison group; therefore, they do not yet have classifiable evidence under these criteria.

What is the importance of these findings? In this review, we followed the current convention of classifying general categories of intervention approaches, rather than evaluating specific brand-name packaged programs, to inform family, provider, community, and health plan decision-making. The Evidence Base Update criteria were designed to identify the psychological treatments with the most promise to reduce the youth mental health burden (Southam-Gerow & Prinstein, 2014). The highest level of evidence documented here was the Probably Efficacious classification, suggesting that the four intervention approaches meeting this classification have the greatest potential for impact on **infant and early childhood mental health.**

What are the next steps? Clinicians and public health practitioners can work to increase the reach of couple and parent-based psychosocial interventions that demonstrate evidence of positive infant and childhood mental health outcomes, such as those in the *Probably Efficacious* grouping. As public health researchers, we continue to gather and summarize evidence on approaches to best support infant and early childhood mental health. In addition, we recognize that couple- and family-based psychosocial interventions may not be sufficient alone to support population-level infant and childhood mental health. As we navigate through a national emergency of children's mental health that disproportionately affects black, indigenous, and people of color (American Academy of Pediatrics, 2021), a broader public health approach has been recommended for children's mental health (Hoagwood & Kelleher, 2020). This approach could include additional attention to (1) making services available in locations convenient to the family; (2) examining alternatives to our current healthcare payment system approaches to children's mental health; and (3) promoting equity by meeting parents' basic mental health and economic security needs.

Note: The findings and conclusions are those of the authors, and may not represent the official position of the Centers for Disease Control and Prevention.

Kimberly Newsome, MPH, is with the National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control & Prevention, Atlanta, GA.

Jennifer W. Kaminski, PhD, is with the National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control & Prevention, Atlanta, GA.

Lara R. Robinson, PhD, MPH, is with the National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control & Prevention, Atlanta, GA.

Helena Hutchins, MPH, is with the National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control & Prevention, Atlanta, GA, and the Oak Ridge Institute for Science and Education, Centers for Disease Control and Prevention Research Participation Programs, Oak Ridge, TN.

Caroline Barry, MPH, is with Emory University, Atlanta, GA.

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Brandon Eddy, PhD

"Forget Me Not": A Population Silently Begging for Systemic Treatment

Eleven years ago, my life changed forever when I became a father. It was something I had always wanted. In fact, I dreamed about it. Maybe it was because I came from a "broken home" or because I never had father who was involved: I don't know. But I looked forward to fatherhood and was thrilled when the day finally came. A short few months later, however, I felt like our world had been flipped upside down. After a lengthy struggle, my wife was diagnosed with postpartum depression (PPD); more specifically, postpartum obsessive-compulsive disorder.

My wife and I both felt totally unprepared for the experience and the diagnosis. No healthcare professional had explained postpartum depression or any similar conditions to us, which was surprising given the severity of the situation. I also found that we weren't alone. Several others had similar (and horrible) experiences. I decided that experience of being totally blindsided by PPD would never happen to us again. Next time, we would be prepared.

As an academic, I did what I know how to do: plunged myself into the scholarly literature on perinatal mental health to both understand and heal my experience. I couldn't consume enough and read everything I could get my hands on. Hidden within the broad spectrum of perinatal studies, I uncovered a brief mention of postpartum depression in fathers. I had never even considered the possibility that men could suffer from postpartum depression. I was surprised, but I also felt sadness and remorse. Despite being a father, a family scholar, and a family treatment professional, I neglected to consider how the transition to parenthood affects fathers. Was it simply an oversight? Or have we all been conditioned to focus solely on mothers during pregnancy, and as a result we forget how stressful and overwhelming the experience can be for fathers? Is it the gender stereotypes and expectations of stoic, non-emotional, and uninvolved fathers? Is that why we give so little thought to the mental health of fathers?

To be honest, it is probably a little of all these things. A subsequent literature review of all of the articles on perinatal mental health I conducted shortly thereafter revealed little to nothing on men's experiences with PPD, miscarriage, infertility, or topics associated with the transition to parenthood. Paternal PPD, a significant relational issue for both couples and families, has been recognized since 2006, yet little has been written about this topic to guide systemic therapists in their assessment, recognition, and treatment of this condition. For

Have we all been conditioned to focus solely on mothers during pregnancy, and as a result we forget how stressful and overwhelming the experience can be for fathers?

example, looking briefly at five well-respected journals in our field, within an estimated 2,800 articles over the past 15 years, just two of those have been on the topic of postpartum depression in mothers and only one has covered postpartum depression in fathers (Eddy, 2022). The lack of attention given to fathers and their well-being in our scholarship as a field unintentionally communicates a lack of value in fathers as both partners and parents. What does our lack of attention say about such an important moment in father's lives? What does it say about the way we value fathers? One could easily surmise that we don't care all that much about fathers, especially new fathers.

My professional experiences also confirmed what I was reading. The fathers in my research, who describe their experiences in ways that broke my heart and led me to tears, stood in stark contrast to comments at professional conferences where many noted how "skeptical" they are of this topic and dismiss its reality. My publication attempts didn't fare any better: in many cases, my submissions could not get past the editor's desk into the hand of reviewers, receiving comments that the topic wasn't systemic or wasn't a real issue. But I kept trying. I felt responsible to share the father's experiences from my research, so I gave publication another attempt. I searched for journals that regularly published about fathers, which was difficult to find. To my relief, the manuscript was finally accepted (Eddy et al., 2019). Tears filled my eyes. Someone finally cared! These fathers' experience would be heard.

What came after made it worth all the heartache. The article was published and the media relations specialist at my university highlighted it in the weekly newsletter. And people were excited about it. People cared. It was one of the most widely read articles the journal published that year. During the next year, I was interviewed numerous times, participated in podcasts about the article, and guest lectured on the topic in various forums. But the most rewarding part was random emails from fathers who had read the article or listened to the podcast. These fathers now better understood what they had experienced, they had something to call it, something that validated their experience, and they started sharing the article and their experience with others. Those emails give me the fuel to push through any difficulty in publishing or spreading the research.

Three years ago, I wrote in this magazine (Eddy & Hess, 2018) about how CFTs are the best group equipped to treat PPD, because we are. I still believe that. The need is real and cannot be understated. Almost 3.8 million children were born in the United States last year (Centers for Disease Control; CDC, 2021). Statistically, 15% of those mothers and 10% of those fathers will suffer from PPD (Leung, Letourneau, Giesbrecht, Ntanda, & Hart, 2017). To put those numbers in perspective, that's just shy of 1 million families who will be impacted by PPD. In these families, we are likely to see insecure attachment between parent and child, increased substance use in fathers, emotional and physical abuse within the family, increased affairs and divorces, and several instances where a parent dies

by suicide or kills their baby. Yeah, those stories we see on the news where a parent drowns their newborn baby, that's untreated postpartum depression that has escalated to postpartum psychosis. I'm sure a few readers will wince when reading some of these things, but that's the reality and sometimes we shouldn't be shielded from it. As couple and family therapists, we are uniquely positioned to address this. We have a responsibility to not dismiss this population. To dismiss the experience or even the potential of PPD in men is tantamount to dismissing fathers themselves. As a field, we must do much better in educating and training clinicians about postpartum depression. There are people relying on us to do so, and they deserve our attention.

In this piece, I argue that PPD in men is a systemic issue. It affects their individual selves, their relationships, and their attachment to their children. The losses and issues men experience as a result of PPD are incalculable and must be better addressed by relational specialists. As CFTs, we have unique training and a variety of outlets to finally shine the light on mental health and fathers transitioning to parenthood. Here are a few suggestions I have on how CFT can take the lead on this important topic.

1. CFT journal editors should consider a special edition on postpartum families in a CFT journal. I have no doubt there are clinicians who share my concern for this population, but are uncertain where to begin or how to help these families. A special edition on postpartum families would give those families the attention and spotlight they deserve, as well as provide clinicians with information on how to recognize, assess, and systemically treat PPD.

2. Create specialized trainings on perinatal mental health at our yearly conferences. These conferences are well attended, provide cutting edge research, and are an ideal forum to spread this valuable information.

3. Curriculum on treating postpartum families in our CFT training programs. There are several courses that this information would fit into quite well, such as a diagnosis, couple's therapy, families across the lifespan, or a medical family therapy course. At UNLV, I have included material into both undergraduate and graduate level courses and have found students show great interest in the topic. In fact, many of our graduate students choose community internship sites that provide them with the opportunity to work with postpartum families.

4. Collaboration with healthcare providers is essential. Healthcare providers such as obstetricians and pediatricians regularly come into contact with new parents. During these appointments they often assess for PPD, but their solution is usually medication based. Many patients are hesitant about taking medication or prefer therapy. As CFT's, we need to establish relationships with healthcare providers so we can be an additional resource for clients.

It is my hope that the CFT field can use this information to forge a strong emphasis, more than any other mental health profession, on supporting postpartum families, both clinically and in research. We all know someone who has suffered with postpartum depression, even if we aren't aware of it. No field is adequately addressing the complex needs of postpartum families. It's time for systemic therapists to change that.

Brandon Eddy, PhD, is an AAMFT Professional Member holding the Approved Supervisor designation, and an assistant professor and internship coordinator in the Couple and Family Therapy Program at the University of Nevada Las Vegas (UNLV). He received his PhD in Couple, Marriage, and Family Therapy from Texas Tech University and received his master's degree in Marriage and Family Therapy from the University of Nebraska-Lincoln. Eddy's research agenda focuses on the transition to parenthood with an emphasis in postpartum depression, miscarriage, and infertility. He also specializes in helping families with Autism Spectrum Disorder. Eddy is a member of the Solution Focused Brief Therapy Association (SFBTA), and Postpartum Support International (PSI).
brandon.eddy@unlv.edu

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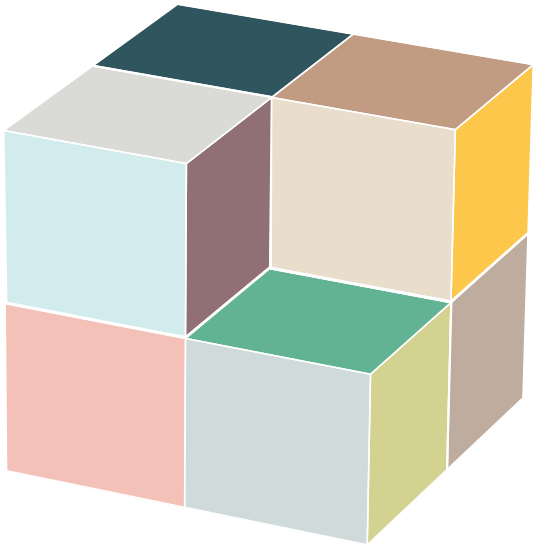


Sara Schwarzbaum, EdD

One Size Does Not Fit All in Couple Therapy

The Case for Theory Integration

Couple therapy is a complex and challenging activity even for the most experienced marriage and family therapists (MFTs). There are many models to choose from, and integrating them is not easy for most MFTs who wish to improve their skills in working with couples. Some are attachment based and others emphasize differentiation. Some focus on the systemic interactional pattern, while some are more focused on the individual. How do we figure out what to do?

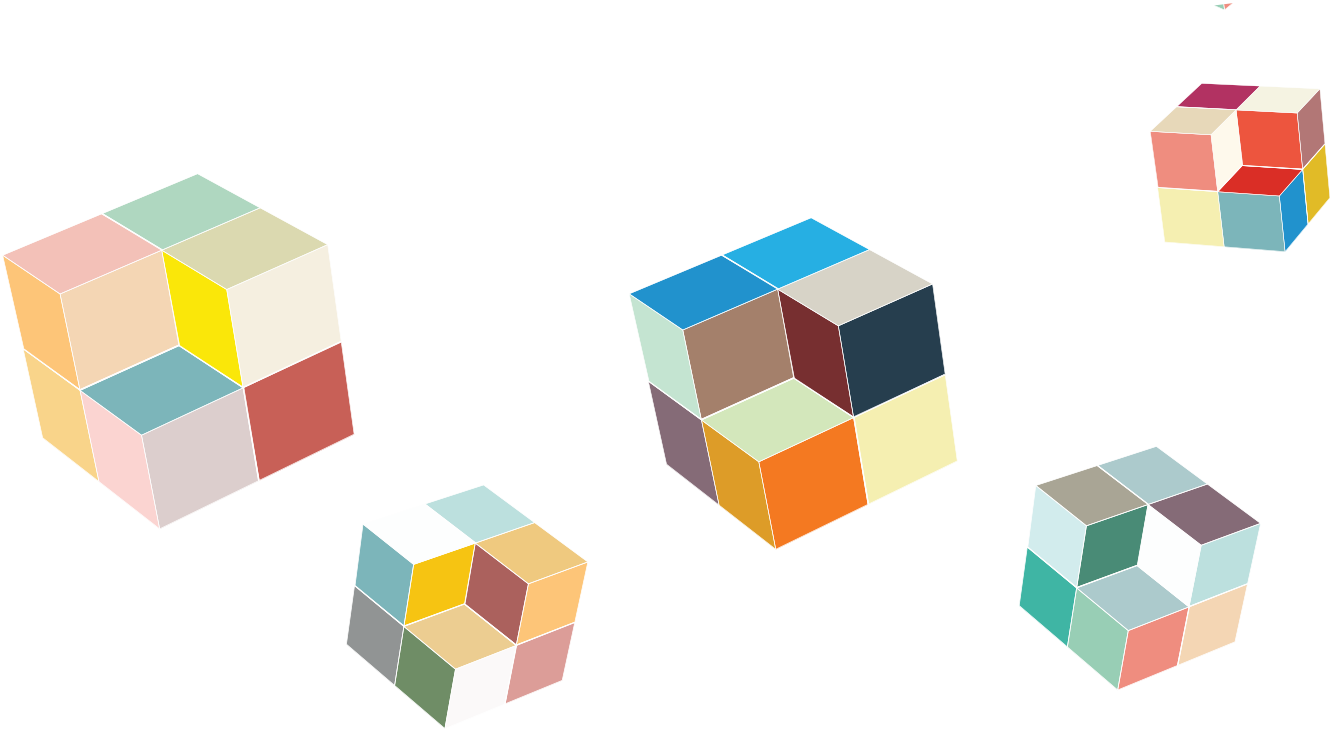
A model may work well in one stage of the treatment process, but not so well in another stage. In this article, I will explain why framework integration in couples therapy is important, explore one way of integrating models, and describe one case, using sequencing frameworks at different stages of the treatment process with a couple who presented in a high level of distress.

Every proponent of a framework for couple therapy tries to answer similar questions:

- Why is intimate relationship distress so prevalent?
- How and why do problems develop in couples?
- What helps couples change?
- What is the role of the MFT in the process of change?

Some proponents of frameworks concentrate on a particular period of time: The present, the past or the future. Bowenians (Bowen, 1978) propose to take a couple back several generations. MFTs with a psychodynamic orientation will have couples go back at least one generation (Nielsen, 2016). Emotionally focused couple therapists take couples back to past emotional injuries sustained in the current couple relationship where healing also takes place (Makinen & Johnson, 2006). MFTs who use the Gottman model (Gottman & Silver, 1999) address issues predictive of relationship distress in the current couple relationship and consider the couples' dreams for the future. Solutions focused therapists (Zigler & Hiller, 2001) and narrative therapists (Combs & Friedman, 1995) mainly look ahead, focusing on the vision of the future when the problems are solved and using questions as the main intervention. Additionally, there are frameworks that focus more particularly on either thinking, feeling, or on behavior as the door of entry into the change process.

There are many advantages of using a pure form of a couple therapy framework. To have a road map as a guide helps the therapist focus the attention and tends to make the work less overwhelming. Having multiple tools can cause confusion if MFTs don't know how to choose among them (Nielsen, 2016). Therapists faced with too many options may be tempted to cling to one theory, in part because it is easier and less confusing.



Adherence to one framework, however, has limitations. Therapists may attempt to make the client fit into the theory; a model gives structure but not the freedom to adapt to the needs of a particular couple; a model may work well in one stage of the treatment process but not so well in another stage (Schwarzbaum, 2021); and a pure form of a framework can lead to therapeutic errors (Pinsof, 1995).

Why an integrative approach?
There are many compelling reasons to use an integrative approach.

There is large body of research concluding that there is not one framework that works better than others for sustained relationship success or relationship change (Asay & Lambert, 1999; Lambert, 2013). The best treatment approaches are personalized and individualized, in an integrative way, drawing from different perspectives to intervene with a particular couple.

The clinical needs of each couple, the strength of the alliance between the couple and the MFT (Miller, Hubble, & Duncan, 1995), and the attention to the stage of the treatment process tend to be the most important factors in treatment outcomes. In terms of the clinical needs of each couple, there are too many variables to consider using a pure form of the same framework: The couples' level of distress, the level of differentiation, their attachment histories, their motivation for treatment, their level of hope about the viability of the relationship, their self-protective measures, to name a few.

While different schools of couple therapy emphasize their uniqueness and their differences, they actually overlap considerably in what they consider helpful. Many approaches to couples therapy use different terms to describe similar phenomena.

When MFTs start working with a couple, they never know for how long they will remain in treatment. We learn more about a couple the more we interact with them. Some hypotheses are more useful than others, which is why some frameworks work well with some people and not with others.

A moment of integration often occurs when an MFT begins to wonder: "What else could I have done?" It's a question that makes it possible to reach outside a framework and begin to look for alternatives. As mentioned, the application of a pure form of a framework may lead to errors in therapy (Pinsof, 1995), such of ruptures in the therapeutic alliance.

The Therapeutic Alliance
One of the most important aspects of treatment with a couple is the therapeutic alliance (Miller, Hubble, & Duncan, 1995). Do the partners and the therapist have alignment on goals and tasks (Duncan & Miller, 2000)? Is there an agreement on what needs to be fixed and how? Does the couple believe that the therapist can help them? Does the couple trust that the therapist is invested in the well-being of each member of the couple? Does each member of the couple allow the MFT to influence them?

The therapeutic alliance is more important than the framework and needs to take precedence over it. Consider the following examples.

A Bowenian therapist will want to do a Genogram fairly early in the in the process, but one member of the couple fails to acknowledge the connection between the family of origin legacy issues and current couple impasses and refuses to cooperate.

An MFT thinks the honest and vulnerable expression of feelings is the most important factor in a treatment with a couple (as many do) but a partner does not feel safe expressing vulnerable feelings, or does not believe in the value of expressing feelings because "it would make me look weak."

Proponents of postmodern frameworks (Solution Therapy or Narrative Therapy) consider the couple as the experts in solving their own problems, and frequently utilize interventive questioning. What if the couple feels like they are "coming to the therapist for expertise" and request more guidance?

MFTs with a systemic or insight orientation believe that awareness of the dynamic, or awareness of the legacy issues are sufficient, and tend not engage in behavioral interventions. What if the couple achieves a high level of awareness but their behavior still doesn't change?

It's clear that the alliance could suffer if the couple and the therapist don't agree on the reasons for the development of problems, and on the ways to alleviate them. Sometimes, adherence to a pure form of a framework risks rupturing the alliance.

How can framework integration be implemented?

The severity of the presenting issue does not determine the outcome in a case. Rather, it seems that the most important factors are what maintains the presenting issue (Pinsof, 1995), what roadblocks there are to solving them, and what constraints people have (Breunlin, Schwartz, & Mac Kune-Karrer, 1997).

When a couple begins a treatment process, it's difficult to know for how long they will stay engaged in treatment. One way to think about integrating interventions is to apply the least invasive interventions to a problem and observe its effects.

When a couple begins a treatment process, it's difficult to know for how long they will stay engaged in treatment. One way to think about integrating interventions is to apply the least invasive interventions to a problem and observe its effects. We can go from the "here and now" approaches (solution focused, narrative, cognitive behavioral), to the "there and then" (Intergenerational and psychodynamic) in a sequential manner by applying the more direct, and shortest interventions first, and leave the more sophisticated, time-consuming interventions if those first ones fail or prove to be insufficient (Pinsof, 1995).

Many couples may be able to improve dramatically in a relatively short period of time provided that the issues that maintain the problems are not too constraining or too deep, regardless of the initial level of distress. Therapy involves the continuing testing of hypotheses and of interventions derived from them. It is the failure of such interventions that signal that the constraints may be broader or deeper.

To implement framework integration, MFTs are encouraged to consider sequencing the treatment process (Schwarzbaum, 2021). In the first stage of the treatment process, when the MFT does not know the couple well and it's not clear how long they will engage in therapy, many couples can get stabilized with present and future-oriented frameworks. Past-oriented frameworks can be implemented in the second stage, if couples agree to go deeper. Finally, in the last stage of the treatment process, the consolidation stage, the MFT can review the past gains, go even deeper, and work on preventing relapses.

Case illustration using treatment sequencing

When Roy and Beatrice, a heterosexual couple in their late 30s, married less than a decade, with two children under five, came to their first appointment, Roy reported that they were struggling with high conflict, that issues were never resolved, and that he didn't feel supported. Beatrice said that there was a lot of tension, very little affection and sex, and that she did not know how to deal with his intensity and anger. Their level of distress was moderate to high, and their level of hope about the viability of the relationship was low. When I asked them how they would know that therapy had been successful, they said they would have better communication and more sex. I also asked them what kind of partner they wanted to be. They agreed that they both wanted to have more fun; they wanted to take things more lightly and less seriously.

In the early stages, couple therapy can focus more on "what could be" happening than on "what is" or "what was" happening. It's important to help partners focus on the "partner I want to be" rather than on the "partner I want to have." This is what I did with Roy and Beatrice during the stabilization stage of treatment, and

it reflects my use of future-oriented questions, like the solution focused or the narrative frameworks (Ziegler & Hiller, 2001).

Generally, the post-modern approaches focus primarily on the future. The proponents of these frameworks are interested in assessing and eliciting strengths, resilience, and pride factors. Some of the approaches are more behavioral and others are more cognitive based. Some of Gottman's ideas are also future oriented.

Like so many couples, as Roy and Beatrice got stabilized, their level of hope about the viability of the relationship increased dramatically after they discovered what strengths they brought into their relationship and described what gave them a sense of pride. They were able to focus on what kind of partner they wanted to be. They figured out how to shift the focus to the positives. In a short time, they increased their awareness of impact of their behaviors on each other.

They managed to create a vision of their relationship, but when they fought, things got out of hand because of their mutual blaming, so I turned to Gottman's model. Using Gottman's approach, Roy and Bea figured out how to stop a fight; they learned to listen to each other and to recognize more quickly when they got flooded, so they could stop a conversation that was not going well. They learned to initiate conversations when they were not tired or hungry or emotionally depleted to avoid a "harsh start-up" (Gottman and Silver, 1999). I also introduced concepts of neuroscience to help them understand how their brains were involved in their fights and what they could do to achieve emotional regulation (Fishbane, 2013).

Not everything was easy for them. Roy struggled with impatience when triggered; Beatrice struggled with shutting down when he became impatient. At one point Roy said: "I am a screamer, and I come from a screamer family, that's who I am, why should I change?" Bea said: "I guess I do defend myself when he attacks me, but what else can I do?" To answer those questions, I turned my attention to the Emotionally Focused Couple Therapy (EFT) approach. This framework focuses on strengthening the attachment bond through the awareness and expression of vulnerable feelings (Makinen & Johnson, 2006).

EFT also focuses on a systemic understanding of interactional patterns. Roy and Beatrice learned to identify their triggers, their feelings and their interactional patterns: The more impatient and upset he became, the more she got defensive and shut down and the more she shut down, the more impatient he became.

To create a bridge between the interactional and the intrapsychic work, we explored what was under the anger. For Roy it was fear of rejection, for Bea it turned out to be that when she felt controlled, she decided she didn't need him, and thus rejected him, completing the cycle. The more he felt rejected, the more inpatient and upset he became; the more impatient, the more she rejected him. Once we understood what was under the anger, we were able to turn our attention to the family of origin and the attachment history to go even deeper into the intrapsychic work.

Sometimes, with the application of EFT, Gottman and solution focused ideas, couples get better or simply move on. But sometimes, they are motivated to go deeper or they don't get better. One way to go deeper is to use intergenerational approaches including Bowenian, Imago, and psychodynamic frameworks.

As we delved into their life stories, I learned that when Roy's parents were screaming at each other when he was very young, he often hid under the table and covered his ears so he wouldn't hear them. Not surprisingly, Beatrice complained that he "doesn't hear" her and that he hides his feelings. Beatrice, on the other hand, had a chaotic childhood, moved frequently and was never in one place for long. She survived by learning to rely only on herself, and solve her own problems. She learned not to depend on anybody. Roy complained that she rejected him and was not a team player, that she did her own thing and didn't "need" him. Each was re-enacting in their relationships some aspect of their attachment history (Nielsen, 2016).

As time went on, I started interviewing them individually, but in the presence of each other. I wanted to understand their protective and defensive positions better, their sibling position in the family of origin, their attachment history. I empathized with each of them as we began to put words around their reactions. They were used to triggering each other's childhood attachment injuries and shame-based reactions. Roy had been bullied and he vowed that "nobody was going to make me feel weak and inadequate ever again." When Bea complained, he felt inadequate and resorted to his survival strategy of counter-attacking her. Bea on the other hand, had been emotionally neglected and when Roy attacked her, she literally shut herself off from him, went to her room the way she did growing up and said to herself: "I can do this on my own, I don't need him," which in turn triggered his fear of rejection and hostile behaviors.

As time went on, the description of their interactional patterns became much richer. We worked on their family of origin history and connected their childhood defensive positions to the ways in which they got triggered. In time, they accessed the origins of

their shame and vulnerability. They were courageous and stuck with it, but their progress was marred by repeated cycles of progression and regression. They would move toward greater openness and flexibility only to return to the old familiar negative cycles. As a testament to their courage and perseverance, and to the strength of the therapeutic alliance, the negative cycles became less long and less severe.

There are many excellent models for doing couple therapy not mentioned here. The frameworks I chose are based, in part, on my own beliefs about the reasons for couples distress and my own views about how couples improve, developed over time. MFTs who can articulate their own beliefs about such matters will find choosing and integrating frameworks easier to achieve.

Sara Schwarzbaum, EdD, LMFT, LCPC, is the founder of The Academy for Couples Therapists, an integrative online training program for MFTs who want to improve their skills working with couples. She also Founded Couples Counseling Associates in Chicago. As a professor, now Emerita, in the Family Counseling Program at Northeastern Illinois University in Chicago, she taught framework integration to future MFTs for 18 years. She has a master's degree in clinical psychology from Buenos Aires, Argentina and doctoral degree in counseling with an emphasis in family therapy from Northern Illinois University. Her papers have appeared in the *Psychotherapy Networker*, *Counseling Today*, and other publications. She is a consultant, trainer, and presenter at state and national conferences.

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Debbie Marielle Elzea, JD
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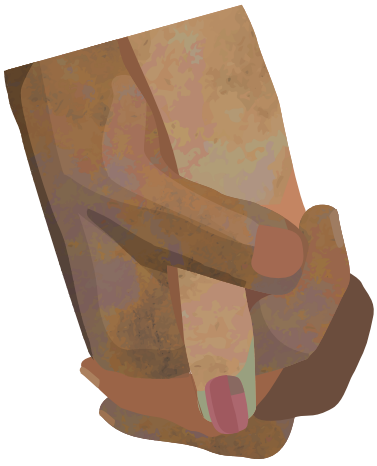
How's Your Clients' Sex Life?

We live in a culture that is both sex-obsessed and starving for genuine, loving connection. According to the *Journal of the American Medical Association* (Laumann, Paik, & Rosen, 1999), an astounding 42% of American women have low libido or desire, pain, and/or elusive orgasms. Many more lack emotional connection with their lovers. This is a concern for marriage and family therapists, as disappointing or non-existent sex lives are leading causes of breakups and family dissolution (Weiner-Davis, 2003). Further, healthy, fulfilling sexual lives are essential for physical, mental, and emotional well-being, and sex provides a unique opportunity for connection and bonding.

Couples face many sexual challenges, and it is natural for MFTs to view issues from a systemic perspective. However, many sexual problems are individual challenges. Blocks like body shame (Brown, 2012), negative conditioning, or the inability to relax and 'get out of her head' are very common for females regardless of background or relationship. To determine whether a challenge is a couples or individual issue, a rule of thumb is to consider whether the challenges predate the couple's relationship and/or would exist independently of the relationship. If so, the individual may be best served in a one-on-one setting. The following will help MFTs understand the most common blocks and challenges from the female perspective. It will also distinguish, at a high-level, distinct approaches used by sex therapists versus sex educators and coaches, so you can feel comfortable making referrals when sexual issues take you out of your expertise or comfort zone. You may be more apt to ask, "How's your sex life?" Sexual issues are often a root cause of dysfunction, yet shame and conditioning may prevent the couple from bringing the subject up themselves. Conversely, many therapists are reluctant to ask this question, as they have limited training in working with sexual problems and may even be embarrassed by having sex talks. Not addressing sexual challenges is a lost opportunity, because a loving physical bond can cause other grievances to lose importance as great sex floods lovers with pleasure and bonding hormones (Wise, 2020).

While traditional sex therapy is often about healing past wounding, trauma, abuse and understanding emotions, coaching is skills and mindset based, and future oriented. If therapy has a goal of getting a client to a baseline of normal, sex coaching's goal is to empower the client to create the pleasurable, connected sex life they desire.

Not every sexual dysfunction has its origin in trauma or the past. If a woman struggles, she is not broken; it may simply be that female sexuality is inherently complex, a science, an



art, and a learned skill, that no one taught her. It may be that she has received negative messages about her body or desires (Brown, 2012), doesn't have experience or education, or she doesn't feel comfortable discussing sex. Sex and intimacy coaching fills a gap between therapy and self-growth, helping women shed shame, negative conditioning, learn about their bodies, arousal and response cycles, their unique likes, dislikes and turn-ons, and how to ask for what she wants from her lover.

Written by a trained female sex and intimacy coach who works with a heteronormative population, and a licensed marriage and family therapist working toward a certification in sex therapy from American Association of Sex Educators, Counselors, and Therapist (AASECT) this article is limited in scope and does not address the gender and sexual orientation spectrum. The sex coach author believes that for women to have enjoyable, connected sex lives over the long term, they need six things: knowledge, worthiness, time, embodiment, creativity, and emotional connection.

Knowledge

Few women understand physiological facts about arousal: for instance, that the clitoris is similar in size to a penis, with 95% under the surface like an iceberg (Aswell, 2018); that there are a half dozen types of orgasms to experience; that neglect or trauma may cause a body to feel desensitized or numb; that the brain is the most important sex organ, and that it can be rewired to experience more pleasure via practice, touch, and imagination (Wise, 2020).

Coaching provides personalized sex education so a woman learns not only the facts, but also discovers her own preferences, turn-ons, and arousal cycles, as well as dislikes and boundaries. She learns how to communicate her desires and preferences to her partner in a way that feels connected and not critical.

Worthiness and confidence

Growing up, many women received negative messages about their sexuality, bodies and desires, which can cause lasting shame, confusion and guilt (Brown, 2012). These might be considered micro-traumas as opposed to "capital T" trauma sex therapists regularly see. A goal of both therapy and coaching is to release shame and shift mindsets in an atmosphere of empathy and support. Talking about and normalizing sex gives a woman 'permission' to enjoy her sensual self and celebrate her desires and fantasies. In addition, as a stressed out, unhappy woman is unlikely to experience much physical pleasure and joy, in coaching she is encouraged to keep her spirit and self-love tank full with self-care and gratitude practices. Worthiness means she does not need a perfect body, relationship or performance to enjoy pleasure, because confidence, skill, relaxation and enjoyment are what make her a satisfied and exciting lover.

Time

A great sex life does not just happen; it needs priority and time. 'Mutually spontaneous desire' is a myth, and there is nothing wrong with planning sexy times. Coaching keeps her accountable for stress relief and self-care practices that boost her happiness and confidence, and lovemaking is given time and priority; not just relegated to the end of the day when partners are exhausted.

In addition to prioritizing lovemaking, the female body needs time for arousal. If a man's sexual response is like a microwave, a woman is more like a wood stove that needs kindling and fuel to be stoked. Parts of female anatomy need 20-40 minutes of attention to be primed (Castleman, 2021) yet the average sex act is over in an average of six minutes! It is no wonder women have an orgasm deficit compared to men and faking is so prevalent. In coaching, she discovers turn-ons, techniques, rituals and touch she likes—then applies them in an unrushed, sensuous way.

Sex and intimacy coaching includes relationship components that help dissolve resentments and fighting, including gratitude, reframing, expectation setting, and giving.

Embodiment
A top sexual complaint of women is the inability to get 'out of their heads' and into pleasure—it can be a challenge to banish distracting thoughts, judgment, performance anxiety and the furtive chase of orgasms. Many women feel numb or distracted (Nagoski, 2015), as their touch sensitivity has been diminished by a lack of pleasurable touch, menopause, or trauma. Fortunately, sensitivity and focus can be revived and enhanced through mindful sensation practices, which use elements of breath, movement, touch, sound, and imagination (Brotto, 2018). Rewiring the body and brain to receive more pleasure is a process that takes effort and support. Guided visualization, breathwork, mindful touch and home play practices help her break out of distracting thought patterns and connect with heart, body, and sensuality.

Coaching teaches embodied sensuality; however, if her lack of ability to relax is due to unresolved trauma, a trained sex therapist can help resolve negative cognitions and freeze responses that will allow women to move back into their bodies and experience their sensual self.

Creativity
Despite a vast sexual menu, most couples have the same type of sex, year after year, and bedroom boredom is a leading cause of relationship dissatisfaction (Frederick, Lever, Gillespie, & Garcia, 2017). In coaching, we explore what she wants sex to mean emotionally, as well as the scenarios that turn her on. A client has the opportunity to experiment with varied themes such as passion, romance, energy, submission and dominance, plus the many forms of stimulation and lovemaking beyond the standard penis-in-vagina intercourse from which less than a third of women reliably orgasm (Castleman, 2021).

Connection
Sex with deep emotional connection is often the ultimate goal. If a romantic relationship lacks emotional connection, a woman is unlikely to feel 'in the mood' or fulfilled. Sex and intimacy coaching includes relationship components that help dissolve resentments and fighting, including gratitude, reframing, expectation setting, and giving.

She learns to communicate desires to her partner in a connecting and playful way, rather than the dreaded, 'we need to talk.' In coaching, she learns how to 'invite' her partner's attention, create an atmosphere of loving appreciation and intimacy.

Where to Refer a Client
You can see now how sexual problems are not always couples problems, and how a woman may benefit from therapy, education, practices, skills, and/or confidence building independent of her partner. When considering whom to refer to, both can help with the most common challenges such as low and inhibited desire, arousal and orgasm problems, and painful sex. A sex therapist helps a client understand how the past got them to where they are today, and an intimacy and sex coach (Britton, 2005) helps a client move from the present to their future desired sexual self.

A sex therapist is a licensed clinician who has often completed extensive training after their Master's or PhD/PsyD and may have been certified through AASECT. Typically, a sex therapist helps a client explore the past, heal from trauma around sex and sexuality, understand how trauma or mental health affects their sex life, and identify negative cognitions that underlie sexual dysfunction when no medical or organic reason exists. A sex therapist understands the intersection of biological, psychological, and social factors that impact a person's sexual health. Sessions are talk-based and therapeutic.

An intimacy and sex coach may have extensive training in sex education, coaching, and methods such as sacred sexuality, but there is no formal regulating body. Coaching is about education and empowerment and may resemble life coaching for the sex life. Coaching stays in the present and helps the client work towards their future desired sexual self. Most coaches use embodied practices. It is a good practice for MFTs to get personally acquainted with a sex coach or two to build trust and get a feel for their approach and methods.

When considering whether to refer to an intimacy and sex coach, the most pertinent consideration is whether mental health or trauma is a core concern. If so, therapeutic intervention is appropriate. If trauma or mental health is not a consideration and she would benefit from empowerment, confidence, skills and creativity, coaching is an option. Coaching also has a place when a woman has already worked on healing trauma in therapy, but still doesn't know what she likes, or how to create the playful, pleasurable, connected sex life she desires.

"How's your sex life?"
Sexual dysfunction, frustration, and sexless relationships are rampant for women and their partners. Sex problems and a lack of intimate connection harm mental, physical and emotional health, and break up many families. Shame, guilt, low expectations, and ignorance of alternatives mean that most of these women (and their partners) suffer in silence from sexual difficulties their entire lives, never seeking professional help. As the professional, it is appropriate to ask about the quality of the couple's sex life, to uncover sources of conflict, and opportunities for growth and bonding.

Even if sexuality is not your specialty, we hope that this article has helped you understand that sexual challenges are not always a couples issue and that transformation can take various forms. New sources of help are available in the form of not only professional sex therapy, but also intimacy education and coaching.

Debbie Marielle Elzea, JD, BA, is an intimacy and sex coach and educator for women, and a Colorado psychotherapist (not licensed).
www.MoreIntimacy.net

Jennie Marie Battistin, MA, LMFT, is an AAMFT Professional Member holding the Clinical Fellow designation, and AASECT applicant with Hope Therapy Center, Burbank, CA.

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