JOURNAL OF FAMILY THERAPY
ASSOCIATION FOR FAMILY THERAPY AND SYSTEMIC PRACTICE

Journal of Family Therapy (2009) **31**: 46–74
0163-4445 (print); 1467-6427 (online)

The effectiveness of family therapy and systemic interventions for adult-focused problems

Alan Carr[a]

This review updates a similar paper published in this Journal in 2000. It presents evidence from meta-analyses, systematic literature reviews and controlled trials for the effectiveness of couples and family therapy for adults with various relationship and mental health problems. The evidence supports the effectiveness of systemic interventions, either alone or as part of multimodal programmes, for relationship distress, psychosexual problems, domestic violence, anxiety disorders, mood disorders, alcohol abuse, schizophrenia and adjustment to chronic physical illness.

Introduction

This paper summarizes the evidence base for systemic practice with adult-focused problems, and updates a similar paper published in the *Journal of Family Therapy* eight years ago (Carr, 2000). It is also a companion paper to a review of research on the effectiveness of systemic interventions for child-focused problems (Carr, 2009). The overall effectiveness of systemic therapy is now well established. In a review of twenty meta-analyses of couples and family therapy trials for a range of mental health problems across the life cycle, Shadish and Baldwin (2003) concluded that the average treated case fared better after therapy and at six- to twelve-month follow-up than in excess of 71 per cent of families in control groups who, for the most part, received standard services. This research finding provides strong support for a policy of funding systemic therapy as an integral part of mental health services. However, more detailed conclusions than this are essential if family therapists are to use research to inform their routine practice. There is a need for specific evidence-based statements about the types of systemic interventions that are most effective for particular types of problems. This paper addresses this question

[a] Clanwilliam Institute and University College Dublin, Professor of Clinical Psychology, School of Psychology, Newman Building, University College Dublin, Belfield, Dublin 4, Ireland. E-mail: alan.carr@ucd.ie.

with particular reference to relationship distress, psychosexual problems, domestic violence, anxiety disorders, mood disorders, alcohol abuse, schizophrenia, and adjustment to chronic physical illness. This particular set of problems has been chosen because extensive computer and manual literature searches showed that, for each of these areas, controlled trials of systemic interventions have been reported.

Currently there is an international trend favouring evidence-based practice and increasing pressures for health systems to prioritize the provision of evidence-based interventions. For mental health professionals from various psychotherapeutic traditions there is competition for limited resources. To successfully compete for such resources, it is vital for systemic practitioners to be conversant with the evidence base for marital and family therapy and to become skilled in evidence-based systemic practices. For these reasons this review is both timely and significant.

A broad definition of systemic practices has been taken in this paper, which covers family therapy and other family-based interventions such as carer psychoeducation and support groups, which engage family members in the process of resolving problems for adults over the age of 18 to older adulthood. Extensive computer and manual literature searches were conducted for systemic interventions with a wide range of adult-focused problems. Major databases, family therapy journals and mental health journals were searched, as well as major textbooks on evidence-based practice. Where available, meta-analyses and systematic review papers were selected for review, since these constitute the strongest form of evidence. If such papers were unavailable, controlled trials, which constitute the next highest level of evidence, were selected for review. Only in the absence of such trials were uncontrolled studies selected. This strategy was adopted to permit the strongest case to be made for systemic evidence-based practice with a wide range of adult-focused problems, within the space constraints of a single paper.

Relationship distress

Relationship distress, dissatisfaction and conflict are extremely common problems and currently in Western industrialized societies, where 40 to 50 per cent of marriages end in divorce. In a proportion of cases, couples therapy alleviates relationship distress. In a systematic review of six meta-analyses of couples therapy, Shadish and Baldwin (2003) found an average effect size of .84, which indicates

that the average treated couple fared better than 80 per cent of couples in control groups. Caldwell *et al*. (2007) estimated that the free provision of effective couples therapy would lead to considerable and significant cost savings because it would prevent a range of legal and healthcare costs from arising from divorce and divorce-related health problems. Most trials of systemic interventions for distressed couples have evaluated behavioural or emotionally focused couples therapy. In a meta-analysis of twenty-three studies, Wood *et al*. (2005) found that for mildly distressed couples both of these approaches were equally effective, but with moderately distressed couples emotionally focused couples therapy was more effective than behavioural marital therapy.

Emotionally focused couples therapy

This approach rests on the premise that an insecure attachment bond underpins relationship distress and related conflict (Johnson, 2004). Partners are anxious that their attachment needs will not be met within their relationship, and this anxiety fuels chronic relationship conflict. The aim of emotionally focused couples therapy is to help partners understand this, and develop ways to meet each other's attachment needs, so that they experience attachment security within their relationship. The best predictors of a good outcome in emotionally focused couples therapy are the strength of the therapeutic alliance, and the female partner's belief that her male partner still cares about her (Johnson, 2003; Johnson *et al*., 1999).

Behavioural couples therapy

This approach rests on the premise that an unfair relationship bargain underpins relationship distress and related conflict (Jacobson and Christensen, 1998). Partners fail to negotiate a fair exchange of pleasing responses to each other, and this sense of injustice fuels chronic relationship conflict. The aim of behavioural marital therapy is to help partners develop communication and problem-solving skills, and behavioural exchange procedures so that they can negotiate a fairer relationship. Cognitive components have been added to this basic model to help couples challenge destructive beliefs and expectations which contribute to relationship distress, and replace these with more benign alternatives (Epstein and Baucom, 2002). In a review of controlled studies, Byrne *et al*. (2004a) concluded that these cognitive

innovations add little to the effectiveness of behavioural couples therapy. Integrative behavioural couples therapy, a refined version of behavioural marital therapy, includes a strong emphasis on building tolerance for partners' negative behaviours, acceptance of irresolvable differences, and empathic joining around such problems. A single trial has shown that this approach does not enhance the overall effectiveness of traditional behavioural marital therapy, but may lead to more rapid and sustained improvement in couples who stay together (Christensen *et al*., 2006). Younger couples with non-traditional values, and lower levels of distress, who are more emotionally engaged with each other, and who do not opt for premature closure during conflict resolution, benefit most from behavioural marital therapy (Jacobson and Addis, 1993).

Insight-oriented marital therapy

In a comparative trial, Snyder *et al*. (1991) found that, four years after treatment, only 3 per cent of cases who had completed insight-oriented marital therapy were divorced, compared with 38 per cent of those in behavioural marital therapy. Insight-oriented marital therapy holds considerable promise as a particularly effective approach to couples therapy. This approach to marital therapy rests on the premise that the inadvertent use of unconscious defences and relational patterns, which evolved within partners' families of origin or previous relationships, underpin relationship distress and conflict. The aim of therapy is to help partners understand how family-of-origin experiences, or experiences in previous relationships, compel them to inadvertently engage in destructive interaction patterns, and then to replace these with more constructive alternatives (Snyder and Schneider, 2002).

The results of this review suggest that in developing services for distressed couples, emotionally focused couples therapy is currently the treatment of choice. Behavioural couples therapy and insight-oriented couples therapy are second-line alternatives. Programmes should span up to twenty sessions over at least six months, with the intensity of input matched to couples' needs.

Psychosexual problems

Hypoactive sexual desire in men and women; orgasmic disorder, dysparunia and vaginismus in women; and erectile disorder and

premature ejaculation in men are the main psychosexual problems for which systemic interventions have been developed. The overall prevalence of these various psychosexual problems ranges from 8 to 33 per cent (Laumann *et al*., 1999). Relationship distress typically accompanies such difficulties (Leiblum, 2006).

Hypoactive sexual desire

Systematic reviews of trials of sex therapy for hypoactive sexual desire conclude that 50 to 70 per cent of cases showed improvements in levels of desire following therapy, but in up to half of these cases, improvement in desire was not sustained at three-year follow-up, although improved sexual satisfaction continued (Duterte *et al*., 2007; Segraves and Althof, 2002). Effective programmes are couples-based and involve both cognitive and behavioural elements. Cognitive interventions focus on challenging beliefs, attitudes and expectations that diminish sexual desire and psychological intimacy. Masters and Johnson's (1970) sensate focus exercise is the main behavioural intervention in effective therapy for hypoactive sexual desire. This begins with psychoeducation about the human sexual response. Couples are advised to refrain from sexual intercourse and sexual contact, except as outlined in prescribed homework exercises. These involve giving and receiving pleasurable caresses, along a graded sequence progressing over a number of weeks from non-sexual, to increasingly sexual areas of the body, culminating in full intercourse.

Female orgasmic disorder

In a narrative review of twenty-nine psychological treatment outcome studies for female orgasmic disorder, involving over 500 participants, Meston (2006) concluded that directed masturbation combined with sensate focus exercises was effective in most cases. This couples-based sex therapy involves a graded programme which begins with psychoeducation and is followed by a series of exercises that are practised over a number of weeks by the female with partner support initially, and later with the partner's full participation. These exercises involve visual and tactile total body exploration; masturbation using sexual fantasy and imagery; optional use of a vibrator; masturbating to orgasm in the presence of one's partner and later explaining sexual techniques that are effective for achieving orgasm to one's partner, and finally practising these as a couple. Meston (2006) concluded that

this intervention was more effective than systematic desensitization and sensate focus.

Female sexual pain disorders

Female dysparunia and vaginismus are most commonly associated with vulvar vestibulitis syndrome. In this syndrome burning pain occurs in response to touch or pressure, due to erythema of the tissues surrounding the vagina and eurethra openings. In a systematic narrative review of outcome studies, Meston and Bradford (2007) concluded that couples-based cognitive behavioural sex therapy was particularly effective for reducing dysparunia and vaginismus in women with vulvar vestibulitis syndrome. Effective programmes included psychoeducation; cognitive therapy to challenge beliefs and expectations underpinning anxiety about painful sex; and systematic desensitization. Systematic desensitization involves initially abstaining from attempts at intercourse; learning progressive muscle relaxation; and then pairing relaxation with the gradual insertion of a series of dilators of increasing diameter into the vagina, until this can be achieved without discomfort; and finally progressing through sensate focus exercises to intercourse.

Male erectile disorder

Prior to 1998 and the marketing of Sildenafil (Viagra), psychological interventions based on Masters and Johnson's (1970) sensate focus sex therapy was the main treatment for male erectile problems. It was shown to be effective in up to 60 per cent of cases. However, with the introduction of Sildenafil and other phosphodiesterase Type 5 (PDE-5) inhibitors, these have come to be first-line intervention for erectile disorder (Bekkering *et al*., 2007). However, not all cases respond to PDE-5 inhibitors, and there is an emerging practice of using multimodal programmes involving PDE-5 inhibitors combined with psychological interventions in such cases because they have synergistic effects (McCarthy and Fucito, 2005). In a study of fifty-three cases of acquired erectile disorder, Banner and Anderson (2007) found that those who received Sildenafil and cognitive behavioural sex therapy had a 48 per cent success rate for erectile function and 65 per cent for satisfaction. In contrast, those who received Sildenafil alone had only a 29 per cent erection success rate, and only a 37 per cent satisfaction rate.

Premature ejaculation

For premature ejaculation, Masters and Johnson (1970) developed a couples-based sex therapy programme which includes the stop-start and squeeze techniques. In this programme, each time ejaculation is imminent, couples cease intercourse and squeeze the base of the penis to prevent ejaculation. Once the male has controlled the impulse to ejaculate, intercourse is resumed, until ejaculation is again imminent, and the procedure is repeated. The programme is practised over a number of weeks. In a narrative review of mainly uncontrolled trials, Duterte *et al*. (2007) concluded that success rates with this method may be initially as high as 80 per cent but decline in the long term to 25 per cent at follow-up. The short-lived effectiveness of psychological interventions led to the development of pharmacotherapies for premature ejaculation. In an extensive review of controlled trials and meta-analyses, Hellstrom (2006) concluded that antidepressants (such as fluoxetine and clomipramine) are effective in alleviating premature ejaculation, but currently dapoxetine hydrochloride (DPX), a serotonin transport inhibitor, is the pharmacological treatment of choice for this condition owing to its rapid onset of action, and profile of minimal side-effects compared with antidepressants. Hellstrom (2006) also concluded that there is evidence from a number of trials to show that topical formulations which contain anaesthetic agents can increase ejaculatory latency times. It is probable that multi-modal programmes that combine pharmacotherapy and couples sex therapy will be developed and evaluated in the future.

General prognostic factors for psychosexual problems

In an extensive review, Hawton (1995) concluded that motivation for treatment (particularly the male partner's motivation); early compliance with treatment; the quality of the relationship (particularly as assessed by the female partner); the physical attraction between partners and the absence of serious psychological problems are predictive of a positive response to treatment for psychosexual difficulties.

The results of this review suggest that in developing services for couples with psychosexual difficulties, couples-based sex therapy should be provided within a context that allows for multi-modal programmes involving sex therapy and medication to be offered for disorders such as erectile dysfunction and premature ejaculation, and

that also permits couples to receive therapy for relationship distress. Programmes for psychosexual problems tend to be brief (up to ten sessions) over three months, with the intensity of input matched to couples' needs, especially where there is co-morbid relationship distress.

Domestic violence

Stith and Rosen (2003), in a narrative review of six studies, found that couples therapy was effective in reducing domestic violence. However, couples therapy is only effective for cases of domestic violence in which couples are committed to staying together, and in which the violent partner can agree to a no-harm contract. There is also evidence from one comparative trial that multi-couple therapy may be more effective than single-couple therapy for such cases. In this trial Stith *et al*. (2004) found that male violence recidivism rates were 25 per cent for the multi-couple group, and 43 per cent for the individual couple group. Key elements of treatment included the perpetrator taking responsibility for the violence; solution-focused practices; challenging beliefs and cognitive distortions which justify violence; anger management training; communication and problem-solving skills training; and relapse prevention. Anger management training focuses on teaching couples to recognize anger cues; to take time out when such cues are recognized; to use relaxation and self-instructional methods to reduce anger-related arousal; to resume interactions in a non-violent way, and to use communication and problem-solving skills more effectively for conflict resolution.

This review suggests that in developing services for couples within which domestic violence has occurred, initial assessment for treatment suitability is essential. Where the assessment shows that couples wish to stay together, and the violent partner can agree to a no-harm contract, group-based couples therapy with a specific focus on violence reduction should be offered.

Anxiety disorders

Family-based therapies are effective for two of the most debilitating anxiety disorders – agoraphobia with panic disorder and obsessive compulsive disorder. The twelve-month prevalence rates for panic disorder with agoraphobia and obsessive compulsive disorder are 3 per cent and 1 per cent respectively, and both conditions are more

common among women (Kessler *et al*., 2005). Although some people with these disorders respond to serotonin reuptake inhibitors (Dougherty *et al*., 2007; Roy-Byrne and Cowley, 2007), a significant proportion are not helped by medication, cannot tolerate medication side-effects, or do not wish to take medication for other reasons. In addition, relapse is common once medication is no longer taken. All of these reasons provide a rationale for a psychotherapeutic approach to anxiety disorders. Furthermore, systemic interventions create a context within which families can support recovery, and a forum within which family interaction patterns and belief systems that often inadvertently maintain anxiety disorders can be transformed.

Panic disorder

Recurrent unexpected panic attacks are the central feature of panic disorder (APA, 2000; WHO, 1992). Normal fluctuations in autonomic arousal are misperceived as signals for the inevitable onset of panic attacks, and so these fluctuations in arousal are anxiety-provoking. Secondary agoraphobia often develops, where there is an avoidance of public places in which panic attacks are expected to occur. Family members often come to share this belief system and inadvertently become involved in patterns of interaction that maintain the constricted lifestyle of the person with agoraphobia. Effective family-based treatment aims to disrupt this process and enlist the aid of family members in helping the symptomatic person expose himself in a planned way to feared situations, and control his anxiety within these contexts.

In a review of twelve studies of couples-based treatment for panic disorder for agoraphobia, Byrne *et al*. (2004b) concluded that partner-assisted, cognitive-behavioural exposure therapy provided on a per-case or group basis led to clinically significant improvement in agoraphobia and panic symptoms for 54 to 86 per cent of cases. This type of couples therapy was as effective as individually based cognitive-behavioural treatment, widely considered to be the treatment of choice. Treatment gains were maintained at follow-up. In some studies couples-based interventions had a positive impact on co-morbid relationship distress, although this has also been found in studies of individually based exposure therapy. The most effective couples programmes include communication training; partner-assisted exposure; enhancement of coping skills; and cognitive therapy to address problematic beliefs which underpin avoidant behaviour.

With partner-assisted exposure, the symptomatic person and his or her partner go on a series of planned outings to a hierarchy of places or situations that are increasingly anxiety-provoking or threatening. In these situations the partner supports the symptomatic person in using coping skills (such as controlled breathing, relaxation and self-talk) to successfully manage anxiety and control panic.

Obsessive compulsive disorder (OCD)

OCD is characterized by obsessive thoughts elicited by specific cues (such as dirt) and compulsive, anxiety-reducing rituals (such as hand washing) (APA, 2000; WHO, 1992). However, compulsive rituals only have a short-term anxiety-reducing effect. Obsessional thoughts quickly return and the rituals are repeated. Family members, particularly partners, often inadvertently become involved in patterns of interaction that maintain compulsive rituals by assisting with them, not questioning their legitimacy, or engaging in conflict about them. In effective family-based treatment for obsessive compulsive disorder, the aim is to disrupt family interaction patterns that maintain compulsive rituals, and enlist the aid of family members in helping the person with the condition overcome his obsessions and compulsions.

Five trials of systemic couples or family-based approaches to the treatment of OCD, reviewed by Renshaw *et al*. (2005), have shown that such approaches are as effective, or in some instances more effective, than individually based cognitive behaviour therapy for adults with OCD (Emmelkamp *et al*., 1990; Emmelkamp and De-Lange, 1983; Grunes *et al*., 2001; Mehta, 1990; Van Noppen *et al*., 1997). Systemic therapy may be provided in conjoint or separate sessions, or in multiple family sessions. Effective protocols involve psychoeducation about OCD combined with exposure and response prevention. The aim of psychoeducation is to help family members reduce the extent to which they over-accommodate or antagonistically respond to the symptomatic person's compulsive rituals or accounts of their obsessions. With exposure and response prevention, the therapist coaches partners in supporting their obsessive-compulsive spouses while they enter a hierarchy of increasingly anxiety-provoking situations (such as coming into contact with dirt) in a planned manner and preventing themselves from engaging in compulsive anxiety-reducing responses (such as repeated hand washing).

In planning systemic services for people with panic disorder and OCD, treatment protocols as described in the preceding sections should be offered on an outpatient basis over ten to twenty sessions, depending on client need. In cases that do not respond to systemic therapy, a multi-modal programme involving systemic therapy and serotonin reuptake inhibitors is appropriate (Dougherty *et al*., 2007; Roy-Byrne and Cowley, 2007).

Mood disorders

Effective family-based treatments have been developed for major depression and bipolar disorder. Both conditions have a profound impact on quality of life, with depression being more common than bipolar disorder. The twelve-month prevalence of major depression is approximately 7 per cent and of bipolar disorder 3 per cent (Kessler *et al*., 2005).

Depression

Major depression is an episodic disorder characterized by low mood, loss of interest in normal activities, and most of the following symptoms: psychomotor agitation or retardation, fatigue, low self-esteem, pessimism, inappropriate excessive guilt, suicidal ideation, impaired concentration, and sleep and appetite disturbance (APA, 2000; WHO, 1992). Over the course of their lifetime, on average, people with major depression have four episodes, each of about four months' duration. Integrative theories of depression propose that episodes occur when genetically vulnerable individuals become involved in stressful social systems in which there is limited access to socially supportive relationships (Carr and McNulty, 2006). Systemic interventions aim to reduce family stress and increase support, although there are other factors that provide a rationale for systemic interventions for depression in adults. Not all people with major depression respond to antidepressant medication or wish to take it, because of possible side-effects. In addition, in the year after treatment, relapse rates following pharmacotherapy are about double those of relapse rates following psychotherapy (65 per cent vs. 29 per cent: Vittengl *et al*., 2007).

Narrative reviews of controlled trials of systemic interventions for depression support the effectiveness of outpatient and inpatient systemic couples therapy, family therapy based on the McMaster model, emotionally focused couples therapy, behavioural marital therapy, cognitive marital therapy, and conjoint interpersonal therapy

(Barbato and D'Avanzo, 2006; Beach, 2003; Gupta *et al*., 2003; Lemmens *et al*., in press). All of these approaches to couples therapy require fewer than twenty conjoint therapy sessions and focus on both relationship enhancement and mood management.

Systemic couples therapy. In two trials, systemic couples therapy was found to be more effective than standard care (Leff *et al*., 2000; Lemmens *et al*., in press). Leff *et al*. (2000) found that systemic couples therapy was more effective than antidepressants in reducing depressive symptoms in outpatients, after treatment and at two-year follow-up. It was also no more expensive than antidepressant medication, because clients who received medication used a range of other health services to compensate for the limited effects of antidepressants. In a comparative trial of depressed inpatients, Lemmens *et al*. (in press) found that when offered to single families, or in multi-family groups, systemic couples therapy (with some additional family sessions involving children) combined with antidepressant medication led to a significantly higher rate of treatment responders and to fewer patients being on antidepressants at fifteen-month follow-up, compared with standard treatment. The therapeutic approach used in these studies was manualized and involved enactment of couples' issues in therapy sessions, disruption of problematic behavioural cycles, setting tasks to develop less problematic ways of interacting, and helping couples cope better with the way depression affected their lives (Jones and Asen, 2000).

McMaster family therapy. In a comparative study of depressed inpatients, Miller *et al*. (2005) found that family therapy combined with antidepressant medication led to more rapid recovery and a higher improvement rate than antidepressants combined with cognitive therapy. The McMaster model is a manualized structured, problem-centred, systemic approach to therapy, which begins with systematic assessment, and proceeds with a task-focused approach to helping families replace problem-maintaining family interaction patterns, with transactions characterized by clear communication, effective collaborative problem-solving and emotional connectedness (Ryan *et al*., 2005).

Emotionally focused couples therapy. In a comparative trial, Dessaulles *et al*. (2003) found that emotionally focused couples therapy was as effective as antidepressants in alleviating depression. This manualized therapeutic approach involved helping couples use non-problematic ways to express and meet each other's attachment needs (Johnson, 2004).

Behavioural marital therapy. In three trials, behavioural marital therapy was as effective as individual cognitive behaviour therapy in alleviating depressive symptoms and more effective than individual therapy in alleviating co-morbid marital distress (Beach and O'Leary, 1992; Emanuels-Zuurveen and Emmelkamp, 1996; Jacobson *et al*., 1991). In one of these trials, Beach and O'Leary (1992) also showed that behavioural couples therapy improved the quality of the marital relationship, which in turn accounted for the alleviation of depressive symptomatology. Behavioural marital therapy aims to improve communication and conjoint problem-solving, and to increase the frequency of satisfying experiences within the relationship. These aims are achieved through problem-solving and communication skills training, and contingency contracting, where couples negotiate increased rates of mutually satisfying exchanges (Beach *et al*., 1990).

Cognitive marital therapy. Two trials of cognitive marital therapy have been conducted. Teichman *et al*. (1995) found that cognitive marital therapy was more effective than standard individual cognitive therapy for depressive symptoms, and Emanuels-Zuurveen and Emmelkamp (1997) found that spouse-assisted cognitive therapy and standard cognitive therapy were equally effective. A central process in cognitive marital therapy is using guided discovery, Socratic questioning and behavioural experiments to identify and modify cognitive factors that maintain dysphoria and relationship distress (Epstein and Baucom, 2002).

Conjoint interpersonal therapy. In a controlled trial, Foley *et al*. (1989) found that conjoint interpersonal couples therapy was as effective as standard, individually administered interpersonal therapy in improving both depression and interpersonal functioning. Conjoint interpersonal therapy aims to alter negative interpersonal situations which maintain depression. In particular, interpersonal therapy helps couples to address unresolved difficulties in the following domains: loss, role disputes, role transitions and interpersonal deficits (Weissman *et al*., 2000).

Bipolar disorder

Bipolar disorder is a recurrent mood disorder characterized by episodes of mania or hypomania, depression and mixed mood states (APA, 2000; WHO, 1992). Genetic factors play a central role in the aetiology of bipolar disorder, but its course is affected by exposure to stress, individual and family coping strategies, and medication

adherence (Lam and Jones, 2006). The primary treatment for bipolar disorder is pharmacological, and involves initial treatment of acute manic or depressive episodes, and subsequent prevention of further episodes with mood-stabilizing medication such as lithium (Geddes *et al*., 2004; Keck and McElroy, 2007). The primary aim of systemic therapy is to reduce relapse and rehospitalization rates, and increase quality of life by improving medication adherence and enhancing the way individuals with bipolar disorder and their families manage stress and vulnerability to relapse. Systematic reviews and meta-analyses concur that when included in multi-modal programmes involving mood-stabilizing medication, systemic therapy and a range of different types of individual therapy significantly reduce relapse rates in people with bipolar disorder (Benyon *et al*., 2008; Gutierrez and Scott, 2004; Jones *et al*., 2005; Mansell *et al*., 2005; Miklowitz and Craighead, 2007; Sajatovic *et al*., 2004; Scott *et al*., 2007).

Results from five trials show that family therapy alone or in combination with interpersonal social rhythm therapy was effective in reducing relapse, and in some instances, rehospitalization in patients with bipolar disorder on maintenance mood stabilizing medication (Miklowitz and Goldstein, 1990; Miklowitz *et al*., 2003a, 2003b, 2007; Rea *et al*., 2003). In these trials family therapy was conducted over twenty-one sessions and included family-based psychoeducation, relapse prevention, communication and problem-solving skills training (Miklowitz and Goldstein, 1990). In three trials, other, less intensive family-based interventions have not yielded these positive effects (Clarkin *et al*., 1990, 1998; Miller *et al*., 2004).

From this review it may be concluded that effective systemic therapy for mood disorders may be offered on an inpatient or outpatient basis, and treatment may span seven to twenty sessions. Systemic services for mood disorders are best offered within a context that permits the option of multi-modal treatment, where appropriate medication may be combined with systemic interventions as described above. Because of the recurrent, episodic nature of mood disorders, services should make long-term re-referral arrangements, so intervention is offered early in later episodes.

Alcohol abuse

Harmful alcohol use constitutes a significant mental health problem. The twelve-month prevalence of alcohol abuse is 3 per cent (Kessler *et al*., 2005). In a systematic quantitative review of 381 clinical trials

involving over 75,000 clients and ninety-nine different treatment modalities, Miller *et al*. (2003) rank ordered interventions in terms of the evidence base for their overall effectiveness and placed two systemic interventions in the top seven most effective treatments. These were: community reinforcement (Smith and Meyers, 2004) and behavioural marital therapy (O'Farrell and Fals-Stewart, 2006). O'Farrell and Fals-Stewart (2003) conducted a systematic narrative review of thirty-eight controlled studies of systemic interventions for the treatment of alcohol problems and concluded that these approaches were effective in helping families promote the engagement of family members with alcohol problems in treatment, and in helping people with alcohol problems recover. This conclusion is shared by other reviewers (Finney *et al*., 2007; McCrady and Nathan, 2006).

Community Reinforcement and Family Training. For helping families promote the engagement of family members with alcohol problems in therapy, O'Farrell and Fals-Stewart (2003) concluded that Community Reinforcement and Family Training (Smith and Meyers, 2004) was more effective than all other family-based methods, leading to engagement rates above 60 per cent in controlled trials. This approach helps sober family members improve communication, reduce the risk of physical abuse, and encourage sobriety and treatment-seeking in people with alcohol problems. It also helps sober family members engage in activities outside the family, to reduce dependence on the person with the alcohol problem.

Behavioural couples therapy. For helping people with alcohol problems recover, O'Farrell and Fals-Stewart (2003) concluded that behavioural couples therapy was more effective than other systemic and individual approaches. Compared with individual approaches, behavioural couples therapy produced greater abstinence, fewer alcohol-related problems, greater relationship satisfaction, and better adjustment in children of people with alcohol problems. It also showed greater reductions in domestic violence, and periods in gaol and hospital, leading to very significant cost savings. The most effective forms of behavioural couples therapy incorporate either a disulfiram ('Antabuse') contract, or a sobriety contract into a treatment programme which includes problem-solving and communication training and relationship-enhancement procedures. The therapy aims to reduce alcohol abuse, enhance family support for efforts to change, and promote patterns of interaction conducive to long-term abstinence (O'Farrell and Fals-Stewart, 2006).

Social behavioural network therapy. Social behavioural network therapy, a novel systemic intervention developed in the UK, was found to be as effective as individually based motivational enhancement therapy in the largest ever UK alcohol abuse treatment trial (UKATT Research Team, 2005). Social behaviour network therapy helps clients address their alcohol problems by building supportive social networks and developing coping skills (Copello *et al*., 2002).

In planning systemic services, this review suggests that therapy for alcohol abuse may be offered on an outpatient basis initially over a time-limited period. A clear distinction should be made between the processes of engagement, and treatment. For individuals who are alcohol-dependent, systemic services should be provided within a context that permits a period of inpatient or outpatient detoxification to precede therapy. Because relapses following recovery from alcohol abuse are common, services should make long-term re-referral arrangements, so intervention is offered early following relapse.

Schizophrenia

Schizophrenia is a recurrent episodic psychotic disorder characterized by positive and negative symptoms and disorganization (APA, 2000; WHO, 1992). Delusions and hallucinations are the main positive symptoms of schizophrenia. Negative symptoms include poverty of speech, flat affect and passivity. While genetic and neurodevelopmental factors associated with pre- and perinatal adversity play a central role in the aetiology of schizophrenia, its course is affected by stress, individual and family coping strategies, and medication adherence (Kuipers *et al*., 2006; Walker *et al*., 2004). The primary treatment for schizophrenia is pharmacological. It involves the initial treatment of acute psychotic episodes, and the subsequent prevention of further episodes with antipsychotic medication (Sharif *et al*., 2007). About half of medicated clients with schizophrenia relapse, and relapse rates are higher in unsupportive or stressful family environments, characterized by high levels of criticism, hostility or overinvolvement (Kuipers, 2006). The aim of psychoeducational family therapy is to reduce family stress and enhance family support, so as to delay or prevent relapse and rehospitalization.

Pfammatter *et al*. (2006) conducted a review of three meta-analyses of psychoeducational family therapy (Pharoah *et al*., 2006; Pilling *et al*., 2002; Pitschel-Walz *et al*., 2001) and a new meta-analysis of the thirty-one most methodologically robust available randomized controlled

trials involving over 3,500 clients. They found that compared with medication alone, multi-modal programmes which included psychoeducational family therapy and anti-psychotic medication led to lower relapse and rehospitalization rates, and improved medication adherence. One to two years after treatment, the average effect sizes across these four meta-analyses for relapse and rehospitalization rates were .32 and .48 respectively. This indicates that the average case treated within the context of a multi-modal programme involving medication and family therapy fared better in terms of relapse and rehospitalization than 63 per cent and 68 per cent of cases, respectively, who received medication only. The effect size for medication adherence was .30. This indicates that the average case treated with family therapy showed better medication adherence than 62 per cent of those who did not receive family therapy. In a review of eighteen studies containing over 1,400 cases, the authors of the UK NICE guidelines for schizophrenia concluded that, to be effective, psychoeducational family therapy must span at least six months and include at least ten sessions (NICE, 2003).

Psychoeducational family therapy may take a number of formats, including therapy sessions with single families (Kuipers *et al*., 2002); therapy sessions with multiple families (McFarlane, 2004); group therapy sessions for relatives; or parallel group therapy sessions for relative and patient groups. Family therapy for schizophrenia involves psychoeducation, based on the stress vulnerability or bio-psychosocial models of schizophrenia, with a view to helping families understand and manage the condition, anti-psychotic medication, related stresses and early warning signs of relapse. Emphasis is placed on blame reduction, and the positive role family members can play in the rehabilitation of the family member with schizophrenia. Psychoeducational family therapy also helps families develop communication and problem-solving skills. Skills training commonly involves modelling, rehearsal, feedback and discussion. Effective interventions typically span nine to twelve months, and are usually offered in a phased format with three months of weekly sessions; three months of fortnightly sessions; three months of monthly sessions; followed by three monthly reviews and crisis intervention as required.

It may be concluded from this review that systemic therapy services for families of people with schizophrenia should be offered within the context of multi-modal programmes that include anti-psychotic medication. Because of the recurrent, episodic nature of schizophrenia,

services should make long-term re-referral arrangements, so intervention is offered early in later episodes.

Chronic physical illness

With chronic illness such as heart disease, cancer or chronic pain, systemic interventions are offered as one element of multi-modal programmes involving medical care (McDaniel *et al*., 1992; Rolland, 1994). Systemic interventions include couples and family therapy as well as multi-family support groups, and carer support groups. These interventions provide psychoeducaiton about the chronic illness and its management. They also offer a context within which to enhance support for the person with the chronic illness, and other family members. They provide, in addition, a forum for exploring ways of coping with the condition, and its impact on family relationships. In a meta-analysis of seventy studies, Martire *et al*. (2004) found that systemic interventions for people with chronic illnesses were more effective than standard care. The studies included cases with dementia, heart disease, cancer, chronic pain, stroke, arthritis and traumatic brain injury. Couples therapy (but not family therapy) was particularly effective in alleviating depression in people with chronic illnesses. Systemic interventions that aimed to improve the well-being of other family members and carers were particularly effective when they focused explicitly on relationship issues. Such interventions alleviated care-giving burden, depression and anxiety. These systemic interventions included groups for relatives of people with chronic illnesses as well as family therapy. These findings suggest that systemic services for people with chronic illnesses deserve development as part of multi-modal programmes for people with such conditions, a conclusion consistent with previous systematic reviews (e.g. Campbell and Patterson, 1995).

Discussion

A number of comments may be made about the evidence reviewed in this paper. First, well-articulated systemic interventions are effective for a wide range of common adult mental health and relationship problems. Second, these interventions are brief and may be offered by a range of professionals on an outpatient or inpatient basis, as appropriate. Third, for many of these interventions, useful treatment manuals have been developed which may be flexibly used by clinicians

in treating individual cases. Fourth, an important issue is the generalizability of the results of the studies reviewed in this paper to typical health service settings. It is probable that the evidence-based practices described in this paper are somewhat less effective when used in typical health service settings by busy clinicians, who receive limited supervision, and carry large case loads of clients with many co-morbid problems. This is because participants in research trials tend to have fewer co-morbid problems than typical service users, and most trials are conducted in specialist university-affiliated clinics where therapists carry small case loads, receive intensive supervision, and follow flexible manualized treatment protocols. Clearly, an important future research priority is to conduct treatment effectiveness trials in which evidence-based practices are evaluated in routine non-specialist health service clinics with typical clients and therapists. Fifth, controlled trials of systemic therapy for prevalent problems such as personality disorders have not been reported in the literature, although clinical models for their treatment have been developed (MacFarlane, 2004). Clearly these should be a priority for future research. Such trials should include relatively homogeneous samples, and involve the flexible use of treatment manuals. Sixth, the contribution of common factors (such as the therapeutic alliance) and specific factors (such as techniques specified in protocols) to therapy outcome have rarely been investigated, and future research should routinely build an exploration of this issue into the design of controlled trials (Sprenkle and Blow, 2004). Seventh, the bulk of systemic interventions which have been evaluated in control trials have been developed within the cognitive-behavioural, psychoeducational and structural-strategic psychotherapeutic traditions. More research is required on social constructionist and narrative approaches to systemic practice, which are very widely used in the UK, Ireland and elsewhere. Eighth, for some adult-focused problems such as schizophrenia and bipolar disorder, the research evidence shows that systemic therapy is particularly effective, not as an alternative to medication, but when offered as one element of a multi-modal treatment programme involving pharmacotherapy. A challenge for systemic therapists using such approaches in routine practice, and for family therapy training programmes, will be to develop coherent, overarching frameworks within which to conceptualize the roles of systemic therapy and pharmacotherapy in the multi-modal treatment of such conditions. Ninth, because there is so little evidence on the conditions under which systemic therapy is not effective for the

adult-focused mental health problems covered in this paper, it is probably appropriate for practitioners to use evidence-based systemic interventions in situations where family members are available and willing to engage in therapy, to contribute to problem resolution and to disengage from family processes that maintain the identified patients presenting problems.

The results of this review are broadly consistent with the important role accorded to systemic interventions and family involvement in psychosocial treatment within NICE guidelines for a range of adult mental health problems including schizophrenia (NICE, 2003), depression (NICE, 2004), bipolar disorder (NICE, 2006) and OCD (NICE, 2005). In contrast, the potentially helpful role of family-based interventions found in this review is not reflected in NICE guidelines for the treatment of panic disorder with agoraphobia (NICE, 2007).

A broad definition of family therapy and systemic intervention has been adopted in this paper. There are pros and cons to this approach. On the positive side, it provides the widest scope of evidence on which to draw in support of systemic practice. This is important in a climate where there is increasing pressure to point to a large and significant evidence base to justify funding any particular type of psychotherapy service. However, the broad definition of systemic intervention taken in this paper potentially blurs the unique contribution of those practices developed within the tradition of marital and family therapy, as distinct from interventions where partners or other family members are included in an adjunctive role to facilitate individually focused therapy.

The findings of this review have clear implications for training and practice. Family therapy training programmes should include coaching in evidence-based practices in their curricula. Qualified family therapists should make learning evidence-based practices, relevant to the client group with whom they work, a priority when planning their own continuing professional development. Experienced clinicians working with clients who present with the types of problems discussed in this paper may benefit their clients by incorporating essential elements of effective family-based treatments into their own style of practice. To facilitate this, a list of accessible treatment manuals is included at the end of both papers. The incorporation of such elements into one's practice style is not incompatible with the prevailing social constructionist approach to family therapy, as I have argued elsewhere (Carr, 2006).

Treatment resources

Gurman, A. and Jacobson, N. (eds) (2002) *Clinical Handbook of Couple Therapy* (3rd edn). New York: Guilford Press. Gives guidance on working with couples with a range of couples therapy models and a range of different relationship difficulties including adult mental health problems.

Snyder, D. and Whisman, M. (eds) (2003) *Treating Difficult Couples. Helping Clients with Coexisting Mental and Relationship Disorders*. New York: Guilford Press. Gives guidance on working with couples with a range of different adult mental health problems.

Relationship distress

Epstein, N. and Baucom, D. (2002) *Enhanced Cognitive-behavioural Therapy For Couples: A Contextual Approach*. Washington, DC: American Psychological Association.

Gottman, J. (1999) *The Marriage Clinic: A Scientifically-based Marital Therapy*. New York: Norton.

Jacobson, N. and Christensen, A. (1998) *Acceptance and Change in Couple Therapy: A Therapist's Guide to Transforming Relationships*. New York: Norton.

Johnson, S. (2004) *The Practice of Emotionally Focused Couple Therapy: Creating Connection* (2nd edn). New York: Guilford Press.

Psychosexual problems

Hawton, K. (1985) *Sex Therapy: A Practical Guide*. Oxford: Oxford University Press.

Leiblum, S. (2006) *Principles and Practice of Sex Therapy* (4th edn). New York: Guilford Press.

McCarthy, B. and McCarthy, E. (2003) *Rekindling Desire: A Step-by-step Program To Help Low-sex And No-sex Marriages*. New York: Brunner/Routledge.

Schnarch, D. (1991) *Constructing the Sexual Crucible: An Integration of Sexual and Marital Therapy*. New York: Norton.

Wincze, J. and Carey, M. (2001) *Sexual Dysfunction: A Guide for Assessment and Treatment* (2nd edn). New York: Guilford Press.

Anxiety disorders

Baucom, D., Stanton, S. and Epstein, N. (2003) Anxiety disorders. In D. Snyder and M. Whisman (eds) *Treating Difficult Couples. Helping Clients with Coexisting Mental and Relationship Disorders* (pp. 57-87). New York: Guilford Press.

Mood disorders

Beach, S., Sandeen, E. and O'Leary, K. (1990) *Depression in Marriage: A Model for Aetiology and Treatment*. New York: Guilford Press.

Jones, E. and Asen, E. (2000) *Systemic Couple Therapy and Depression*. London: Karnac.

Milkowitz, D. and Goldstein, M. (1997) *Bipolar Disorder: A Family-focused Treatment Approach*. New York: Guilford Press.

Ryan, B., Epstein, N., Keitner, G., Miller, I. and Bishop, D. (2005) *Evaluating and Treating Families: The McMaster Approach*. New York: Routledge.

Weissman, M., Markowitz, J. and Klerman, G. (2000) *Comprehensive Guide to Interpersonal Psychotherapy*. New York: Basic Books.

Alcohol and drug abuse

Copello, A., Orford, J., Hodgson, R. and Tober, G. (2002) *Social Behaviour and Network Therapy Manual*. Birmingham: University of Birmingham and the UKATT. Available from Gary.Slegg@new-tr.wales.nhs.uk.

O'Farrell, T. and Fals-Stewart. W. (2006) *Behavioural Couples Therapy for Alcoholism and Substance Abuse*. New York: Guilford Press.

Smith, J. and Meyers, R. (2004) *Motivating Substance Abusers to Enter Treatment. Working with Family Members*. New York: Guilford Press.

Schizophrenia

Anderson, C., Reiss, D. and Hogarty, G. (1986) *Schizophrenia and the Family*. New York: Guilford Press.

Barrowclough, C. and Tarrier, N. (1997) *Families of Schizophrenic Patients – Cognitive Behavioural Intervention* (New edn). London: Nelson Thornes.

Bloch Thorsen, G., Gronnestad, T. and Oxnevad, A. (2006) *Family and Multi-family Work with Psychosis*. London: Routledge.

Falloon, I., Laporta, M., Fadden, G. and Graham-Hole, V. (1993) *Managing Stress in Families*. London: Routledge.
Kuipers, E., Leff, J. and Lam, D. (2002) *Family Work for Schizophrenia* (2nd edn). London: Gaskell.
Leff, J. (2005) *Advanced Family Work for Schizophrenia*. London: Gaskell.
McFarlane, W. (2004) *Multifamily Groups in the Treatment of Severe Psychiatric Disorders*. New York: Guilford Press.
Smith, G., Gregory, K. and Higgs. A. (2007) *An Integrated Approach to Family Work for Psychosis: A Manual for Family Workers*. London: Jessica Kingsley.

Chronic physical illness

McDaniel, S., Hepworth, J. and Doherty, W. (1992) *Medical Family Therapy*. New York: Basic Books.
Rolland, J. (1994) *Families, Illness, and Disability: An Integrative Treatment Model*. New York: Basic Books.

References

APA (2000) *Diagnostic and Statistical Manual of the Mental Disorders (4th edn – Text Revision, DSM –IV-TR)*. Washington, DC: APA.
Banner, L. and Anderson, R. (2007) Integrated Sildenafil and cognitive-behaviour sex therapy for psychogenic erectile dysfunction: a pilot study. *Journal of Sexual Medicine*, **4**: 1117–1125.
Barbato, A. and D'Avanzo, B. (2006) Marital therapy for depression. *Cochrane Database of Systematic Reviews*, Issue 2. Art. No.: CD004188. DOI: 10.1002/14651858.CD004188.pub2.
Beach, S. (2003) Affective disorders. *Journal of Marital and Family Therapy*, **29**: 247–261.
Beach, S. and O'Leary, K. (1992) Treating depression in the context of marital discord: outcome and predictors of response for marital therapy versus cognitive therapy. *Behaviour Therapy*, **23**: 507–258.
Beach, S., Sandeen, E. and O'Leary, K. (1990) *Depression in Marriage: A Model for Aetiology and Treatment*. New York: Guilford Press.
Bekkering, G., Abou-Settaand, A. and Kleijnen, J. (2007) The application of quantitative methods for identifying and exploring the presence of bias in systematic reviews: PDE-5 inhibitors for erectile dysfunction. *International Journal of Impotence Research*, advance online publication 6 December 2007; doi: 10.1038/sj.ijir.3901626. http://www.nature.com/ijir/journal/vaop/ncurrent/abs/3901626a.html.
Benyon, S., Soares-Weiser, K., Woolacott, N., Duffy, S. and Geddes, J. (2008) Psychosocial interventions for the prevention of relapse in bipolar disorder: systematic review of controlled trials. *British Journal of Psychiatry*, **192**: 5–10.

Byrne, M., Carr, A. and Clark, M. (2004a) The efficacy of behavioural couples therapy and emotionally focused therapy for couple distress. *Contemporary Family Therapy*, **26**: 361–387.

Byrne, M., Carr, A. and Clarke, M. (2004b) The efficacy of couples based interventions for panic disorder with agoraphobia. *Journal of Family Therapy*, **26**: 105–125.

Caldwell, B., Woolley, S. and Caldwell, C. (2007) Preliminary estimates of cost-effectiveness for marital therapy. *Journal of Marital and Family Therapy*, **33**: 392–405.

Campbell, T. and Patterson, J. (1995) The effectiveness of family interventions in the treatment of physical illness. *Journal of Marital and Family Therapy*, **21**: 545–583.

Carr, A. (2000) Research update: Evidence-based practice in family therapy and systemic consultation. II. Adult focused problems. *Journal of Family Therapy*, **22**: 273–295.

Carr, A. (2006) *Family Therapy: Concepts Process and Practice* (2nd edn). Chichester: Wiley.

Carr, A. (2009) The effectiveness of family therapy and systemic interventions for child-focused problems. *Journal of Family Therapy*, **31**: 3–45.

Carr, A. and McNulty, M. (2006) Depression. In A. Carr and M. McNulty (eds) *Handbook of Adult Clinical Psychology* (pp. 291–345). London: Routledge.

Christensen, A., Atkins, D., Yi, J., Baucom, D. and George, W. (2006) Couple and individual adjustment for 2 years following a randomized clinical trial comparing traditional versus integrative behavioural couple therapy. *Journal of Consulting and Clinical Psychology*, **74**: 1180–1191.

Clarkin, J., Carpenter, D., Hull, J., Wilner, P. and Glick, I. (1998) Effects of psychoeducational intervention for married patients with bipolar disorder and their spouses. *Psychiatry Services*, **49**: 531–533.

Clarkin, J., Glick, I., Haas, G., Spencer, J., Lewis, A., Peyser, J., Demane, N., Good-Ellis, M., Harris, E. and Lestelle, V. (1990) A randomized clinical trial of inpatient family intervention, V: Results for affective disorders. *Journal of Affective Disorders*, **18**: 17–28.

Copello, A., Orford, J., Hodgson, R., Tober, G. and Barrett, C. on behalf of the UKATT Research Team (2002) Social behaviour and network therapy: basic principles and early experiences. *Addictive Behaviour*, **27**: 345–366.

Dessaulles, A., Johnson, S. and Denton, W. (2003) Emotion-focused therapy for couples in the treatment of depression: a pilot study. *The American Journal of Family Therapy*, **31**: 345–353.

Dougherty, D., Rauch, S. and Jenike, M. (2007) Pharmacological treatments for obsessive compulsive disorder. In P. Nathan and J. Gorman (eds) *A Guide to Treatments that Work* (3rd edn, pp. 447–474). New York: Oxford University Press.

Duterte, E., Segraves, T. and Althof, S. (2007) Psychotherapy and pharmacotherapy for sexual dysfunctions. In P. Nathan and J. Gorman (eds) *A Guide to Treatments that Work* (3rd edn, pp. 531–569). New York: Oxford University Press.

Emanuels-Zuurveen, L. and Emmelkamp, P. M. (1996) Individual behavioural-cognitive therapy vs. marital therapy for depression in maritally distressed couples. *British Journal of Psychiatry*, **169**: 181–188.

Emanuels-Zuurveen, L. and Emmelkamp, P. M. (1997) Spouse-aided therapy with depressed patients. *Behaviour Modification*, **21**: 62–77.
Emmelkamp, P. and DeLange, I. (1983) Spouse involvement in the treatment of obsessive-compulsive patients. *Behaviour Research and Therapy*, **21**: 341–346.
Emmelkamp, P., de Haan, E. and Hoogduin, C. (1990) Marital adjustment and obsessive compulsive disorder. *British Journal of Psychiatry*, **156**: 55–60.
Epstein, N. and Baucom, D. (2002) *Enhanced Cognitive-behavioural Therapy for Couples: A Contextual Approach*. Washington, DC: American Psychological Association.
Finney, J., Wilbourne, P. and Moos, R. (2007) Psychosocial treatments for substance use disorders. In P. Nathan and J. Gorman (eds) *A Guide to Treatments that Work* (3rd edn, pp. 179–202). New York: Oxford University Press.
Foley, S., Rounsaville, B., Weissman, M., Sholomskas, D. and Chevron, E. (1989) Individual versus conjoint interpersonal psychotherapy for depressed patients with marital disputes. *International Journal of Family Psychiatry*, **10**: 29–42.
Geddes, J., Burgess, S., Hawton, K., Jamison, K. and Goodwin, G. (2004) Long-term lithium therapy for bipolar disorder: systematic review and meta-analysis of randomized controlled trials. *American Journal of Psychiatry*, **161**: 217–222.
Grunes, M., Neziroglu, F. and McKay, D. (2001) Family involvement in the behavioural treatment of obsessive-compulsive disorder: a preliminary investigation. *Behaviour Therapy*, **32**: 803–820.
Gupta, M., Coyne, J. and Beach, S. (2003) Couples treatment for major depression: critique of the literature and suggestions for some different directions. *Journal of Family Therapy*, **25**: 317–346.
Gutierrez, M. and Scott, J. (2004) Psychological treatment for bipolar disorders: a review of randomised controlled trials. *European Archives of Psychiatry and Clinical Neuroscience*, **254**: 92–98.
Hawton, K. (1995) Treatment of sexual dysfunctions by sex therapy and other approaches. *British Journal of Psychiatry*, **17**: 307–314.
Hellstrom, W. (2006) Current and future pharmacotherapies of premature ejaculation. *Journal of Sexual Medicine*, **3**: 332–341.
Jacobson, N. and Addis, M. (1993) Research on couples and couple therapy: what do we know? *Journal of Consulting and Clinical Psychology*, **61**: 85–93.
Jacobson, N. and Christensen, A. (1998) *Acceptance and Change in Couple Therapy: A Therapist's Guide to Transforming Relationships*. New York: Norton.
Jacobson, N., Dobson, K., Fruzzetti, A. E., Schmaling, K. and Salusky, S. (1991) Marital therapy as a treatment for depression. *Journal of Consulting and Clinical Psychology*, **59**: 547–557.
Johnson, S. (2003) The revolution in couple therapy: a practitioner-scientist perspective. *Journal of Marital and Family Therapy*, **29**: 365–384.
Johnson, S. (2004) *The Practice of Emotionally Focused Couple Therapy: Creating Connection* (2nd edn). New York: Guilford Press.
Johnson, S., Hunsley, J., Greenberg, L. and Schindler, D. (1999) Emotionally focused couples therapy: status and challenges. *Clinical Psychology: Science and Practice*, **6**: 67–79.
Jones, E. and Asen, E. (2000) *Systemic Couple Therapy and Depression*. London: Karnac Books.

Jones, S., Sellwood, W. and McGovern, J. (2005) Psychological therapies for bipolar disorder: the role of model-driven approaches to therapy integration. *Bipolar Disorder*, **7**: 22–32.

Keck, P. and McElroy, S. (2007) Pharmacological treatments for bipolar disorder. In P. Nathan and J. Gorman (eds) *A Guide to Treatments that Work* (3rd edn, pp. 323–350). New York: Oxford University Press.

Kessler, R., Chiu, W., Demler, O. and Walters, E. (2005) Prevalence, severity and comorbidity of 12 month DSM-IV Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, **62**: 617–627.

Kuipers, E. (2006) Family interventions in schizophrenia: evidence for efficacy and proposed mechanisms of change. *Journal of Family Therapy*, **28**: 73–80.

Kuipers, E., Leff, J. and Lam, D. (2002) *Family Work for Schizophrenia* (2nd edn). London: Gaskell.

Kuipers, E., Garety, P., Fowler, D., Freeman, D., Dunn, G. and Bebbington, P. (2006) Cognitive, emotional, and social processes in psychosis: refining cognitive behavioural therapy for persistent positive symptoms. *Schizophrenia Bulletin*, **32** (Supplement 1), S24–S31.

Lam, D. and Jones, S. (2006) Bipolar disorder. In A. Carr and M. McNulty (eds) *Handbook of Adult Clinical Psychology* (pp. 346–38). London: Routledge.

Laumann, E., Paik, A. and Rosen, R. (1999) Sexual dysfunctions in the United States: prevalence and predictors. *Journal of the American Medical Association*, **281**: 537–544.

Leff, J., Verneals, S., Brewin, C., Wolff, G., Alexander, B., Asen, E., Dayson, D., Jones, E., Chisholm, D. and Everitt, B. (2000) The London depression intervention trial: randomized controlled trial of antidepressants v. couple therapy in the treatment and maintenance of people with depression living with a partner: clinical outcome and costs. *British Journal of Psychiatry*, **177**: 95–100.

Leiblum, S. (2006) *Principles and Practice of Sex Therapy* (4th edn). New York: Guilford Press.

Lemmens, G., Eisler, I., Buysse, A., Heene, E. and Demyttenaere, K. (in press) The effects on mood of adjunctive single family and multi-family group therapy in the treatment of hospitalized patients with major depression: a 15 months follow-up study. *Psychotherapy and Psychosomatics*.

MacFarlane, M. (2004) *Family Treatment of Personality Disorders: Advances in Clinical Practice*. New York: Haworth Clinical Practice Press.

Mansell, W., Colom, F. and Scott, J. (2005) The nature and treatment of depression in bipolar disorder: a review and implications for future psychological investigation. *Clinical Psychology Review*, **25**: 1076–1100.

Martire, L., Lustig, A., Schultz, R., Miller, G. and Helgeson, V. (2004) Is it beneficial to involve a family member? A meta-analysis of psychosocial interventions for chronic illness. *Health Psychology*, **23**: 599–611.

Masters, W. and Johnson, V. (1970) *Human Sexual Inadequacy*. Boston, MA: Little-Brown.

McCarthy, B. and Fucito, L. (2005) Integrating medication, realistic expectations, and therapeutic interventions in the treatment of male sexual dysfunction. *Journal of Sex and Marital Therapy*, **31**: 319–328.

McCrady, B. and Nathan, P. (2006) Technique factors in treating substance use disorders. In L. Castonguay and L. Beutler (eds) *Principles of Therapeutic Change that Work* (pp. 319–340). Oxford: Oxford University Press.

McDaniel, S., Hepworth, J. and Doherty, W. (1992) *Medical Family Therapy*. New York: Basic Books.

McFarlane, W. (2004) *Multifamily Groups in the Treatment of Severe Psychiatric Disorders*. New York: Guilford Press.

Mehta, M. (1990) A comparative study of family-based and patient-based behavioural management in obsessive-compulsive disorder. *British Journal of Psychiatry*, **157**: 133–135.

Meston, C. (2006) Female orgasmic disorder: treatment strategies and outcome results. In I. Goldstein, C. Meston, S. Davis and A. Traish (eds) *Women's Sexual Function and Dysfunction: Study, Diagnosis, and Treatment* (pp. 449–461). London: Taylor & Francis.

Meston, C. and Bradford, A. (2007) Sexual dysfunctions in women. *Annual Review of Clinical Psychology*, **3**: 233–256.

Miklowitz, D. and Craighead, W. (2007) Psychosocial treatments for bipolar disorder. In P. Nathan and J. Gorman (eds) *A Guide to Treatments that Work* (3rd edn, pp. 309–323). New York: Oxford University Press.

Miklowitz, D. and Goldstein, M. (1990) Behavioural family treatment for patients with bipolar affective disorder. *Behaviour Modification*, **14**: 457–489.

Miklowitz, D., George, E. and Richards, J. (2003a) A randomized study of family-focused psychoeducation and pharmacotherapy in the outpatient management of bipolar disorder. *Archives of General Psychiatry*, **60**: 904–912.

Miklowitz, D., Richards, J., George, E., Frank, E., Suddath, R. and Powell, K. (2003b) Integrated family and individual therapy for bipolar disorder: results of a treatment development study. *Journal of Clinical Psychiatry*, **64**: 182–191.

Miklowitz, D., Otto, M., Frank, E., Reily Harrington, N., Wisniewski, S., Kogan, J., Nierenberg, A., Calabrese, R., Marangell, L., Gyulai, L., Araga, M., Gonzalez, J., Shirley, E., Thase, M. and Sachs, G. (2007) Psychosocial treatments for bipolar depression: a 1-year randomized trial from the Systematic Treatment Enhancement Program. *Archives of General Psychiatry*, **64**: 419–427.

Miller, W., Wilbourne, P. and Hettema, J. (2003) What works? A summary of alcohol treatment outcome research. In R. Hester and W. Miller (eds) *Handbook of Alcoholism Treatment Approaches: Effective Alternatives* (3rd edn, pp. 13–63). Boston, MA: Allyn & Bacon.

Miller, I., Solomon, D., Ryan, C. and Keitner, G. (2004) Does adjunctive family therapy enhance recovery from bipolar I mood episodes. *Journal of Affective Disorders*, **82**: 431–436.

Miller, I., Keitner, G., Ryan, C., Solomon, D. and Cardemil, E. (2005) Treatment matching in the posthospital care of depressed inpatients. *American Journal of Psychiatry*, **162**: 2131–2138.

NICE (2003) *Schizophrenia; Full National Clinical Guidelines on Core Interventions in Primary and Secondary Care*. London: Gaskell Press.

NICE (2004) *Depression: Management of Depression in Primary and Secondary Care*. London: National Institute for Clinical Excellence.

NICE (2005) *Obsessive Compulsive Disorder: Core Interventions in the Treatment Of Obsessive Compulsive Disorder and Body Dysmorphic Disorder*. London: The National Institute for Clinical Excellence.

NICE (2006) *Bipolar Disorder: The Management of Bipolar Disorder in Adults, Children And Adolescents, in Primary and Secondary Care*. London: National Institute of Clinical Excellence.

NICE (2007) *Anxiety (Amended). Management of Anxiety (Panic Disorder, with and without Agoraphobia, and Generalized Anxiety Disorder) in Adults in Primary, Secondary and Community Care*. London: National Institute of Clinical Excellence.

O'Farrell, T. and Fals-Stewart, W. (2003) Alcohol abuse. *Journal of Marital and Family Therapy*, **29**: 121–146.

O'Farrell, T. and Fals-Stewart, W. (2006) *Behavioural Couples Therapy for Alcoholism and Substance Abuse*. New York: Guilford Press.

Pfammatter, M., Junghan, U. and Brenner, H. (2006) Efficacy of psychological therapy in schizophrenia: conclusions from meta-analyses. *Schizophrenia Bulletin*, **32** (Suppl 1), S64–S80.

Pharoah, F., Mari, J., Rathbone, J. and Wong, W. (2006) Family intervention for schizophrenia. *Cochrane Database of Systematic Reviews*, Issue 2. Art. No.: CD000088. DOI: 10.1002/14651858.CD000088.pub2.

Pilling, S., Bebbington, P., Kuipers, E., Garety, P., Geddes, J., Orbach, G. and Morgan, C. (2002) Psychological treatments in schizophrenia: I. Meta-analysis of family intervention and cognitive behaviour therapy. *Psychological Medicine*, **32**: 763–782.

Pitschel-Walz, G., Leucht, S., Bäuml, J., Kissling, W. and Engel, R. (2001) The effect of family interventions on relapse and rehospitalization in schizophrenia – a meta-analysis. *Schizophrenia Bulletin*, **27**: 73–92.

Rea, M., Tompson, M., Miklowitz, D., Goldstein, M., Hwang, S. and Mintz, J. (2003) Family-focused treatment versus individual treatment for bipolar disorders and suicide disorder: results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, **71**: 482–492.

Renshaw, K., Steketee, G. and Chambless, D. (2005) Involving family members in the treatment of OCD. *Cognitive Behaviour Therapy*, **34**: 164–175.

Rolland, J. (1994) *Families, Illness, and Disability: An Integrative Treatment Model*. New York: Basic Books.

Roy-Byrne, P. and Cowley, D. (2007) Pharmacological treatments for panic disorder, generalized anxiety disorder, specific phobia, and social anxiety disorder. In P. Nathan and J. Gorman (eds) *A Guide to Treatments that Work* (3rd edn, pp. 395–430). New York: Oxford University Press.

Ryan, B., Epstein, N., Keitner, G., Miller, I. and Bishop, D. (2005) *Evaluating and Treating Families: The McMaster Approach*. New York: Routledge.

Sajatovic, M., Davies, M. and Hrouda, D. (2004) Enhancement of treatment adherence among patients with bipolar disorder. *Psychiatric Services*, **55**: 264–269.

Scott, J., Colom, F. and Vieta, E. (2007) A meta-analysis of adjunctive psychological therapies compared to usual psychiatric treatment for bipolar disorders. *International Journal of Neuropsychopharmacology*, **10**: 123–129.

Segraves, R. and Althof, S. (2002) Psychotherapy and pharmacotherapy for sexual dysfunctions. In P. Nathan and J. Gorman (eds) *A Guide To Treatments That Work* (2nd edn, pp. 497–524). New York: Oxford University Press.

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

Sharif, Z., Bradford, D., Stroup, S. and Lieberman, J. (2007) Pharmacological treatments for schizophrenia. In P. Nathan and J. Gorman (eds) *A Guide to Treatments that Work* (3rd edn, pp. 203–242). New York: Oxford University Press.

Smith, J. and Meyers, R. (2004) *Motivating Substance Abusers to Enter Treatment. Working with Family Members*. New York: Guilford Press.

Snyder, D. and Schneider, W. (2002) Affective reconstruction: a pluralistic, developmental approach. In A. Gurman and N. Jacobson (eds) *Clinical Handbook of Couples Therapy* (3rd edn, pp. 151–179). New York: Guilford Press.

Snyder, D., Wills, R. and Grady-Fletcher, F. (1991) Long-term effectiveness of behavioural versus insight-oriented marital therapy: a 4-year follow-up study. *Journal of Consulting and Clinical Psychology*, **59**: 138–141.

Sprenkle, D. and Blow, A. (2004) Common factors and our sacred models. *Journal of Marital and Family Therapy*, **30**: 113–129.

Stith, S. and Rosen, K. (2003) Effectiveness of couples treatment for spouse abuse. *Journal of Marital and Family Therapy*, **29**: 407–426.

Stith, S., Rosen, K., McCollum, E. and Thomsen, C. (2004) Treating intimate partner violence within intact couple relationships: outcomes of multi-couple versus individual couple therapy. *Journal of Marital and Family Therapy*, **30**: 305–318.

Teichman, Y., Bar-El, Z., Shor, H., Sirota, P. and Elizur, A. (1995) A comparison of two modalities of cognitive therapy (individual and marital) in treating depression. *Psychiatry: Interpersonal and Biological Processes*, **58**: 136–148.

UKATT Research Team (2005) Effectiveness of treatment for alcohol problems: findings of the randomized UK alcohol treatment trial (UKATT). *British Medical Journal*, **331**: 541–544.

Van Noppen, B., Steketee, G., McCorkle, B. and Pato, M. (1997) Group and multifamily behavioural treatment for obsessive compulsive disorder: a pilot study. *Journal of Anxiety Disorders*, **11**: 431–446.

Vittengl, J., Clark, L., Dunn, T. and Jarrett, R. (2007) Reducing relapse and recurrence in unipolar depression: a comparative meta-analysis of cognitive-behavioural therapy. *Journal of Consulting and Clinical Psychology*, **75**: 475–488.

Walker, E., Kestler, L. and Bollini, A. (2004) Schizophrenia: aetiology and course. *Annual Review of Psychology*, **55**: 401–430.

Weissman, M., Markowitz, J. and Klerman, G. (2000) *Comprehensive Guide to Interpersonal Psychotherapy*. New York: Basic Books.

WHO (1992) *The ICD-10 Classification of Mental and Behavioural Disorders*. Geneva: WHO.

Wood, N., Crane, D., Schaalje, B. and Law, D. (2005) What works for whom: a meta-analytic review of marital and couples therapy in reference to marital distress. *American Journal of Family Therapy*, **33**: 273–287.