



The evidence base for couple therapy, family therapy and systemic interventions for adult-focused problems

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This review updates similar articles published in JFT in 2000 and 2009. It presents evidence from meta-analyses, systematic literature reviews and controlled trials for the effectiveness of couple 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 multi-modal programmes, for relationship distress, psychosexual problems, intimate partner violence, anxiety disorders, mood disorders, alcohol problems, schizophrenia and adjustment to chronic physical illness.

Introduction

This article summarizes the evidence base for systemic practice with adult-focused problems and updates previous similar articles (Carr, 2000, 2009). It is also a companion article to a review of research on the effectiveness of systemic interventions for child-focused problems (Carr, 2014, in this issue). The overall effectiveness of systemic therapy is now well established. Sprenkle (2012) edited a special issue of the *Journal of Marital and Family Therapy* (JMFT) on research and concluded that a large and growing evidence base now supports the effectiveness of systemic interventions. This work updates previous special issues of the *Journal of Marital and Family Therapy* (Pinsof and Wynne, 1995; Sprenkle, 2002). In a review of twenty meta-analyses of couple and family therapy trials for a range mental health problems across the lifecycle, Shadish and Baldwin (2003) concluded that the average treated patient fared better after therapy and at 6–12 months follow up than more than 71 per cent of families in control groups who, for the most part, received standard services. In a series of US

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studies using four large databases, Crane and Christenson (2012) showed that the medical cost offset associated with couple and family therapy covers the cost of providing therapy and in many cases leads to overall cost savings.

The results of existing evaluation and cost-effectiveness research provide strong support for a policy of funding systemic therapy as an integral part of adult mental health services. However, more detailed conclusions than this are essential if systemic 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. The present article addresses this question with particular reference to relationship distress, psychosexual problems, intimate partner violence, anxiety disorders, mood disorders, alcohol problems, schizophrenia and adjustment to chronic physical illness. This particular set of problems has been chosen because extensive computer and manual literature searches show that, for each of these areas, controlled trials of systemic interventions have been reported.

A broad definition of systemic practices has been used in this article. It covers couple and family therapy and other family-based interventions such as carer psycho-education and support groups that engage family members in the process of resolving problems for adults over the age of 18. As with previous reviews by this author, extensive computer and manual literature searches were conducted for systemic interventions with a wide range of adult-focused problems. For the present review the search extended to July 2013. Major databases, couple and family therapy journals and mental health journals were searched, as well as key textbooks on evidence-based practice. Where available, meta-analyses and systematic review articles were selected for review, since these constitute the strongest form of evidence. If such articles 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. It was intended that this article be primarily a review of the reviews, with a major focus on substantive findings of interest to practicing therapists, rather than on methodological issues. This overall review strategy was adopted to permit the strongest possible case to be made for systemic evidence-based practices with a wide range of adult-focused problems and to offer useful guidance to therapists, within the space constraints of a single article.

Relationship distress

In western cultures, by the age of 50 about 85 per cent of people have been married at least once; about one-third to half of couples separate or divorce; about half of all divorces occur in the first 7 years of marriage; of couples that remain married about 20 per cent experience relationship distress and, compared with distressed or separated couples, those who sustain mutually satisfying relationships have better physical and mental health, live longer, experience better financial prosperity and engage in better parenting practices, and their children have better academic achievement and psychological adjustment (Halford and Snyder, 2012; Lebow *et al.*, 2012). Systematic reviews show that evidence-based couple therapy, which typically involves about twenty sessions over 6 months, is effective for many couples (Lebow *et al.*, 2012; Snyder and Halford, 2012). About 40 per cent of couples benefit a lot from couple therapy and about 30 per cent benefit somewhat. In a review of six meta-analyses of couples therapy, Shadish and Baldwin (2003) found an average effect size of 0.84, which indicates that the average treated couple fares better than 80 per cent of couples in control groups. Caldwell *et al.* (2007) estimated that the free provision of effective couple therapy would lead to significant cost savings because it would prevent a range of legal and healthcare costs arising from divorce and divorce-related health problems. Most trials of systemic interventions for distressed couples have evaluated some version of behavioural couple therapy 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 couple therapy was more effective than behavioural couple therapy.

Emotionally focused couple therapy

This approach rests on the premise that an insecure attachment bond underpins relationship distress and related conflict (Johnson, 2004, 2008). 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 couple therapy is to help partners understand this and develop ways to meet each other's attachment needs, so that they experience attachment security within their relationship. Therapy progresses through three stages. The initial stage is of de-escalating destructive pursuer–distancer

interactional patterns. The middle phase is of facilitating partners' authentic expression of, and response to each other's attachment needs. The closing phase is where these more adaptive patterns of attachment behaviour are consolidated. Process research confirms that the positive effects of emotionally focused couple therapy on relationship distress arise from expressing and responding to attachment needs in an emotionally meaningful way during therapy and a growing body of outcome research shows that emotionally focused couple therapy is particularly effective with trauma survivors (Lebow *et al.*, 2012). The best predictors of a good outcome in emotionally focused couple therapy are the strength of the therapeutic alliance and the female partner's belief that her male partner still cares about her (Johnson, 2008).

Behavioural couple therapy

This approach rests on the premise that an unfair relationship bargain underpins relationship distress and related conflict (Jacobson and Margolin, 1979). Partners fail to negotiate a fair exchange of preferred responses to each other and their resulting sense of injustice fuels chronic relationship conflict. The aim of behavioural couple therapy is to help partners develop communication and problem-solving skills, and behavioural exchange procedures so they can negotiate a fairer relationship. Cognitive components have been added to this basic model to help couples challenge destructive beliefs and expectations that contribute to relationship distress and replace them with more benign alternatives (Baucom *et al.*, 2008). In a review of controlled studies, Byrne *et al.* (2004a) concluded that these cognitive innovations add little to the effectiveness of behavioural couple therapy. Integrative behavioural couple therapy, which evolved from traditional behavioural couple therapy, includes a strong emphasis on building tolerance of partners' negative behaviour, their acceptance of irresolvable differences and empathic joining over such problems, as well as including behavioural change techniques from traditional behavioural couple therapy (Dimidjian *et al.*, 2008). In a major comparative study of the effectiveness of traditional and integrative behavioural couple therapy for severely distressed couples, summarized in Lebow *et al.* (2012), there were two key findings. Both treatments led to improvements in relationship satisfaction by enhancing couple communication, positive behaviour and acceptance of their partners' incompatibilities. At a 5-year follow up, about half the treated couple

had clinically recovered and only a quarter had divorced. A growing body of research shows that behavioural couple therapy is particularly effective for treating couples with alcohol problems (Powers *et al.*, 2008).

Model integration and common factors in couple therapy

There is an increasing trend towards identifying factors common to effective approaches to couple therapy and integrating different models of clinical practice. In one of the most coherent statements about common factors in couple therapy, Benson *et al.* (2012) proposed that five principles are common to evidence-based couple therapies. These are (i) altering the couple's view of the presenting problem to be more objective, contextualized and dyadic; (ii) decreasing dysfunctional emotion-driven behaviour; (iii) eliciting emotion-based, avoided, private thoughts; (iv) increasing constructive communication patterns and (v) promoting strengths and reinforcing gains. To implement these factors effectively therapists typically have a clinical case formulation that explains the couple's interactional pattern underpinning their distress.

Affective-reconstructive (or insight-oriented) couple therapy is a particularly well-developed integrative model supported by a clinical trial. The aim of affective-reconstructive couple therapy is to help partners understand how their family of origin experiences or experiences in previous relationships compel them to engage inadvertently in destructive interaction patterns, and then to replace these with more constructive alternatives (Snyder and Mitchell, 2008). This approach rests on the premise that the inadvertent use of unconscious defences and relational patterns, which evolved in the partners' families of origin or previous relationships, underpins relationship distress and conflict. Therapeutic tasks are conceptualized as progressing sequentially along a six-level hierarchy from collaborative alliance through containing crises, strengthening the couple, promoting relationship skills and challenging cognitive aspects of relationship distress to exploring the developmental origins of relationship distress (Abbott and Snyder, 2012; Snyder and Balderrama-Durbin, 2012). To address tasks at these six levels therapists may draw on practices from multiple pure couple therapy models. In a comparative trial, Snyder *et al.* (1991) found that, 4 years after treatment, only 3 per cent of patients who had completed insight-oriented, affective-reconstructive couple therapy were divorced, compared with 38 per cent of those in

behavioural couple therapy. Affective-reconstructive couple therapy holds considerable promise as a particularly effective approach to helping distressed couples.

The results of this review suggest that in developing services for distressed couples, emotionally focused couple therapy and behavioural couple therapy are currently the treatments of choice. Affective-reconstructive couple therapy is a promising emerging approach. Programmes should span up to twenty sessions over at least 6 months with the intensity of input matched to the couples' needs.

Psychosexual problems

Hypoactive sexual desire in men and women, orgasmic disorder, dyspareunia and vaginismus in women and erectile disorder and premature ejaculation in men are the main psychosexual problems for which couples seek help. International epidemiological surveys show that the overall prevalence of these various psychosexual problems, which increase with age, ranges from 20 to 30 per cent for men and from 40 to 45 per cent for women (Lewis *et al.*, 2010). Relationship distress typically accompanies such difficulties (Binik and Hall, 2014).

Systematic reviews and a major meta-analysis conclude that couples treated with psychosocial interventions show greater improvement than untreated controls (Berner and Günzler, 2012; Frühauf *et al.*, 2013; Günzler and Berner, 2012). In a meta-analysis of twenty studies, Frühauf *et al.* (2013) found an effect size of 0.58 across all disorders indicating that the average treated couple fared better after therapy than 73 per cent of cases in waiting list control groups. In this meta-analysis therapy was particularly effective for women with hypoactive sexual desire and orgasmic disorders. Most studies included in this meta-analysis evaluated interventions that combined elements of Masters and Johnson's (1970) sex therapy with various cognitive behavioural interventions. Masters and Johnson's sex therapy is couple based and includes psycho-education about the sexual response cycle, counselling and exercises such as sensate focus. In this exercise couples are invited initially to refrain from sexual intercourse but instead to give and receive 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. These exercises are intended to reduce performance anxiety and facilitate the experience of sexual pleasure.

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 that begins with psycho-education and is followed by a series of exercises that are practiced over a number of weeks by the woman, initially with partner support and later with full partner participation. These exercises involve visual and tactile total body exploration, masturbation using sexual fantasy and imagery, the optional use of a vibrator, masturbating to orgasm in the presence of one's partner and later, with the therapist explaining sexual techniques that are effective in achieving a partner's orgasm and finally, practicing these as a couple. Meston (2006) concluded that this intervention was more effective than systematic desensitization and sensate focus.

Female sexual pain disorders

Female dyspareunia 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 tissue surrounding the vagina and urethra openings. In a systematic narrative review of outcome studies, Meston and Bradford (2007) concluded that couple-based cognitive behavioural sex therapy was particularly effective for reducing dyspareunia and vaginismus in women with vulvar vestibulitis syndrome. Effective programmes included psycho-education, 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 intervention 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 patients. However, with the introduction of sildenafil and other phosphodiesterase type 5 (PDE-5) inhibitors, these have come to be the first-line intervention for erectile disorder (Bekkering *et al.*, 2008). However, not all cases respond to PDE-5 inhibitors and there is an emerging practice of using a multi-modal programme including PDE-5 inhibitors combined with systemic 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 a 37 per cent satisfaction rate. Similar results favouring couple therapy combined with sildenafil compared with medication alone were found by Aubin *et al.* (2009).

Premature ejaculation

For premature ejaculation, Masters and Johnson (1970) developed a couple-based sex therapy programme which includes the stop-start and squeeze techniques. In this programme, each time ejaculation is immanent, couples cease intercourse and squeeze the base of the penis to prevent ejaculation. Once the man has controlled the impulse to ejaculate intercourse is resumed until ejaculation is again immanent and the procedure is repeated. The programme is practiced 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 declines in the long term to 25 per cent at follow up. The short-lived effectiveness of psychological interventions has 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, a serotonin transport inhibitor, is the pharmacological treatment of choice for this condition because of its rapid onset of action and minimal side-effects compared with antidepressants. Hellstrom (2006) also concluded that there is evidence from a number of trials that topical formulations that 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 the 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, couple-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 problem tend to be brief (up to ten sessions) over 3 months, with the intensity of input matched to couples' needs, especially where there is comorbid relationships distress.

Intimate partner violence

Methodologically robust family violence surveys show that intimate partner violence is not exclusively a male to female process. About 12 per cent of men and women engage in intimate partner physical violence and in about 4 per cent of cases severe violence occurs (Esquivel-Santoveña and Dixon, 2012; Langhinrichsen-Rohling *et al.*, 2012). Systematic reviews and meta-analyses of treatment programmes for intimate partner violence conclude that most traditional programmes for violent men have small effects. The most effective programmes for mild to moderate intimate partner violence are couple-based and effective programmes address both violence and substance use, which often contributes significantly to violence (Barner and Carney, 2011; Murphy and Ting, 2010a, 2010b; O'Farrell and Clements, 2012; Stith *et al.*, 2012; Stover *et al.*, 2009). Thus couple therapy is appropriate for treating relatively low-level situational violence and preventing it from escalating into severe violence. It is not appropriate for couples in which one partner perpetrates chronic severe 'characterological' violence. To safely offer couple therapy in

family violence partners must agree to a no-harm contract and commit to work together for the duration of the treatment, which is usually about 6 months.

Behavioural couple therapy for intimate partner violence and substance use (Fals-Stewart *et al.*, 2009) and domestic-violence-focused couples treatment (Stith *et al.*, 2011) are the two most strongly supported evidence-based couple therapy programmes for intimate partner violence. In behavioural couple therapy partners engage in a sobriety contract and also learn skills for increasing their positive interactions, communicating, problem-solving and managing conflict in constructive ways (Fals-Stewart *et al.*, 2009). Non-substance using partners support substance-using spouses in their attempts to remain sober. From a review of a series of controlled trials and naturalistic studies O'Farrell and Clements (2012) concluded that behavioural couple therapy halves the rate of intimate partner violence.

Domestic-violence-focused couples treatment is an 18-week programme facilitated by a team of two co-therapists and may be offered to a single couple or in a multi-couple group format (Stith *et al.*, 2011). For the first 6 weeks partners are seen separately, with separate therapists working with the male and female partners. During this phase of the programme clients develop a vision of a healthy relationship that serves as a guide for the later phase of therapy. They also receive psycho-education about intimate partner violence and develop the safety skills required for conjoint work, including self-soothing through meditation, safety plans and a time-out procedure for de-escalating potentially violent incidents. Partners with substance use problems are engaged in a motivational enhancement intervention to address their concurrent alcohol and drug use problems during the first phase of the programme. In the conjoint phase of the programme co-therapists convene brief separate meetings with partners at the beginning and end of each session to monitor the risk of violence confidentially. The main focus of the conjoint phase of the programme is helping couples make constructive changes in their lives and resolve conflicts in a non-violent way. A solution-focused brief therapy practice model is used (Franklin *et al.*, 2011). The primary emphasis is on working towards positive visualized goals by increasing the frequency and intensity of naturally occurring positive interactions between the couple. In a comparative trial Stith *et al.* (2004) found that that while single and multi-couple formats for this approach to treatment are effective, multi-couple therapy may be more effective. Male violence recidivism rates were 25 per cent for

those treated in a multi-couple format and 43 per cent for those treated in an individual couple format.

This review suggests that in developing services for couples between whom domestic violence has occurred, the initial assessment for treatment suitability is essential. Where the assessment shows that the couple wishes to stay together and the violent partner can agree to a no-harm contract, group-based or individual couple therapy spanning about 6 months of weekly sessions with a specific focus on violence reduction and substance use should be offered.

Anxiety disorders

Family-based therapies are effective for three of the most debilitating anxiety disorders: agoraphobia with panic disorder, obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD). Reviews of international surveys show that the lifetime prevalence rate for panic disorder with agoraphobia is 2–5 per cent. For OCD it is 2–3 per cent and for PTSD it is 1–2 per cent in western Europe, 6–9 per cent in North America and over 10 per cent in countries where there is sectarian violence (Kessler *et al.*, 2010). Although some people with these disorders respond to serotonin reuptake inhibitors, a significant proportion are not helped by medication, cannot tolerate the side effects of medication or do not wish to take medication for other reasons. Furthermore, relapse is common once medication is discontinued (Antony and Stein, 2009). All of these reasons provide a rationale for a psychotherapeutic approach to anxiety disorders. Systemic interventions create a context within which families can support recovery and a forum within which the family interaction patterns and belief systems that often inadvertently maintain anxiety disorders can be transformed.

Panic disorder with agoraphobia

Unexpected recurrent panic attacks are the central feature of panic disorder (American Psychiatric Association, 2013; World Health Organization, 1992). Normal fluctuations in autonomic arousal are misperceived as signals for the inevitable onset of panic attacks. These fluctuations in arousal, therefore, provoke anxiety. When people with panic disorder consistently avoid the public places in which they expect panic attacks to occur, and this is accompanied by a sense of relief and safety, secondary agoraphobia develops. Partners and other

family members may inadvertently maintain the restricted lifestyle of the person with agoraphobia by doing apparently helpful things to enable the anxious person to avoid situations which they believe will trigger panic attacks. Effective couple therapy aims to disrupt this process and enlist the aid of non-anxious partners in helping the symptomatic person expose themselves in a planned way to feared situations and control their anxiety within these contexts.

In a review of twelve studies of couple therapy 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 amelioration of agoraphobia and panic symptoms for 54 to 86 per cent of patients. This type of couple 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 couple-based interventions had a positive impact on comorbid relationship distress, although this has also been found in studies of individually based exposure therapy. The most effective couple-based programmes include communication training, partner-assisted graded exposure to anxiety-provoking situations, the enhancement of coping skills and cognitive therapy to address the problematic beliefs and expectations that underpin avoidant behaviour. With partner-assisted graded exposure the symptomatic person and their 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 non-anxious partner supports the symptomatic person in using coping skills such as controlled breathing, relaxation and self-talking to successfully manage anxiety and control panic.

OCD

OCD is characterized by obsessive thoughts elicited by specific cues (such as dirt) and compulsive, anxiety-reducing rituals (such as hand washing) (American Psychiatric Association, 2013; World Health Organization, 1992). However, compulsive rituals only have a short-term anxiety-reducing effect. Obsessional thoughts quickly return and the rituals are repeated. Partners and other family members often inadvertently become involved in patterns of interaction that maintain compulsive rituals by assisting with them and not questioning their legitimacy, or engaging in conflict about them. These processes may lead to significant relationship distress (Renshaw *et al.*,

2005). In effective couple or family-based treatment for OCD, the aim is to disrupt the family interaction patterns that maintain the compulsive rituals and enlist the aid of partners and family members in helping the person with the condition overcome their obsessions and compulsions.

Five trials of systemic couple or family-based approaches to the treatment of OCD reviewed by Renshaw *et al.* (2005) and a more recent pilot study (Abramowitz *et al.*, 2013) have shown that such approaches are as effective, or in some instances more effective, than individually based cognitive behaviour therapy for adults with OCD. Systemic therapy may be provided in conjoint or separate sessions or in multiple family sessions. Effective protocols involve psycho-education about OCD combined with exposure and response prevention. The aim of psycho-education is to help partners and other family members reduce the extent to which they over-accommodate or respond antagonistically to the symptomatic person's compulsive rituals or accounts of their obsessions. With exposure and response prevention, the therapist coaches non-anxious partners in supporting their symptomatic partners 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).

PTSD

PTSD occurs after catastrophic trauma such as natural or man-made disasters, life-threatening accidents, rape, armed combat, torture or terrorist attacks. PTSD is characterized by intrusive, recurrent traumatic memories (flashbacks and nightmares); intense anxiety in response to these memories and ongoing hyper-arousal in anticipation of their recurrence, and attempts to regulate anxiety and hyper-arousal by avoiding the cues that trigger traumatic memories. PTSD patients attempt to suppress these memories when they intrude into their consciousness (American Psychiatric Association, 2013; World Health Organization, 1992). Recurrent, traumatic memories occur in response to the internal or external cues that symbolize the traumatic event or aspects of it. Because they anticipate the recurrence of traumatic memories, people with PTSD experience chronic hyper-arousal that may lead to uncontrolled anger, difficulty concentrating, hyper-vigilance and sleep difficulties. There may also be feelings of guilt or

shame for having survived the trauma, beliefs that the world is unsafe, a loss of trust in others, a loss of interest in sex and low mood. In PTSD, the avoidance of trauma-related situations and attempts to suppress traumatic memories (a process in which both symptomatic and non-symptomatic partners may engage) may initially be relatively unsuccessful and lead, paradoxically, to an increase in the frequency and intensity of the flashbacks, panic attacks and violent outbursts. However, in chronic cases, frequent recurrent attempts to keep trauma-related memories out of consciousness eventually result in an inability to recall traumatic memories and emotional numbing. With emotional numbing, not only are trauma-related emotions such as anxiety and anger excluded from consciousness but tender feelings such as love and joy are no longer experienced either. PTSD is associated with significant relationship distress (Taft *et al.*, 2011). There is evidence from a small number of trials that both cognitive behavioural and emotionally focused couple therapy can ameliorate PTSD symptomatology and increase relationship satisfaction.

Emotionally focused couple therapy. In a controlled trial involving 24 couples in which one partner had post-traumatic symptoms arising from sexual abuse, Dalton *et al.* (2013) found that, compared with waiting list controls, those who engaged in emotionally focused couple therapy showed a significant reduction in trauma symptoms and relationship distress. Two open trials of couples in which one partner had PTSD due to childhood sexual abuse (MacIntosh and Johnson, 2008) or military combat experiences (Weissman *et al.*, 2011) showed that emotionally focused couple therapy reduced trauma symptoms and increased relationship satisfaction. In these trials, emotionally focused couple therapy involved up to thirty sessions and progressed through three stages. In the initial stage there was a de-escalation of destructive interactional patterns arising from the couples' difficulty in managing trust issues associated with prior traumatic experiences. During the middle phase of therapy, partners' authentic expression of, and response to each other's attachment needs were facilitated. This involved partners expressing and responding to the sense of hurt, betrayal, anxiety and anger and their avoidance of closeness associated with prior trauma. In the closing phase more adaptive patterns of attachment behaviour were consolidated (Johnson, 2002).

Cognitive behavioural couple therapy. In a controlled trial Monson *et al.* (2012) found that among couples in which one partner had PTSD,

those who engaged in fifteen sessions of cognitive behavioural couple therapy showed a reduction in PTSD symptoms and increased relationship satisfaction compared with waitlist controls. Couple therapy involved a preliminary phase of psycho-education about PTSD and the development of couple safety routines for managing anger. In the middle phase key issues were training in communication and problems-solving skills and facilitating a reduction in the avoidance of trauma-related cues. In the final phase the couples' belief systems were restructured with a focus on a range of themes including acceptance, blame, trust, control, closeness and intimacy (Monson and Fredman, 2012).

In planning systemic services for people with panic disorder, OCD and PTSD, treatment protocols as described in the preceding sections should be offered on an outpatient basis over about fifteen to thirty sessions, depending on clients' needs. In cases that do not respond to systemic therapy, a multi-modal programme involving systemic therapy and serotonin reuptake inhibitors may be appropriate (Antony and Stein, 2009).

Mood disorders

Effective family-based treatments have been developed for major depressive disorder and bipolar disorder. Both conditions have a profound impact on the patients' quality of life, with depression being more common than bipolar disorder. In a major US study the lifetime prevalence of major depressive disorder was 14.4 per cent and that of bipolar disorder was 2.3 per cent (Kessler *et al.*, 2012).

Depression

Major depressive disorder is an episodic condition 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 and excessive guilt, suicidal ideation, impaired concentration and sleep and appetite disturbance (American Psychiatric Association, 2013; World Health Organization, 1992). Over the course of their lifetime, on average people with major depression have four episodes, each of about 4 months' duration. Depressive episodes occur when genetically vulnerable individuals become involved in stressful social systems in which there is limited access to socially supportive relationships (Gotleib and Hammen,

2009; Hollon and Sexton, 2012). Systemic interventions aim to reduce relationship distress 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 its side effects. Moreover, in the year following treatment, relapse rates following pharmacotherapy are about double those of relapse rates following psychotherapy (65 versus 29 per cent; Vittengl *et al.*, 2007).

Narrative reviews and a meta-analysis of controlled trials support four main conclusions about the treatment of depression with systemic therapy (Barbato and D'Avanzo, 2008; Beach and Whisman, 2012; Whisman *et al.*, 2012). Firstly, systemic interventions are more effective than no treatment. Secondly, they are as effective as individual approaches for the treatment of depression. Thirdly, couple therapy and individual cognitive behaviour therapy (widely considered to be the treatment of choice) are equally effective. Fourthly, for those with relationship distress, couple therapy leads to greater improvements in relationship satisfaction than individual cognitive behaviour therapy. Finally, a range of couple and family-based interventions effectively alleviates depression. These include systemic couple therapy (Jones and Asen, 2000; Leff *et al.*, 2000); emotionally focused couple therapy (Denton *et al.*, 2012; Johnson, 2004); various versions of behavioural couple therapy, including traditional behavioural couple therapy (Jacobson *et al.*, 1991), cognitive behavioural couple therapy (Beach *et al.*, 1990), coping-oriented couple therapy (Bodenmann *et al.* 2008) and brief couple therapy (Cohen *et al.*, 2010); conjoint interpersonal therapy (Foley *et al.*, 1989; Weissman *et al.*, 2000); family therapy for depression based on the McMaster model, (Miller *et al.*, 2005; Ryan *et al.*, 2005) and behavioural family therapy for families of depressed mothers of children with disruptive behaviour disorders (Sanders and McFarland, 2000).

All these approaches to couple and family therapy require fewer than about twenty conjoint therapy sessions and focus on both relationship enhancement and mood management. They also involve a staged approach to address mood and relationship issues (Beach and Whisman, 2012). In the initial phase the focus is on increasing the ratio of positive to negative interactions, decreasing demoralization and generating hope by showing that change is possible. Therapists take the initiative in structuring sessions, facilitating positive within-session experiences and motivating clients to have similar or related experiences between sessions. Once some initial positive changes

have occurred, the second phase focuses on helping clients jointly reflect on positive and negative recurrent patterns of interaction, related constructive and destructive belief systems and underlying relationship themes. Therapists help clients jointly reflect on positive and negative aspects of their lives between sessions and facilitate the development of the skills and competencies for doing this autonomously without falling back into problematic patterns. Relapse prevention is the main theme of the third phase of therapy. Here the primary concern is helping clients develop plans for anticipating and managing situations in which low mood and relationship distress are likely to recur.

Bipolar disorder

Bipolar disorder is a recurrent condition characterized by episodes of mania or hypomania, depression and mixed mood states (American Psychiatric Association, 2013; World Health Organization, 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 adherence to medication (Miklowitz and Craighead, 2007). The primary treatment for bipolar disorder is pharmacological and involves initial treatment of acute manic or depressive episodes and the subsequent prevention of further episodes with mood-stabilizing medication such as lithium (Geddes and Miklowitz, 2013). The primary aim of systemic therapy is to reduce relapse and rehospitalization rates and increase the patients' quality of life by improving their medication adherence and enhancing the way in which individuals with bipolar disorder and their families manage stress and their 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; Schöttle *et al.*, 2011 Scott *et al.* 2007).

Results from a series of trials show that family therapy alone or in combination with interpersonal social rhythm therapy was effective in reducing relapse and in some instances, rehospitalization rates, in patients with bipolar disorder on maintenance mood-stabilizing medication (Miklowitz *et al.*, 2003, 2007; Miklowitz and Goldstein, 1990;

Rea *et al.* 2003). In these trials family therapy was conducted over twenty-one sessions and included family-based psycho-education, communication and problem-solving skills training and relapse prevention (Miklowitz, 2008). A trial of a fifteen-session adaptation of Miklowitz's (2008) systemic therapy for groups of carers of people with bipolar disorder showed that this intervention led to decreases in depressive symptoms in both the carers and the patients, compared with routine video-based health education about bipolar disorder (Perlick *et al.*, 2010). In three trials, other less intensive family-based interventions have not yielded these positive effects (Clarkin *et al.*, 1990, 1998; Miller *et al.*, 2004). Madigan *et al.* (2012) found that solution-focused group therapy and family psycho-education both had positive effects on caregivers' knowledge about bipolar disorder and alleviated caregiver stress.

From this review it may be concluded that effective systemic therapy for mood disorders may span fifteen to twenty-one sessions. Systemic services for mood disorders are best offered in 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 that intervention is offered promptly in later episodes.

Alcohol problems

Harmful alcohol use constitutes a significant mental health problem. In the USA the lifetime prevalence of alcohol abuse is 13.2 per cent (Kessler *et al.*, 2005). Martin and Rehm (2012) conducted a systematic review of all major reviews and meta-analyses of studies evaluating the treatment of alcohol problems conducted since 2000 and found strong support for the effectiveness for brief interventions, motivational interviewing and cognitive behavioural interventions, notably using behavioural couple therapy (O'Farrell and Fals-Stewart, 2006). In a systematic narrative review of controlled studies conducted since 2000 O'Farrell and Clements (2012) concluded that systemic interventions were effective in helping sober families promote the engagement in treatment of family members with alcohol problems and in helping people recover from these problems. This conclusion is shared by other major reviews (Finney *et al.*, 2007; McCrady and Nathan, 2006; Powers *et al.*, 2008; Ruff *et al.*, 2010; Templeton *et al.*, 2010).

Community reinforcement and family training

For helping sober family members promote the engagement of people with alcohol and substance use problems in therapy, O'Farrell and Clements (2012) concluded that community reinforcement and family training (Smith and Meyers, 2004) was more effective than all other family-based methods. It led to average engagement rates of 55–86 per cent across five controlled trials for families of people with alcohol and other drug problems. This approach helps sober family members improve communication, reduce the risk of being physically abused and encourage sobriety and treatment-seeking in people with alcohol and drug problems. It also helps sober family members engage in activities outside the family to reduce their dependence on the person with the alcohol problem.

Behavioural couple therapy

To help people with alcohol problems recover, O'Farrell and Clements (2012) concluded that behavioural couple therapy was more effective than other systemic and individual approaches. Compared with individual approaches, behavioural couple therapy produced greater abstinence, fewer alcohol-related problems, greater relationship satisfaction and better adjustment in children of people with alcohol problems. Behavioural couple therapy also led to greater reductions in domestic violence and in periods in jail and hospital, and this was associated with very significant cost savings. Behavioural couple therapy has been shown to be effective in couples in which the male and female partners have alcohol problems, in gay and lesbian couples, in couples with other drug problems and in couples with comorbid, combat-related PTSD. Behavioural couple therapy is as effective in community clinics as in specialist services. Behavioural couple therapy typically involves twelve sessions and includes alcohol-focused interventions to promote abstinence and relationship-focused interventions to increase positive feelings, shared activities and constructive communication within couples. The most effective forms of behavioural couple therapy incorporate either a disulfiram contract or a sobriety contract in a treatment programme which includes problem-solving and communication training and relationship enhancement procedures. The therapy aims to reduce alcohol use, enhance family support for efforts to change and promote patterns of interaction and problem-solving skills 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 and cost effective as individually based motivational enhancement therapy in the largest ever UK alcohol abuse treatment trial (United Kingdom Alcohol Treatment Trial [UKATT] Research Team, 2005a, 2005b). Social behaviour network therapy helps clients address their alcohol problems by building supportive social networks (usually involving partners and family members) and developing coping skills (Copello *et al.* 2009).

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

Schizophrenia

The term schizophrenia refers to a collection of seriously debilitating conditions characterized by positive and negative symptoms and disorganization (American Psychiatric Association, 2013; World Health Organization, 1992). Delusions and hallucinations are the main positive symptoms of schizophrenia. Negative symptoms include poverty of speech, flat affect and passivity. Although just under 1 per cent of people suffer from schizophrenia, the World Health Organization has ranked it as second only to cardiovascular disease in terms of the overall international disease burden (Murray and Lopez, 1996). While genetic and neurodevelopmental factors associated with prenatal and perinatal adversity play a central role in the aetiology of schizophrenia, its course is affected by stress, individual and family coping strategies and adherence to medication (Lieberman and Murray, 2012). 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 (Miyamoto *et al.*, 2012). 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 over-involvement (Barrowclough and Lobban, 2008). The aim of psycho-educational family therapy is to reduce family stress and enhance family support, so as to delay or prevent relapse and rehospitalization.

A series of international systematic reviews and meta-analyses involving over fifty studies conducted around the world provide robust support for the effectiveness of psycho-educational family therapy (as one element of a multi-modal programme that includes antipsychotic medication) in the treatment of schizophrenia in adulthood (Jewell *et al.*, 2009; Lobban *et al.*, 2013; Lucksted *et al.*, 2012; Murray-Swank and Dixon, 2004; Pfammatter *et al.*, 2006; Pharoah *et al.*, 2006; Pilling *et al.*, 2002; Pitschel-Walz *et al.*, 2001; Rummel-Kluge and Kissling, 2008; Taylor *et al.*, 2009). Compared with using medication alone, multi-modal programmes that include psycho-educational family therapy and anti-psychotic medication lead to lower relapse and rehospitalization rates and improved medication adherence. For example, Pfammatter *et al.* (2006) found that 1–2 years after treatment the effect sizes for relapse and rehospitalization rates were 0.32 and 0.48, respectively. This indicates that the average patient treated in the context of a multi-modal programme involving medication and family therapy fared better in terms of relapse and rehospitalization than 63 and 68 per cent of patients, respectively, who received medication only. The effect size for medication adherence was 0.30. This indicates that the average patient treated with family therapy showed a better medication adherence than 62 per cent of those who did not receive family therapy. In a review of fifty studies Lobban *et al.* (2013) found that family intervention for schizophrenia in most studies had a positive effect on the adjustment of non-symptomatic family members. There is also a consensus that longer systemic intervention programmes are more effective than shorter ones.

Psycho-educational family therapy may take a number of formats, including therapy sessions with single families (for example, Kuipers *et al.*, 2002), therapy sessions with multiple families (for example, McFarlane, 2004), group therapy sessions for relatives or parallel group therapy sessions for relative and patient groups. Regardless of the format, systemic interventions for schizophrenia aim to (i) provide families with information about the condition, (ii) help families acquire skills to cope with it and to manage crises and (iii) support families and help them to develop a supportive family culture. Effective family therapy programmes involve psycho-education, based on

the stress vulnerability or bio-psycho-social models of schizophrenia. Through psycho-education families learn to understand and manage the condition, to take prescribed antipsychotic medication regularly, to cope with stress and to identify early warning signs of relapse. Therapists provide families with support and crisis intervention as required. Throughout treatment emphasis is placed on blame reduction and the positive role that family members can play in the rehabilitation of the person with schizophrenia. Psycho-educational family therapy also helps families develop communication, problem-solving and coping skills. Skills training commonly involves modelling, rehearsal, feedback and discussion. Effective systemic interventions typically span 9–12 months and are usually offered in a phased format with 3 months of weekly sessions, 3 months of fortnightly sessions and 3 months of monthly sessions, followed by 3-monthly reviews and crisis intervention as required.

From this review it may be concluded that systemic therapy services for families of people with schizophrenia should be offered in the context of multi-modal programmes that include antipsychotic medication. Because of the recurrent, episodic nature of schizophrenia, services should make long-term re-referral arrangements so intervention is offered promptly 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.*, 2013; Rolland, 1994). Systemic interventions include couple and family therapy as well as multi-family support groups and carer support groups. These interventions provide psycho-education 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 fifty-two randomized controlled trials (including 8,896 patients) with a range of conditions including cardiovascular disease, stroke, cancer and arthritis, Hartmann *et al.* (2010) found that systemic interventions led to significantly better physical health in patients and better physical and mental health in both patients and other family members compared with routine care. Systemic interventions included groups for the relatives of people with chronic illnesses

as well as couple and family therapy. Depression, anxiety, quality of life and caregiver burden were the most common indices of spouses' mental health. Effect sizes were small to medium, ranging from 0.28 to 0.35, indicating that the average patient treated with systemic therapy fared better than 61–64 per cent of patients who received routine care. The effects were stable over long follow-up periods. Longer interventions involving spouses, rather than other family members, tended to be more effective. Relationship-focused family interventions tended to be more effective than exclusively educational interventions. 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 those from other systematic reviews and meta-analyses (Baik and Adams, 2011; Baucom *et al.*, 2012; Campbell and Patterson, 1995; Hopkinson *et al.*, 2012; Martire *et al.* 2004; Northouse *et al.*, 2010).

Discussion

A number of comments may be made about the evidence reviewed in this article. Well-articulated systemic interventions are effective for a wide range of common adult mental health and relationship problems. These interventions are brief and may be offered by a range of professionals on an outpatient or in-patient basis, as appropriate. For many of these interventions, useful treatment manuals have been developed that may be flexibly used by clinicians in treating individual cases. Moreover, an important issue is the generalizability of the results of the studies reviewed in this article to routine health service settings. It is probable that the evidence-based practices described in this article are somewhat less effective when used in routine community clinics by busy therapists who receive limited supervision and carry large case loads of clients with many comorbid problems. This is because participants in research trials tend to have fewer comorbid problems than typical service users and most trials are conducted in specialist university-affiliated clinics where therapists carry small caseloads, receive intensive supervision and follow flexible manualized treatment protocols. 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.

Few controlled trials of systemic therapy for prevalent problems such as borderline personality disorder have been reported in the

literature, apart from Balfour and Lanman (2012) and Kamalabadi *et al.* (2012). These should be a priority for future research. Such trials should include relatively homogeneous samples and involve the flexible use of treatment manuals. Furthermore, 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 (Davis *et al.*, 2012).

The bulk of systemic interventions that have been evaluated in controlled trials have been developed in the cognitive behavioural, psycho-educational and structural-strategic psychotherapeutic traditions, although there are exceptions (Seikkula *et al.*, 2013). More research is required on social constructionist and narrative approaches to systemic practice, which are very widely used in the UK, Ireland and elsewhere. Furthermore, in 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.

Finally, 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 the article 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 the family processes that maintain the identified patients' presenting problems.

The results of this review are consistent with those of reviews that take a narrower definition of systemic therapy and exclude some of the family-based interventions covered in the present review (for example, Baucom *et al.*, 2012; Sexton *et al.*, 2013; von Sydow *et al.*, 2010). Our conclusions are more somewhat more optimistic than those of reviewers who have used more stringent methodological criteria for making decisions about programme effectiveness (for example, Meis *et al.*, 2013).

The results of this review are broadly consistent with the important role accorded to systemic interventions and family involvement in psychosocial treatment in National Institute for Clinical Excellence (NICE) and other guidelines for a range of adult mental health problems including OCD (NICE, 2005a), depression (NICE 2009a), bipolar disorder (NICE, 2006), alcohol problems (NICE, 2011a) and schizophrenia (Dixon *et al.*, 2010, NICE 2009b). 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, 2011b) or PTSD in adults (NICE, 2005b).

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. This argument has recently been endorsed in the UK and the USA in statements of the core competencies required for systemic therapists (Northey, 2011; Stratton *et al.*, 2011). Qualified family therapists should make it a priority to learn evidence-based practices relevant to the client group with whom they work when planning their own continuing professional development. Experienced clinicians working with clients who present with the types of problems discussed in this article may help 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 this and the accompanying article (Carr, 2014). 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, 2012).

Treatment resources

Gurman, A. (ed.) (2008) *Clinical Handbook of Couple Therapy* (4th edn). New York: Guilford.

Snyder, D. and Whisman, M. (eds) (2003) *Treating Difficult Couples. Helping Clients with Coexisting Mental and Relationship Disorders*. New York: Guilford.

Relationship distress

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

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.

Psychosexual problems

Binik, Y. and Hall, K. (2014) *Principles and Practice of Sex Therapy* (5th edn). New York: Guilford.

Hertlin, K., Weeks, G. and Sendal, S. (2009) *A Clinician's Guide to Systemic Sex Therapy*. New York: Routledge.

Intimate partner violence

Stith, S., McCollum, E. and Rosen, K. (2011) *Couples Therapy for Domestic Violence. Finding Safe Solutions*. Washington: American Psychological Association.

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.

PTSD

Johnson, S. (2002) *Emotionally Focused Couple Therapy with Trauma Survivors: Strengthening Attachment Bonds*. New York: Guilford.

Monson, C. M. and Fredman, S. J. (2012) *Cognitive-Behavioral Conjoint Therapy for PTSD: Harnessing the Healing Power of Relationships*. New York: Guilford.

Mood disorders

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

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

Milkowitz, D. (2008) *Bipolar Disorder: A Family-Focused Treatment Approach* (2nd edn). New York: Guilford.

Alcohol problems

Copello, A., Orford, J., Hodgson, R. and Tober, G. (2009) *Social Behaviour and Network for Alcohol Problems*. London: Routledge.

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

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

Schizophrenia

Falloon, I. Laporta, M., Fadden, G. and Graham-Hole, V. (1993) *Managing Stress in Families*. London: Routledge.

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Chronic physical illness

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