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EVIDENCE BASED PRACTICE IN COUNSELLING AND PSYCHOTHERAPY

Alan Carr

INTRODUCTION

Since Eysenck's (1952) challenging claim over 40 years ago, that there is little evidence for the effectiveness of psychotherapy, there has been a mushrooming of empirical work on psychological intervention for a wide variety of problems. There is now considerable evidence for the efficacy of individually based psychotherapy (Smith, Glass, & Miller, 1980; Nathan & Gorman, 1998; Bergin & Garfield, 1994; Roth & Fonagy, 1996; Beutler & Crago, 1991) and family based interventions for many intrapsychic, interpersonal and medical difficulties for both adults (Pinsof & Wynne, 1995; Shadish et al, 1993; Baucom, Shoham et al, 1998) and children (Carr, 1998; 1999). Results of meta-analyses show that a person receiving psychotherapy or family therapy shows greater improvement in presenting problems at the end of therapy than 70-80% of the cases in control groups who received no treatment and about 66% of adults presenting for outpatient psychotherapy benefit from the experience (whereas only about 34% of those in waiting list control groups show some improvement) (Lambert & Bergin, 1994; Shadish et al, 1993). There is a growing body of evidence which suggests that a majority of clients maintain treatment gains at follow-up. However, relapse rates are high for particular problems such as alcohol and drug abuse or recurrent episodic depression (Lambert & Bergin 1994). This global

conclusion is important because it underlines the value of psychotherapy as a viable intervention modality. Highlighting this overall conclusion is timely, since currently increased emphasis is being placed upon evidence based practice in Ireland, the UK and the US. However, such broad conclusions are of limited value to practicing clinicians in their day-to-day work. In addition to such broad statements about the effectiveness of psychotherapy, there is a clear requirement for specific evidence based statements about the precise types of individual and family based interventions which are most effective with particular types of problems. The present paper address this question with particular reference to the following list of adult-focused difficulties.

- Marital and relationship problems
- Psychosexual problems
- Marital violence
- Anxiety disorders
- Mood disorders
- Personality disorders
- Psychotic disorders
- Alcohol abuse
- Smoking cessation
- Eating disorders
- Sleep disorders
- Surgical recovery
- Chronic pain management
- Adjustment to cancer
- Adjustment to heart disease
- Family management of neurologically impaired adults
- Sexual offending

This particular list has been chosen because extensive computer based and manual literature searches showed that for each of these areas, controlled trials of psychological intervention have been reported in the literature. In the following sections, where possible, reference is made to important review papers and meta-

analyses. When individual treatment outcome studies are cited, unless otherwise stated, these are controlled trials or comparative group outcome studies. Single case reports and single group outcome studies have been largely excluded from this review, because of the limited validity of evidence based on these types of studies.

MARITAL DISTRESS

Marital distress, dissatisfaction and conflict are extremely common problems and currently in western industrialized societies an increasing proportion of marriages are ending in divorce. For example in the USA the rate of divorce now exceeds 50% (Bray & Jouriles, 1995). For marital distress and relationship problems behavioural marital therapy, cognitive marital therapy; cognitive-behavioural marital therapy combination packages; insight oriented marital therapy and emotionally focused couples therapy have been shown to be effective interventions (Baucom, Shoham et al, 1998; Bray & Jouriles, 1995). Behavioural marital therapy involves training in communication and problem solving skills on the one hand and behavioural exchange procedures on the other (Jacobson & Margolin, 1979). Cognitive marital therapy focuses on helping couples challenge destructive attributions, beliefs, assumptions and expectations which contribute to relationship distress and on replacing these with more benign alternatives (Baucom & Epstein, 1990). With insight oriented marital therapy (Snyder & Wills, 1989) and emotionally focused marital therapy (Greenberg & Johnson, 1988) the aim of therapy is to help couples express feelings of vulnerability and unmet needs (which may initially be outside awareness) and to help couples understand how these feelings and needs underpin destructive patterns of interaction within the relationship. While over two dozen well controlled trials of behavioural marital therapy have been conducted, very few studies of the other treatment approaches have been reported.

In meta-analyses of studies of behavioural marital therapy, post-treatment effect sizes of 0.79-0.95 have been obtained indicating that the average treated case fares better after treatment than between 79% and 83% of untreated controls (e.g., Dunn & Schwebel, 1995; Shadish et al, 1993; Hahlweg & Markman, 1988). Dunn & Schwebel (1995) in their meta-analysis found that after an average follow-up period of 9 months, effect sizes ranged from 0.54 to 1.04 indicating that the average treated case fared better, 9 months after treatment, than between 70% and 84% of untreated controls. In terms of clinical significance Baucom, Shoham et al (1998) concluded that between 33 and 66% of couples become clinically non-distressed as a result of treatment and the majority of couples maintain these gains at follow-up. However, a proportion of couples relapse and/or separate 2-4 years following treatment.

Baucom, Shoham et al (1998) drew the following conclusions about other forms of marital therapy. Cognitive restructuring combined with traditional behavioural marital therapy is no more effective than behavioural marital therapy. Emotionally focused therapy may be appropriate for moderately but not severely distressed couples. In the long term, insight oriented marital therapy may lead to more durable positive effects and lower divorce rates than behavioural marital therapy.

Jackobson and Addis (1993) in a wide-ranging review concluded that couples who respond best to marital therapy are younger; are less distressed at the beginning of therapy; are more emotionally engaged with each other; have less rigid gender roles; are less depressed; and do not opt for premature closure in their attempts at relationship-based problem-solving.

A number of common factors may underpin effective marital therapies (Bray & Jouriles, 1995). They tend to be brief and rarely exceed 20 sessions, so hope and the expectation of change is rapidly generated. They involve conjoint sessions in which clear non-defensive communication is facilitated. They promote the development of communication and problem-solving skills. They permit couples to discuss the impact of family of origin issues on current relationship functioning and this in turn may deepen empathy and psychological

intimacy within the relationship. They empower couples to renegotiate relationship roles and this in turn may lead to a more equitable distribution of power within the relationship.

Effective marital therapy may also be conducted with one partner only under certain circumstances (Bennun, 1997). One-person or unilateral marital therapy may be appropriate in cases where only one partner is available to attend treatment; where there are dependence-independence issues in the relationship; where there are problems in sustaining intimate relationships; in cases of domestic violence; where there is a major disparity between partners levels of self-esteem; and where one partner's unresolved family of origin issues contribute significantly to the couples problems. In Bennun's (1997) approach, therapy begins with a conjoint session. During assessment the negative impact of partners difficulties in meeting each other's needs on each partner at an intrapsychic level and on the relationship at a systemic level is explored. In formulating the way presenting problems have emerged and are maintained, a balance is drawn between a focus on individual factors and a focus on relationship factors. Treatment targets and possible difficulties such as resistance and relapse are discussed with both partners at the end of the assessment session. Following assessment, in unilateral marital therapy, treatment is directed at both promoting systemic change within the relationship and the psychological development of both partners as individuals, through working with one partner only. To do this the therapist invites the attending partner (usually a female) to recount the content of each session to her partner; to engage in homework assignments with her partner; and to give the therapist feedback about the impact of these events on the relationship and psychological well-being of each partner. Bennun (1997) has shown that unilateral marital therapy is as effective and conjoint marital therapy. He argues that the in the past individually based interventions for marital problems have yielded negative results because of their almost exclusive focus on individual issues and their lack of attention at a systemic level to relationship issues.

With respect to clinical practice and service development, the findings reviewed here suggest that effective marital therapy may be offered on an outpatient basis over approximately 20 sessions. Treatment protocols for many of the types of marital therapy for which there is evidence of effectiveness are contained in Jacobson & Gurman (1995).

PSYCHOSEXUAL PROBLEMS

Psychosexual problems while essentially relationship difficulties, have been classified in DSM IV (APA, 1994) and ICD-10 (WHO, 1992) as individual male and female disorders affecting sexual desire, sexual arousal, sexual orgasm and sex-related pain. Hypoactive sexual desire, sexual aversion and dyspareunia are recognized as disorder that may affect both men and women. Psychosexual problems unique to women include primary and secondary female orgasmic dysfunction and vaginismus. Psychosexual disorders unique to men include primary and secondary erectile dysfunction, premature ejaculation and retarded ejaculation. Omitting premature ejaculation which occurs in about a third of males, the overall prevalence of psychosexual problems in men and women falls between 10 and 20% (Seagraves & Althof, 1998). Comorbid psychological problems (including depression, anxiety disorders, eating disorders and substance use disorders) occur in a proportion of cases presenting with psychosexual disorders. Comorbid marital distress is extremely common where the primary complaint is a psychosexual problem (Hawton, 1995; Seagraves & Althof, 1998)

Most effective treatments for psychosexual problems are based on Masters and Johnson (1970) sex therapy which begins with psychoeducation about the human sexual response and exploration of the pattern of interaction and beliefs around the couples specific problem area. Couples are advised to refrain from sexual intercourse and sexual contact except as outlined in prescribed exercises. Couples are then coached in a series of sensate focus homework exercises in which partners 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 and culminating in full intercourse. Kaplan (1975, 1995) and other innovative sex therapists who built on the work of Masters and Johnson have developed ways in which sex therapy and marital therapy which addresses intrapsychic and interpersonal issues may be effectively integrated in clinical practice (Lieblum & Rosen, 1989; Weeks & Hof, 1987; Schnarch, 1991).

For primary female orgasmic dysfunction partner assisted sexual skills training has been shown to be effective in up to 90% of cases. (Segraves & Althof, 1998; Baucom, Shoham et al, 1998). Partner assisted sexual skills training begins with psychoeducation; followed by coaching in masturbation using sexual fantasy and imagery; progressing to Masters and Johnson sensate focus exercises; and later females are coached in explaining masturbation techniques that they find effective to their male partners (LoPiccolo & Stock, 1986).

For secondary female orgasmic dysfunction and hypoactive sexual desire marital therapy (as described in the previous section) combined with Masters and Johnson (1970) sex therapy have been found to be effective in about half of all treated cases (Segraves & Althof, 1998; Baucom, Shoham et al, 1998).

For female dyspareunia (painful sexual intercourse) and vaginismus (involuntary spasm of the outer third of the vaginal musculature) between 80 and 100% of cases have been shown to benefit from desensitization programme developed by Masters and Johnson (1970) (Segraves & Althof, 1998). At the outset the couple refrain from intercourse and the female partner completes a series of graduated exercises which involve the gradual insertion of a series of dilators of increasing diameter into the vagina. This is then followed-up with the routine Masters and Johnson sensate focus sex therapy programme.

For acquired male erectile problems the Masters and Johnson conjoint sensate focus sex therapy approach combined with couples therapy has been shown to be effective in up to 60% of cases (Segraves & Althof, 1998).

For premature ejaculation, Masters and Johnson (1970) developed the stop-start and squeeze techniques where the couple cease intercourse and the

base of the penis is squeezed each time ejaculation is imminent. Success rates with this method may be initially as high as 80% but may dwindle to long-term 25% at follow-up (Segraves & Althof, 1998). Sertraline, paroxetine and clomipramine have all been shown to be rapidly effective in alleviating premature ejaculation (Segraves & Althof, 1998).

Hawton (1995) in an extensive review 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.

With respect to clinical practice and service development, the findings reviewed here suggest that effective therapy for psychosexual problems may be offered on an outpatient basis over 10-20 sessions, depending upon the complexity of comorbid relationship difficulties. Protocols for effective sex therapy are contained in Leiblum & Rosen (1989) and formats for integrating sex and marital therapy are described in detail in Schnarch (1991) and Weeks and Hof (1989).

MARITAL VIOLENCE

Straus and Gelles (1990) in a major US survey found that 16% of couples engaged in marital violence and in the majority of instances, violence was from husband to wife. Marital violence is associated with a wide range of variables but particularly with skills deficits in anger control, communication and problem solving skills and alcohol and drug abuse (Holtzworth-Munroe, Beatty & Anglin, 1995). Only a limited number of well controlled studies have been conducted on the effectiveness of interventions with violent marital partners and these show that court-mandated skills-training programmes are probably the most effective, although gains arising from such programmes are at best modest with recidivism rates of 27% occurring following treatment (Hamberger & Hastings, 1993;

Rosenfeld, 1992). Key elements of successful programmes include taking responsibility for the violence; challenging beliefs and cognitive distortions which justify violence; anger management training; communication and problem-solving skills training; and relapse prevention. In couples treatment 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; and to resume interactions in a non-violent way. Conjoint marital therapy is only appropriate in cases where the aggressive male agrees to take steps to reduce danger such as remove weapons from the house; agree to a temporary separation; and engage in treatment for comorbid alcohol and drug problems. Where this does not occur it is more appropriate to treat husbands in group therapy for wife batterers which addresses the same issues as those mentioned for conjoint therapy and for the female partner to join a support group for battered wives and receive individual treatment for post-violence trauma based on evidence based practice guidelines for post-traumatic stress disorder (Holtzworth-Munroe, Beatty & Anglin, 1995).

With respect to clinical practice and service development, the findings reviewed here suggest that effective therapy for marital violence may be offered on an outpatient basis over an extended time period within the context of court mandated treatment. Treatment protocols for marital violence are presented in Holtzworth-Munroe, Beatty and Anglin (1995) and Caesar & Hamberger (1989).

ANXIETY DISORDERS

Anxiety disorders are characterized by debilitatingly high levels of fear which occur in the presence of specific classes of internal or external stimuli or cues (APA, 1994; WHO, 1992). The lifetime prevalences of anxiety disorders summarized in DSM IV are: panic disorder with or without agoraphobia, 1.5-3.5%; specific phobias, 10-11%; social phobias, 3-13%; obsessive compulsive disorder (OCD), 2.5%; post traumatic stress disorder (PTSD) 1-14%; and

generalized anxiety disorder, 5% (APA, 1994). For all of these anxiety disorders cognitive behavioural therapies have been shown to be particularly effective (Barlow, Lawton Esler & Vitali, 1998; Franklin & Foa, 1998; Keane, 1998; Roth & Fonagy, 1996). Broadly speaking, effective therapies for anxiety disorders involve psychoeducation about anxiety; exposure to intrapsychic and environmental anxiety eliciting stimuli until habituation occurs; and the provision of training in using coping strategies or support to help the client cope with the process of exposure and habituation. In treating anxiety disorders, the exposure process may involve helping clients to face external cues and stimuli such as people, places, objects or situations or to deal with internal stimuli such as memories, images and somatic sensations. Exposure may be organized in a graded way, where facing less anxiety provoking stimuli precedes exposure to more frightening situations. This approach is used in systematic desensitization. In other protocols, such as flooding, prolonged exposure to maximally threatening cues occurs from the outset. Clients may be provided with training in the use of both cognitive and behavioural coping strategies to use during the habituation process. Cognitive strategies include challenging catastrophic attributions, beliefs, assumptions and expectations and substituting these with less anxiety provoking beliefs. Behavioural strategies include the use of relaxation exercises or social support to reduce arousal.

For both obsessive compulsive disorder and agoraphobia, there is substantial evidence that treatments which include marital partners and family members in the exposure, habituation and coping processes are as effective or more so than individually-based interventions (Baucom, Shoham et al, 1998). For obsessive compulsive disorder it has been shown that partner assisted *exposure and response prevention* (ERP) is as effective as routine ERP programmes in which clients are exposed to cues which elicit obsessions (such as dirt) and are prevented from engaging in compulsive anxiety reducing responses (such as repeated hand-washing). Similarly, partner assisted exposure treatment for agoraphobia has been found to be as effective as routine exposure treatment. In the partner assisted programmes, the partner helps the client complete homework

assignments which involved actual exposure (such as making increasingly longer excursions from the home); reinforces the client for exposing themselves to feared stimuli or cues; and helps their partners practice coping strategies such as relaxation exercises or using cognitive coping techniques (Baucom, Shoham et al, 1998).

Various tricyclic antidepressants and serotonin reuptake inhibitors have been shown to have clinically significant short-term effects on obsessive compulsive disorder; panic disorder with and without agoraphobia, generalized anxiety disorder; and post traumatic stress disorder (Roy-Byrne & Cowley, 1998; Rauch & Jenike, 1998; Yehuda, Marshall & Giller, 1998). In some instances it may be appropriate for these medications to be combined with individual and family based psychological interventions for anxiety disorders.

With respect to clinical practice and service development, the findings reviewed here suggest that effective therapy for anxiety disorders may be offered on an outpatient basis over 10-20 sessions. Such therapy may be multimodal involving both psychological and pharmacological interventions. Psychological interventions may be individual or family based. Treatment protocols for effective individually based treatment are contained in Hasselt & Hersen (1996) and those for family based interventions are given in Craske & Zoellner (1995) and Bloch, Hanfer et al (1994).

MOOD DISORDERS

Within DSM IV (APA, 1994) and ICD-10 (WHO, 1992) distinctions are made between major depression and bipolar mood disorder. Both are episodic mood disorders with the former being characterized by episodes of low mood, negative cognition, sleep and appetite disturbance and the latter being characterized in addition by episodes of mania in which elation, grandiosity, flight of ideas and expansive behaviour occur. The lifetime prevalence of major depression is 10-25% for women and 5-12% for men and for bipolar disorder the lifetime prevalence is about 1% (APA, 1994). Up to 15% of people with major depression and bipolar disorder commit suicide and comorbid dysthymia, anxiety disorders, substance abuse disorders, eating disorders and borderline personality disorder are common in major depression (APA, 1994).

A range of older and newer antidepressants have been shown to be effective in alleviating major depression (Nemeroff & Schatzberg, 1998). High relapse rates of up to 50% within one year associated with the exclusive use of pharmacological treatments may probably be reduced by concurrent brief (20 sessions) psychological treatment with cognitive behavioural, interpersonal or marital therapies and multimodal intervention involving combined pharmacological and psychological treatments is now considered to be best practice. A number of psychological therapies have been shown to be effective in alleviating major depression in up to 50% of cases and in delaying relapse and these include cognitive therapy, behaviour therapy, interpersonal therapy and behavioural marital therapy (Craighead, Wilcoxon et al, 1998; Prince & Jacobson, 1995; Baucom, Shoham et al, 1998). Behavioural marital therapy has been found to be particularly effective in treating depression with comorbid marital distress (Prince & Jacobson, 1995; Baucom, Shoham et al, 1998). This is not surprising given the complex interlinkages between depression and family processes (Clarkin, Haas & Glick, 1988).

Cognitive therapy focuses on challenging pessimistic or self-deprecating attributions, beliefs, assumptions and expectations (Beck, Rush et al, 1979).

Behavioural interventions for depression aim to increase activity levels and rates of response contingent positive reinforcement (Lewinsohn & Gottleib, 1995). Interpersonal therapy aims to alter negative interpersonal situations which maintain depression and a conjoint version of this has been shown to be effective with couples in which one partner is depressed (Foley et al, 1998; Klerman et al, 1984). Behavioural marital therapy aims to improve communication and problem solving skills and increase the rate of mutually satisfying interpersonal exchanges (Jacobson & Margolin, 1979). Marital therapy and conjoint interpersonal therapy probably alleviate depression and reduce the risk of relapse by reducing family based stress and conflict and increasing marital and family support (Prince & Jacobson, 1995).

For bipolar mood disorders, long term treatment with either lithium carbonate or anticonvulsants (such as carbamazepine) has been shown to lead to clinically significant mood stabilization (Keck, & McElroy, 1998). However, stabilization is not complete and relapses occur. These are associated with alterations in family and work related stress and support and adherence to medication regimes (Craighead, Milkowitz et al, 1998). Clarkin et al (1990) found that psychoeducational family therapy improved clients long term adjustment. The psychoeducational intervention provided family members with information on bipolar disorder as a chronic illness; helped them develop ways to reduce life stress and increase support for the patient; and encouraged them to maximise medication adherence.

With respect to clinical practice and service development, the findings reviewed here suggest that effective multimodal therapy for mood disorders may be offered on an outpatient basis over 10-20 sessions, although it is probable, because of the recurrent episodic nature of major depression and bipolar disorder booster sessions or therapy episodes may be required following relapses. Within such therapy programmes appropriate psychopharmacological therapy may be combined with individual and family based interventions as described above. Protocols for individual cognitive and behavioural treatments are contained in Beck, Rush et al (1979), Becker and Leber (1975), and Hasselt & Hersen (1996).

A protocol for interpersonal treatment is contained in Klerman, Weissman et al (1984) and protocols for family based interventions are given in Clarkin, Hass & Glick (1988). Of course, in instances where there is a high risk of self-harm or severe impairment in social functioning inpatient care may be required for individuals with mood disorders.

PERSONALITY DISORDERS

Within DSM IV (APA, 1994) 10 personality disorders are subclassified into 3 groups. Cluster A includes the paranoid, schizoid and schizotypal personality disorders which are grouped together because they are characterized by eccentric behaviour. Cluster B includes the antisocial, borderline, histrionic and narcissistic personality disorders which are characterized by dramatic or erratic-impulsive behaviour. Cluster C includes the avoidant, dependent and obsessive-compulsive personality disorders all of which are characterized by anxiety and fearfulness. A very similar classification system is used in ICD-10 (WHO, 1992). Personality disorders are marked by an enduring and rigid pattern of behaviour which leads to impaired interpersonal functioning, impulse control, affectivity or cognition. Estimates of the prevalence of personality disorders range from 10-13.5% (Chrits-Christoph, 1998). There is considerable comorbidity among personality disorders with many cases meeting the diagnostic criteria for more than one personality disorder. This observation has led to criticism of the DSM IV classification system and interesting alternative proposals (Clarkin & Lenzenweger, 1996). Within DSM IV personality disorders (which are coded on axis II) are distinguished from axis I disorders and there is considerable evidence that patients with personality disorders are less responsive to treatment for axis I disorders such as mood disorders, anxiety disorders, substance use disorders and eating disorders (Chrits-Christoph, 1998; Roth & Fonagy, 1996).

Psychopharmacological treatments for personality disorders are not well developed, and the current state of such treatments has been reviewed recently by

Woo-Ming and Siever (1998). There is some evidence that antipsychotic agents may lead to partial symptomatic relief for cluster A personality disorders, particularly schizotypal personality disorder. For cluster B personality disorders, particularly borderline personality disorder, antidepressants have been shown to improve mood regulation and fluoxetine, lithium and carbamazepine have been shown to reduce impulsivity in some trials. For cluster C personality disorders, particularly avoidant personality disorder, MAOI antidepressants have been shown to decrease symptomatology.

Despite their prevalence, their serious impact on responsiveness to treatment for axis 1 disorders, and the lack of well developed psychopharmacological treatments, there have been remarkably few controlled treatment outcome studies for personality disorders. Linehan, Huber et al (1991) found that women with borderline personality disorder treated with dialectical behaviour therapy engaged in fewer parasuicidal behaviours and had fewer days of hospitalization compared with cases who received routine outpatient treatment. Also the attrition rate of 17% for cases receiving dialectical behaviour therapy was much lower than the attrition rate of 58% shown by the control group. Dialectical behaviour therapy (Linehan, 1993) is a complex multisystemic intervention programme that includes intensive individual and group work with the patient for approximately 80 sessions over a period of a year and carefully planned case management work with significant members of the patients social network including family members, friends and other involved professionals. The overall programme is goal focused and goals include decreasing suicidal behaviour; decreasing behaviours that interfere with engaging in therapy and maintaining a good quality of life; decreasing PTSD symptomatology; increasing behavioural skills; and increasing self-respect. Group therapy includes psychoeducation, social skills training, and coaching in impulse control and affect regulation. The central feature of individual work in dialectical behaviour therapy involves using dialectical strategies to hold both sides or polarities expressed by clients in focus for a sufficiently sustained period for clients to achieve a more integrated and flexible position.

Psychodynamic psychotherapy has been found in a small number of trials to improve adjustment in patients with borderline personality disorder and other types of personality disorder (Stevenson & Meares, 1992; Munroe & Marziali, 1995; Winston et al, 1994). Psychodynamic psychotherapy firstly involves identifying and interpreting the part-object relationship in the transference and the alternating representations of the self and object within this part-object relationship. For example, the therapist may point out that in one instance that therapist-client transference relationship resembles that of a persecuting parent to a frightened and needy child with the client in the role of the child and that at another time the relationship is the same but the roles are reversed with the client adopting the role of the persecuting parent. Psychodynamic psychotherapy secondly involves interpretations of the links between such negative part-object relationships activated in the transference at some times, and positive or idealized part-object relationships activated in the transference at other times. For example, the therapist may point out that while the persecuting parent-needy child roles typify the transference relationship at one time; at others the therapist-client relationship is like that between a satisfied child and an all-giving mother. The third step in psychodynamic psychotherapy involves interpreting the links between the use of splitting, primitive idealization and projection as defenses to reduce anxiety associated with attempting to integrate the all-good and all-bad primitive object relations. For example, the therapist may point out that one reason for viewing people as all-good or all-bad, is that it preserves the possibility of having one's needs met by an all-gratifying mother. However, the down-side of using splitting and projection is that it prevents the development of sustainable intimate relationships because it requires denying the existence of frustrating characteristics in people defined as all-good, and positive characteristics of people defined as all-bad. Through these types of interpretation, psychodynamic psychotherapy facilitates the integration of dissociated all-good and all-bad primitive object relations and related polarized affects, which in turn leads to improved affect and impulse control (Kernberg, Selzer et al, 1989).

Alden (1989) in a controlled treatment outcome study of patients with avoidant personality disorder found that 10 sessions of closed group behavioural treatment led to significant improvements in patient adjustment compared with a no-treatment control group. In this study three distinct behavioural treatments were compared: graded exposure, standard social skills training, and intimacy-focused social skills training. All were found to be equally effective. Similar results have been found in uncontrolled studies of behavioural treatments (Crits-Cristoph, 1998).

With respect to clinical practice and service development, multisystemic dialectical behaviour therapy and psychodynamic psychotherapy programmes involving weekly sessions over a period of 1-2 years coupled with pharmacological intervention as required should be available on an outpatient basis to individuals with personality disorders. In many instances, treatment for comorbid axis 1 conditions will also be required. Where patients present with parasuicidal behaviour and grossly impaired social functioning episodes of inpatient care may be required. A treatment protocol for dialectical behaviour therapy for borderline personality disorders is contained in Linehan (1993). A protocol for the psychodynamic treatment of borderline personality disorders is presented in Kernberg, Selzer et al (1989).

SCHIZOPHRENIA

Schizophrenia, a debilitating psychological disorder with a prevalence of about 1%, is characterized by positive symptoms such as delusions, hallucinations and thought disorder and negative symptoms such as impaired social functioning and lack of goal-directed behaviour (APA, 1994; WHO, 1992). Comorbid depression is common in schizophrenia and about 10% of people with schizophrenia commit suicide (Kopelowicz & Lieberman, 1998).

Exposure to life stresses, including high levels of expressed emotion (criticism and overinvolvement) in family and residential settings, can adversely

affect the course of schizophrenia (Kopelowicz & Lieberman, 1998). Stress has a marked impact on individuals genetically vulnerable to schizophrenia when it occurs in the absence of protective factors such as personal coping skills, social support and appropriate levels of antipsychotic medication. In view of this, it is not surprising that the treatment of choice for schizophrenia is multimodal and includes antipsychotic medication coupled with individual and family based psychological interventions which aim to reduce stress and increase personal coping resources and social support.

With respect to psychopharmacological interventions, both conventional (e.g., chlorpromazine) and newer (e.g. clozapine) antipsychotic medications have been shown to markedly reduce positive symptoms although conventional medications have serious neurological side effects which make the newer medications preferable (Sheitman, Kinon, Ridgeway & Lieberman, 1998). The newer drugs also partially alleviate the negative symptoms of schizophrenia. However, even with medication, a significant minority of people with schizophrenia continue to have residual positive and negative symptoms and to periodically relapse into episodes of full-blown psychosis.

Psychoeducational family based interventions have been shown in more than six trials to reduce relapse rates in families characterized by high levels of expressed emotion from over 50% in cases receiving medication only, to less than 20% one year following the onset of the psychotic episode (Goldstein & Miklowitz, 1995; Kopelowicz & Liberman, 1998; Baucom, Shoham et al, 1998; Fadden, 1998). Some of the controlled trials of family interventions have also shown that family interventions reduce the amount of maintenance medication required and the number of days of hospitalization required during the follow-up period. There has been considerable variability in the format of family based interventions for schizophrenia. However, it is clear that effective treatments involve at least some conjoint family meetings which include symptomatic and non-symptomatic family members and these meetings may involve multiple families. Relatives support groups which exclude patients are not particularly effective in reducing relapse rates but may reduce the burden of care experienced

by family carers. Treatment intensity and attendance at treatment is associated with positive outcome. Effective interventions typically span 9-12 months of weekly treatment with episodes of intensive crisis intervention as required. Treatment attrition may be reduced by conducting treatment in clients' homes. With respect to the content and process of treatment programmes, a number of core elements typify effective family based interventions for schizophrenia. Considerable effort is devoted to engaging families in treatment and the emphasis is placed on blame-reduction, the positive role family members can play in the rehabilitation of the schizophrenic family member and the degree to which the family intervention will alleviate some of the family's burden of care. All effective family intervention programmes for schizophrenia include psychoeducation. A diathesis-stress model of the disorder is typically presented. Medication management and family stress management are addressed. In addition in effective programmes family members receive training in communication skills and social problem-solving.

Social skills training and cognitive therapy have both been shown to enhance the personal coping resources of people with schizophrenia and to reduce residual symptomatology not ameliorated by antipsychotic medication (Kopelowicz & Liberman, 1998; Benton & Schroeder, 1990; Tarrier, Beckett, Harwood et al, 1993; Drury, Birchwood, Cochrane et al, 1996b, 1996b; Kuipers et al, 1998). Cognitive therapy, has been shown to reduce the negative impact of hallucinations on personal adjustment and to reduce the conviction with which delusional beliefs are held (Tarrier, Beckett, Harwood et al, 1993; Drury, Birchwood, Cochrane et al, 1996b, 1996b; Kuipers et al, 1998). While the primary effect of cognitive therapy is on positive symptoms, social skills training has been shown to address the deficits associated with negative symptoms (Kopelowicz & Liberman, 1998; Benton & Schroeder, 1990). Effective cognitive and social skills therapies are typically of approximately 6 months duration and involve approximately 15-20 sessions, with social skills training being offered on a group basis and cognitive therapy on an individual basis.

With respect to clinical practice and service development, the findings reviewed here suggest that multimodal multisystemic treatment programmes should be made available to people with schizophrenia and their families. Such programmes should include initial hospitalization and initiation of psychopharmacological treatment during the acute phase of a psychotic episode. This should be followed by a year long weekly family based psychoeducational programme with concurrent individual cognitive therapy and social skills training for the person with schizophrenia as required and outpatient follow-up for maintenance antipsychotic medication. Treatment protocols for family intervention in schizophrenia are contained in Anderson, Reiss & Hogarty (1986), Barrowclough and Tarrier (1992), Falloon, Laporta, Fadden & Graham-Hole, 1993; and Kuipers, Leff & Lam (1992). Treatment protocols for individual cognitive-behavioural interventions for schizophrenia are contained in Chadwick, Birchwood & Trower (1992) and Fowler, Garety, & Kuipers (1995).

ALCOHOL ABUSE

A distinction is made in DSM IV between alcohol dependence and alcohol abuse, with the former being characterized by tolerance and withdrawal syndrome in the absence of alcohol and the latter, a broader condition, characterized by impaired social functioning arising from alcohol use. In adults over 18 years of age the prevalence of alcohol dependence and abuse is approximately 7-8% (APA, 1994; Finney & Moos, 1998). Comorbid mood disorders, anxiety disorders, antisocial personality disorder and schizophrenia are common in cases of alcohol abuse or dependence (APA, 1994).

For alcohol abuse, family based treatments have been shown to be particularly effective in helping people with alcohol problems and their families engage in treatment; become drug free or develop a more controlled approach to alcohol use; and avoid relapse (Edwards & Steinglass, 1995; Finney & Moos, 1998).

Family based engagement techniques all involve working with non-alcoholic family members, particularly spouses, and include family intervention (Liepman et al, 1989); unilateral family therapy (Thomas & Ager, 1993); and community reinforcement training (Sisson & Azrin, 1986). These can help 57-86% of cases engage in treatment (both individual or family based) compared with the typical engagement rate of about 0-31% (Edwards & Steinglass, 1995). Family based engagement techniques help non-alcoholic family members create a context within which the chances of the family member with a drink problem entering treatment are maximized. With family intervention, the therapist coaches family members over a series of sessions to stage a formal confrontation with the family member who has the alcohol problem. During this confrontation the family members describe their concerns about the drinking problem and its consequences. Unilateral family therapy includes psychoeducation; relationship enhancement training; training in avoiding enabling behaviour patterns that maintain alcohol use; preparation for confrontation, requests to reduce alcohol use and to enter treatment; coaching in maintaining treatment gains; and relapse prevention (Thomas & Ager, 1993). In cases where separation is the preferred option of the non-alcoholic spouse, then coaching in disengagement is provided. With community reinforcement training (Sisson & Azrin, 1986) the spouse of the person with the alcohol problem is coached in reinforcement based methods for avoiding physical abuse; encouraging sobriety; and managing instances where the spouse with the alcohol problem is maximally motivated to enter treatment. Specifically, spouses are coached in inviting their partners to attend a conjoint meeting with a view to entering treatment when they express a wish to overcome their drink problem and such expressions typically follow incidents where the person with the alcohol problem behaves in a shameful or embarrassing way.

Both inpatient and outpatient family oriented treatment programmes based on systems theory and social learning theory have been shown to be effective in reducing alcohol abuse. Edwards & Steinglass (1995) in a meta-analysis of 13 studies obtained an effect size of 0.8 which shows that up to six months following treatment, the average treated case fared better than 79% of

untreated cases. The two most effective treatment packages were the community reinforcement approach (e.g., Azrin, 1976) and behavioural marital therapy (O'Farrell et al, 1993). Effective treatment programmes included a combination of some or all of the following components: psychoeducation; exploration of the negative consequences of alcohol abuse for all family members; exploration of the patterns of family interaction which maintain alcohol abuse; exploration of ways in which these patterns may be disrupted; enhancement of communication and problem-solving within the couple and family; coaching couples in mutual contingency contracting; coaching non-alcoholic partners to reinforce their spouses for abstinence; adjunctive uses of disulfiram; individually based training in drink refusal and urge control; facilitating the development of an alcohol-free lifestyle; the use of homework assignments; the use of phone-prompting between sessions; and coaching in relapse prevention.

Family based aftercare programmes which aim to prevent relapse have been shown to be more effective than individually based aftercare programmes (Edwards & Steinglass, 1995). Family based after-care programmes typically involve relatively infrequent conjoint marital or family sessions spread over an extended time period.

With respect to individually based therapies, cognitive behavioural interventions; brief motivational counselling and 12 step programmes have all been shown to be effective treatments for alcohol problems, although the weight of evidence would suggest that family based interventions (notably the community reinforcement approach and behavioural marital therapy) are more effective than individually based treatments (Finney & Moos, 1998). Effective cognitive behavioural programmes include social skills training, stress management training, self-control training, cue-exposure treatment, cognitive therapy and covert sensitization based aversion therapy. With brief motivational counselling, a non-confrontational approach is adopted and the client is invited to explore the consequences of continued drinking on the one hand and ceasing alcohol abuse on the other. 12-step programmes provide long term group based

support and a structured rationale for abstinence and the development of an alcohol free lifestyle.

Less effective individually based interventions include hypnosis; aversion therapy (electric shock or nausea based); confrontational interventions; educational interventions; and general counselling (Finney & Moos, 1998).

Both client and therapists characteristics have been shown to affect treatment outcome in cases of alcohol abuse. Family based treatment programmes are more effective when both partners are invested in the relationship and the non-drinking spouse is highly supportive of abstinence (Edwards & Steinglass, 1995). Therapists who are more interpersonally skilled, more empathic and less confrontational tend to be more effective (Finney & Moos, 1998).

With respect to psychopharmacological interventions, naltrexone has been shown to be a useful adjunct to the psychological treatment of alcohol dependence. It diminishes craving during the early stages of abstinence (O'Brien & McKay, 1998). Disulfiram has also been shown to be effective in helping clients remain alcohol free during participation in psychosocial treatment programmes (O'Brien & McKay, 1998).

With respect to clinical practice and service development, the findings reviewed here suggest that effective multimodal therapy for alcohol abuse may be offered on an outpatient basis over an extended time period. Ideally such treatment should be multisystemic and family based with a clear distinction made between the processes of engagement, treatment and aftercare. Individually based cognitive behavioural, 12 step or motivational enhancement treatments may be incorporated into an overall family based multisystemic treatment approach. For individuals who are alcohol dependent, a period of inpatient or outpatient detoxification should precede psychological therapy. To reduce craving naltrexone may be used in the early stages of treatment and later to make alcohol use an aversive option disulfiram may be incorporated into a multimodal multisystemic programme. Treatment protocols for family based and individually

oriented therapies are contained in Hester and Miller (1995) and protocols exclusively for family based interventions are contained in O'Farrell (1993).

SMOKING CESSATION

In westernized cultures such as the USA about 25% of adults smoke (Compas, Haaga et al, 1998). Smoking is a major health problem because of the risk it poses for the development of lung cancer. Cognitive behavioural programmes which include psychoeducation; stimulus control techniques such as removing ashtrays; setting a quit date; moving from urge cued smoking to scheduled smoking; reducing the frequency of smoking and the potency of cigarettes smoked; coping-skills training for managing withdrawal; and relapse prevention training have been shown to be effective for about a third of cases in helping people to quit smoking and remain drug free one year following treatment compared with about 10% of controls (Compas, Haaga, et al, 1998; Viswesvaran & Schmidt, 1992; Baillie, Mattick et al, 1994). The effectiveness of such programmes can be enhanced through the adjunctive use of nicotine replacement therapy involving either nicotine gum and/or nicotine patches (O'Brien & McKay, 1998; Blanchard, 1994).

Successful cessation of smoking has been shown to be associated with spousal support for avoiding smoking and the absence of criticism for continued smoking or relapses (Campbell & Patterson, 1995). Cognitive behavioural smoking cessation programmes which include spouses and facilitate spouse support have been shown to be as effective, but no more so as individually based programmes (Campbell & Patterson, 1995).

With respect to clinical practice and service development, the findings reviewed here suggest that effective multimodal therapy for smoking cessation may be offered on an outpatient basis over 10-20 sessions. Such multimodal programmes should include a core cognitive behavioural treatment package,

spouse support and nicotine replacement therapy. Smoking cessation treatment protocols are contained in APA (1996) and Fiorey, Bailey et al (1996)

EATING DISORDERS

A distinction is made in both DSM IV (APA, 1994) and ICD-10 (WHO, 1992) between anorexia nervosa, a condition characterized by sustained self-starvation and severe weight loss, and bulimia nervosa which is characterized by a cycle of bingeing and purging. Among young adult women the prevalence of anorexia is 1% and that of bulimia is 1-3% (APA, 1994). Comorbid OCD occurs in a proportion of cases with anorexia nervosa. Comorbid mood disorders, substance use disorders and borderline personality disorder are common in cases of bulimia nervosa.

The Maudsley group have shown that for anorexia nervosa, while family therapy is the treatment of choice in young adolescent cases, in older adolescents and adults individually-based focal psychodynamic psychotherapy is significantly more effective than family therapy (Russell et al 1987; Eilser, Dare et al, 1997). The approach to psychodynamic psychotherapy involves developing a unique focal psychodynamic formulation in each case which accounts for the links between the client's early relationships with parents; current life symptomatology relationship difficulties; and relationship with the therapist. Difficulties in the development of autonomy and a coherent sense of self are central to many such formulations. Therapy involves helping clients gain insight into psychodynamics entailed by the formulation and develop less destructive ways to assert autonomy and achieve a stronger sense of personal identity. In cases where severe weight loss has occurred, inpatient refeeding programmes may be necessary before offering outpatient psychotherapy. Rigid behavioural refeeding programmes and more lenient programmes are equally effective and the use of medication does not enhance weight gain (Wilson & Fairburn, 1998).

For bulimia nervosa, manual based cognitive behaviour therapy, is effective for up to 50% of cases and in these cases both bingeing and purging may be brought under control with good long term maintenance of improvement (Wilson & Fairburn, 1998). Cognitive behaviour therapy involves psychoeducation; self-monitoring; mapping the situational, cognitive, behavioural and affective antecedents and consequences of the binge-purge cycle; challenging the attitudes and beliefs that underpin the bingeing and purging cycle; using stimulus control techniques to regularize eating routines; and problem-solving training. Antidepressants may also produce short-term reductions in bingeing and purging and may be useful in treating comorbid depression in cases of bulimia nervosa (Wilson & Fairburn, 1998).

With respect to clinical practice and service development, the findings reviewed here suggest that effective therapy for eating disorders in adults may be offered on an outpatient basis over 20-30 sessions. In instances where severe weight loss has occurred, hospitalization for weight restoration may be required. Treatment protocols for eating disorders are contained in Garner and Garfinkle (1997).

SLEEP PROBLEMS

Approximately 10% of adults suffer from insomnia, including difficulties going to sleep or staying asleep for a sufficient period of time (APA, 1994). For sleep problems, benzodiazepines have been shown to lead to rapid short-term improvement in sleep efficiency but behavioural interventions over the long term produce more sustained effects (Nowell, Buysse, Morin, Reynolds, & Kupfer, 1998). Pharmacological and psychological treatments reduce sleep onset by 15-30 minutes; decrease the number of awakenings to 1-3 per night; and increase overall sleep time by 15-45 minutes. Effective behavioural interventions include psychoeducation; stimulus control techniques; sleep restriction; relaxation training; and coaching in cognitive strategies to challenge cognitions which

perpetuate insomnia (Blanchard, 1994; Nowell et al, 1998). Stimulus control methods include going to bed only when sleepy; using the bedroom exclusively for sleep; arising each day at a set time; and avoiding daytime napping. Sleep restriction increases sleepiness at bedtime and relaxation training helps clients control high arousal levels that prevent sleep.

With respect to clinical practice multimodal programmes are probable the treatment of choice with the gradual withdrawal of pharmacological treatment once clients show proficiency in using behavioural sleep management practices. A psychological treatment protocol for insomnia is contained in Espie (1991).

SURGICAL RECOVERY

Postoperative psychological adjustment and physical recovery may be enhanced through preoperative psychological intervention, with 66-75% of cases that receive psychological intervention having a better outcome than untreated controls (Kiecolt-Glaser, Page et al, 1998). Effective pre-operative interventions include giving procedural and sensory information; providing behavioural instruction on managing post operative pain; relaxation training; cognitive coping skills training; and the provision of emotional support. The interventions tend to be brief lasting 7-90 minutes and often being delivered in a group format. Pre-operative psychological interventions lead to less post-operative pain; less post-operative pain medication usage; shorter post-operative hospitalization; and more rapid physical and psychological post-operative recovery. It seems probable that pre-operative interventions enhance immune system functioning and it is this that aids healing and recovery. The enhanced immune system functioning probably occurs because pre-operative interventions provide patients with social support in a threatening situation and increase patients sense of self-efficacy about managing the post-operative period by reducing uncertainty (Kiecolt-Glaser, Page et al, 1998). Patients differ in their pre-operative informational requirements with some patients benefiting from much information and others

benefiting from a more cursory familiarization with the impending surgical procedures. These individual differences reflect differences in patients preferences for vigilant or distracting coping strategies (Miller, 1992).

With respect to clinical practice and service development, brief pre-operative preparation programmes should be routinely offered to surgical patients. Such programmes need be no longer than a couple of hours and may be delivered by ward staff who have been given adequate training. Ideally the amount of information contained in such programmes should be matched to patients requirements and expressed preferences for using vigilant or distraction based coping strategies.

CHRONIC PAIN MANAGEMENT

Chronic pain, including low-back pain, headaches, and rheumatoid arthritis is only partially responsive to pharmacological interventions. Because of this, psychological interventions grounded in a multidimensional biopsychosocial conceptualizations of pain have been developed. For chronic low back pain operant programmes and cognitive behavioural coping skills training programmes have both been shown to be effective and such coping skills training programmes have also been shown to be effective for rheumatic diseases (Compas, Haaga et al 1998; Simon, 1998; Blanchard, 1994). For migraine, thermal biofeedback plus relaxation training has been shown to be more effective than other forms of psychological treatment (Compas, Haaga et al, 1998; Blanchard, 1994).

Operant pain management programmes entail extensive family involvement (Fordyce, 1976). They rest on the premise that much pain behaviour and sick role behaviour is inadvertently reinforced by family members. Programmes include scheduled increases in physical exercise; reduction in pain medication usage; and arranging for hospital staff and family members to avoid

reinforcing pain and sick role behaviour, while concurrently offering positive reinforcement to the client for engaging in adaptive behaviour.

Traditional cognitive behavioural pain management programmes involve psychoeducation; training in relaxation, guided imagery, activity pacing, and pleasant event scheduling; coaching in the development of cognitive coping skills; and guided practice in using cognitive and behavioural coping strategies in real life pain management situations (Turk, Meichenbaum & Genest, 1983). Effective family-based and spouse-assisted cognitive behavioural training programmes have been developed for a number of conditions including rheumatoid arthritis (Radojevic et al, 1992) and osteoarthritic knee pain (Keefe et al, 1996).

With thermal biofeedback skin temperature signals is continually recorded and amplified by an electronic device and converted into a continuous audio or visual feed display. Clients are coached to use the feedback to alter skin temperature to control pain (Blanchard & Andrasik, 1987).

With respect to service development and clinical practice, psychologically based pain control programmes should be offered by multidisciplinary teams on an outpatient basis to patients with a variety of chronic pain disorders which are unresponsive to pharmacological interventions. Treatment protocols for operant and cognitive behavioural programmes are given in Fordyce (1976) and Turk, Meichenbaum and Genest (1983). Guidelines on thermal biofeedback are given in Blanchard and Andrasik (1987).

ADJUSTMENT TO CANCER

Cancer is one of the top three causes of death in adults (Andersen 1992). Chemotherapy for cancer has many side-effects, including nausea and vomiting, which decrease the quality of life of cancer patients (Carey & Burish, 1988). Improving the quality of life of patients with cancer undergoing chemotherapy and increasing survival time through enhancing psychological well-being and

immune system functioning have been the major foci for psychological interventions in cancer. For cancer patients, cognitive behavioural programmes which include relaxation training and guided imagery have been shown to be effective in helping patients to control anxiety, nausea and vomiting associated with chemotherapy (Compas, Haaga et al, 1998; Carey & Burish, 1988). Such cognitive behavioural programmes and also supportive-expressive group therapy have been shown to increase quality of life, mood, immune system functioning and survival time in specific types of cancer patients (Compas, Haaga et al, 1998; Andersen 1992).

With respect to service development and clinical practice, these findings suggests that psychological intervention programme programmes should be developed for delivery by multidisciplinary teams on an inpatient and outpatient basis to cancer patients. Cognitive behavioural treatment protocols which may be adapted for use with cancer patients are contained in Turk, Meichenbaum and Genest (1983). A treatment protocol for supportive-expressive group therapy is contained in Spiegel & Spira (1991).

ADJUSTMENT TO HEART DISEASE

Heart disease is the leading cause of death in adults (Blanchard, 1994). Hypertension is a risk factor for myocardial infarction and one strategy for addressing the problem of heart disease has been to reduce hypertension. A range of psychological interventions for hypertension have been shown to be effective. These include psychoeducation; relaxation training; biofeedback; cognitive coping skills training; weight loss programmes; restricted (sodium) salt diets; and aerobic exercise programme (Blanchard, 1994).

Alongside hypertension, a high cholesterol diet, obesity, smoking, excessive alcohol use and low rates of physical exercise have all been shown to be risk factors for heart disease. However, when the effects of these factors are taken into account, individuals who display Type A behaviour have double the

risk of developing a myocardial infarction (Rosenman, Brand et al, 1975). The Type A behaviour pattern is characterized by time urgency, hostility, and unrewarded striving and is assessed by a structured interview. Because of its importance as a risk factor for heart disease and because of its behavioural nature, it is not surprising that numerous studies have been conducted to evaluate of the effectiveness of psychological intervention programmes in modifying of Type A behaviour. Cognitive behavioural programmes have been shown to be effective in modifying Type A behaviour and in reducing the rate of subsequent myocardial infarctions by approximately 50% (Blanchard, 1994).

Effective cognitive behavioural programmes include psychoeducation; relaxation training; cognitive coping skills training; communication skills training and advice on diet, alcohol and nicotine use and exercise. While these programmes have been predominantly individually based, a number of family based interventions have been shown to reduce cardiac disease risk related behaviours and improve the adjustment of hypertensive and post-MI cardiac patients and their adherence to treatment and lifestyle regimes (Campbell & Patterson, 1995). Such programmes have included family based psychoeducation; family based counselling on diet, drug use and exercise; interventions which aim to increase spouse support; and interventions which aim to reduce spouses overprotection of their post-MI partners.

With respect to service development and clinical practice, these findings suggests that psychological intervention programmes should be developed for delivery by multidisciplinary teams on an inpatient and outpatient basis to cardiac patients and patients with hypertension or at risk for heart disease. For such programmes to be effective, particularly with patients who show entrenched Type A behaviour patterns, they should be offered on a regular weekly basis over periods of up to a year. A protocol for the modification of Type A behaviour is contained in Roskies (1987).

FAMILY MANAGEMENT OF OLDER NEUROLOGICALLY IMPAIRED ADULTS

Dementia due to Alzheimer's disease or other causes is a condition characterized by multiple cognitive deficits, notably memory impairment, and an associated decline in psychosocial functioning and capacity for independent living. The prevalence of dementia in over 65 year olds is 2-4% and in those over 85 may be as high as 20% (APA, 1994).

Evaluation of psychological interventions, such as Reality Orientation, which aim to improve the functioning of older adults with neurological problems such as Alzheimer's disease have yielded very modest results (Holden & Woods, 1995; Woods & Roth, 1998). In contrast, psychological intervention programmes which focus on empowering carers of older adults with disabilities to manage their disabled relatives more effectively have led to more promising results.

Caring for older adults with neurological problems such as Alzheimer's disease or stroke places an extraordinary psychological burden on carers and may lead to clinically significant psychological symptomatology (Biegel, Sales & Schultz, 1991). Family psychoeducational groups and family support groups are the two main types of psychotherapeutic family interventions have been developed to help families cope with older neurologically impaired adults. Family psychoeducational groups typically involve 8-10 educational meetings offered by a health professional and are attended by a groups of caregivers. Within the meetings caregivers learn the skills to manage the problems they face in caring for older adults with neurological problems. In contrast family support groups are open-ended and focus on mutual support between members rather than on skills acquisition. Campbell and Patterson (1995) conclude from a review of 11 studies that psychoeducational groups consistently lead to significant improvement in the psychological adjustment of caregivers whereas the effects of family support groups are more variable.

With respect to service development and clinical practice, these findings suggest that psychoeducational programmes should be made available to carers of older adults with neurological impairment as a routine part of multidisciplinary care of the elderly. Such programmes may be offered on a group basis over a relatively brief time period and include 10-20 sessions. Treatment protocols for working with older adults and their families are contained in Woods (1996).

SEXUAL OFFENDERS

A distinction is made within the literature on sex-offenders, between rapists who sexually assault adult victims, and paedophiles who confine their sexual assaults to children. It is currently estimated that the prevalence of paedophilia is about 5% of the adult male population (Maletzky, 1998). Cognitive behavioural treatment programmes both prison based and community based have been shown to reduce recidivism rates among sexual offenders from an overall rate of about 40% for untreated offenders down to 19% for rapists and 13% for paedophiles (Maletzky, 1998; Hanson & Brussiere, 1996; Walsh, 1998). Effective cognitive behavioural treatment programmes have been offered within a statutory framework where the sexual offender undergoes due legal process and they entail a number of key elements (Murphy, 1998; Maletzky, 1998). Effective programmes involve explicit contracting and treatment engagement procedures and individualised assessment often involving penile plethysmographic assessment of offenders sexual arousal patterns to a range of sexual stimuli. Effective programmes create a context within which offenders take full responsibility for their offence and give up the process of denial and cognitive distortions that go with this process. Effective programmes promote the development of victim empathy, sometimes through the use of victim impact statements. Effective programmes help offenders develop an understanding of the cycle of sexual offending and the offence decision chain. A variety of

behavioural techniques may be used to alter deviant patterns of arousal including aversion therapy and covert sensitization. Social skills training where offenders learn skills necessary for developing appropriate heterosexual relationships are included in many programmes. Most effective programmes include a relapse prevention component. Hormonal treatments to lower testosterone levels and sexual drive are only effective in the short-term while medication is being taken and relapses occurs once offenders stop taking medication (Maletzky, 1998; Hanson & Brussiere, 1996).

With respect to clinical practice and service development, comprehensive court mandated prison and community based psychological treatment programmes should be available for all sex offenders. These should involve at least weekly sessions over a minimum period of a year and be followed by long-term supervision to monitor relapse and recidivism risk. A treatment protocol for working with sexual offenders is contained in Marshall, Eccles & Fernandez (1999).

CLOSING COMMENTS

All of the evidence based practices addressed in this paper entail both basic counselling skills and specialist technical skills. Basic counselling skills are required to make and maintain effective therapeutic alliances. Specialist technical skills are required to empower clients to engage in specific types of social problem-solving appropriate to their unique problems. Most accredited counselling training programmes focus largely on the development of basic counselling skills but offer only limited training in the development of specialist technical skills. Such counselling training programmes could be enhanced by including modules on some or all of the specialist skills referred to in this paper in their curricula. Short courses on the specialist skills described in this paper are also legitimate areas for continuing professional development for counsellors.

SUMMARY

In this paper the implications of rigorous treatment outcome research for evidence based practice with a number of common relationship problems, psychological disorders; drug problems, medical conditions and sexual offending are presented. Marital distress, psychosexual problems and marital violence are the main relationship difficulties addressed. Consideration is given to a number of psychological disorders including anxiety disorders, mood disorders, personality disorders and psychotic disorders. With respect to drug problems, interventions for alcohol abuse and smoking cessation are considered. The implications of research on eating disorders and sleep disorders for practice are outlined. In the medical domain, research based guidelines are given for the psychological management of recovery from surgery, chronic pain, adjustment to cancer, adjustment to heart disease, and the family management of neurologically impaired adults.

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