The Efficacy of Systemic Therapy for Internalizing and Other Disorders of Childhood and Adolescence: A Systematic Review of 38 Randomized Trials

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Systemic therapy (ST) is one of the most widely applied psychotherapeutic approaches in the treatment of children and adolescents, yet few systematic reviews exist on the efficacy of ST with this age group. Parallel to a similar study on adults, a systematic review was performed to analyze the efficacy of ST in the treatment of children and adolescents. All randomized or matched controlled trials (RCT) evaluating ST in any setting with child and adolescent index patients were identified by database searches and cross-references, as well as in existing meta-analyses and reviews. Inclusion criteria were: index patient diagnosed with a DSM-IV or ICD-10 listed psychological disorder, or suffering from other clinically relevant conditions, and trial published by December 2011. Studies were analyzed according to their sample, research methodology, interventions applied, and results at end-of-treatment and at follow-up. This article presents findings for internalizing and mixed disorders. Thirty-eight trials were identified, with 33 showing ST to be efficacious for the treatment of internalizing disorders (including mood disorders, eating disorders, and psychological factors in somatic illness). There is some evidence for ST being also efficacious in mixed disorders, anxiety disorders, Asperger disorder, and in cases of child neglect. Results were stable across follow-up periods of up to 5 years. Trials on the efficacy of ST for externalizing disorders are presented in a second article. There is a sound

evidence base for the efficacy of ST as a treatment for internalizing disorders of child and adolescent patients.

INTRODUCTION

Family therapy evolved as part of a general paradigm shift in mental health towards an ecological perspective. In contrast to earlier individually oriented conceptualizations of psychological problems, it focused on the social-ecological context in which they arise (Bronfenbrenner, 1979; Engel, 1977; Minuchin, 1974). Many models of family therapy had their roots in treatment projects for severe disorders of children and adolescents, disorders which could not be adequately treated by other forms of therapy (Hoffmann, 1981) — psychosis, eating disorders, substance abuse, or delinquency. Today, systems oriented therapies — having evolved out of earlier family therapy models — belong to the most widely used approaches in the treatment of children and adolescents (Orlinsky & Ronnestad, 2005). Systemic therapy (ST) has had a strong influence on other schools of psychotherapy and, similarly, ideas and concepts from attachment theory, cognitive behavior therapy, experiential/humanistic therapy, and Ericksonian therapy have been integrated into systemic theory and practice (Retzlaff, 2012).

In some countries, psychotherapist licensing regulations rely on empirical evidence for the efficacy of the specific psychotherapy "school" (e.g., behavioral, psychodynamic, humanistic, and systemic). Similarly, health care providers generally require the treatment to be recognized as evidence-based in order for psychotherapy to be reimbursed.

As a step towards gaining scientific recognition by the *German Approval Board of Psychotherapy/Wissenschaftlicher Beirat Psychotherapie (WBP)* and the *German Central Regulatory Board of Health Care Providers*, a systematic review of treatment studies on ST was carried out. A systematic review is a critical assessment and evaluation of all research studies, using an organized method of locating, assembling, and evaluating a body of literature on a particular topic using a set of specific criteria.

The central hypothesis was that there is a sufficient evidence base for the efficaciousness of ST to meet the criteria of the WBP — namely, that there are at least three randomized controlled trials (RCTs) in at least three diagnostic groups showing that ST is equally or more efficacious than established forms of treatment.

Results of our systematic reviews of ST with adults have been published elsewhere (Sydow, Beher, Retzlaff, & Schweitzer-Rothers, 2007a; Sydow, Beher, Schweitzer, & Retzlaff, 2010). An earlier review in German on ST with children and adolescents was published in 2006 (Sydow, Beher, Schweitzer-Rothers, & Retzlaff, 2006).

For this review, we analyzed all randomized controlled (outcome) trials on the efficacy of ST in children and adolescents with internalizing DSM-IV or ICD-10-diagnoses, or other clinically relevant symptoms, published in English, German, Korean, Mandarin Chinese, or Spanish by December 2011. Findings for externalizing disorders will be reported separately (Sydow, Retzlaff, Beher, Haun, & Schweitzer, in press). Clinically relevant conditions included in this article were suicidality and child abuse and neglect. While suicidality and child abuse are currently not classified as disorders, both conditions frequently result in utilizing psychotherapeutic services, and were therefore included.

Family Interventions and Family Therapy Versus Systemic Therapy

In recent years, there has been a move towards psychotherapy integration (Fraenkel & Pinsof, 2001; Grawe, Donati, & Bernauer, 1994; Lebow, 2005; Pinsof, 1995), resulting in a growing trend to combine aspects of different psychotherapy models. Especially in the treatment of children and adolescents, various forms of *family interventions are now applied by therapists of diverse theoretical orientations, such as cognitive behavior therapy (CBT) or psychodynamic therapy*.

While we generally applaud the trend to therapy integration and the proliferation of family interventions into other psychotherapeutic schools, there is risk that specific contributions of the systemic treatment model might be obscured. Most reviews on the efficacy of psychotherapy focus on family interventions and trials in a family setting (Carr, 2000; Sprenkle, 2002) rather than on trials with a distinct systems orientation (Sydow et al., 2010). This tendency might present a skewed picture of what contributes to treatment effectiveness. "*A systems orientation goes beyond working in a family setting or the use of family interventions within an individual framework*" (Sprenkle, 2002, pp. 13–14).

In our classification, we distinguish between different orientations of therapy (e.g., psychodynamic, behavioral, humanistic, systemic) and settings (e.g., individual, couples, family, group or multiple family group setting). We use *systemic therapy or systems oriented therapy*[1] as a general term for a major therapy orientation that can be distinguished from other major approaches like cognitive behavioral therapy (CBT) or psychodynamic therapy (Grawe et al., 1994).

According to the current European mainstream, we define systemic therapy as (1) any form of psychotherapy which perceives human behavior and especially psychological symptoms and disorders within the context of the social systems patients live in; (2) focuses on interpersonal interactions and expectations, the social construction of realities, and recursive causality between symptoms and interactions; (3) includes family members and other important persons (e.g., teachers, friends, professional helpers) directly or indirectly through systemic questioning, hypothesizing, and specific interventions; and (4) appreciates and utilizes clients' perspectives on problems, resources, and preferred solutions (see Sydow et al., 2010). The theory, diagnostics, and interventions of ST with children and adolescents, as well as its basic therapeutic attitude, have been described in depth in textbooks such as Combrinck-Graham (1986, 1989), Ford Sori (2006), and Retzlaff (2012).

In contrast, *family therapy* can be defined as a setting in which psychotherapy is carried out conjointly with relatives or significant others. There is a considerable overlap between ST and family therapy, but they are not identical. Therapy may be implemented in a family setting by therapists of other, not primarily systemic approaches. *Family intervention* is an even broader term and can be defined as therapy techniques that aim at addressing family members (Sprenkle, 2002).

Our operational criteria may differ from how studies are typically assessed in US psychotherapy research; however, this type of classification is quite established in European psychotherapy research (Grawe et al., 1994) and in European health care regulations (e.g., in Austria, Germany, Poland, or Switzerland). European health care regulations will often cover a certain number of sessions with a certain psychotherapy orientation (such as behavior therapy or psychodynamic therapy) in any setting. It should be noted that because we focus *on trials with a predominantly systemic orientation, rather than on therapy in a family setting, our systematic review includes fewer studies than other reviews* (Carr, 2009; Sprenkle, 2002). In a recent review on family-based interventions for

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[1]We prefer the shorter term *systemic therapy*, which is commonly used in countries such as the UK, China, Germany, and partially in the USA.

child and adolescent disorders, Kaslow, Broth, Smith, and Collins (2012) concluded that there is initial support for family interventions in adolescent depression, some pilot indication that it is helpful in bipolar disorder and autism, compelling evidence for family-based interventions in anxiety disorders, and substantial support for the effectiveness of family interventions in anorexia but less evidence for bulimia nervosa. Differences to our review are largely because cognitive and behavioral approaches in a family setting were included in the review of Kaslow et al. (2012).

A problem with a categorical sorting of therapy approaches is that it does not allow for shades and colors beyond black and white. Today, many approaches are much more integrative than in previous decades, and systemic, behavioral, cognitive, narrative as well as psychodynamic elements might contribute to a given treatment. Instead of a rather simplistic sorting into major therapy approaches, a system that allows for a richer description of therapy approaches would seem to be desirable (e.g., Madanes, 1981).

However, our research arose within the context of European health care regulation, and in many countries, psychotherapy approaches can only be practiced, or are only paid for if they belong to one of the major therapy orientations which are accepted as an evidence-based. We are aware that by paying tribute to this necessity, we had to leave out important, clinically highly valuable approaches that for example rely on psychoeducation or a social learning base. While various techniques and settings might be used across many orientations of psychotherapy, systemic therapy can be distinguished by observers from other approaches (such as behavioral family therapy) due to differences in the basic premises, assumptions, and views of how therapy is conducted (Saile & Trosbach, 2001).

METHOD OF THE SYSTEMATIC REVIEW

Identification of Primary Studies

Trials were identified through database searches up to the publication date of December 2011 (methodology described in Sydow et al., 2010). We also searched *China Academic Journals Full-Text Database*, cross-references in reviews, meta-analyses, Cochrane Reviews, and existing primary studies. Members of the *American Academy of Family Therapy* (AFTA) and the *European Federation of Family Therapy* (EFTA) provided additional help.

We analyzed general reviews of effectiveness trials on ST in all age groups (Empt & Schiepek, 1997; Ludewig, 1996; Ochs, Schlippe, & Schweitzer, 1997; Stierlin, 1997; Stratton, 2005); ST with children and adolescents (Cotrell & Boston, 2002; Malone, 2001), specific forms of ST, including solution focused therapy (Kim, 2008; Kim & Franklin, 2009), and especially multisystemic therapy (MST) (Henggeler, 1999, 2004; Littell, 2005; Littell, Campbell, Green, & Toews, 2005); family therapy/family interventions across all age groups (Alexander, Holzworth-Munroe, & Jameson, 1994; Alexander, Sexton, & Robbins, 2002; Asen, 2002; Diamond, Serrano, Dickey, & Sonis, 1996; Gurman & Liddle, 2002; Lebow & Gurman, 1995; Liddle & Rowe, 2004; Liddle, Santisteban, Levant, & Bray, 2002; Pharoah, Mari, Rathbone, & Wong, 2010; Pinsof & Wynne, 1995; Scheib & Balck, 2002; Scheib & Wirsching, 2004; Shadish, Ragsdale, Glaser, & Montgomery, 1995; Sprenkle, 2002); ST with disorders of children and adolescents (Carr, 2000; Diamond & Siqueland, 2001; Diamond et al., 1996; Heekerens, 1991); family therapy/interventions for specific disorders in all age groups (different disorders: Fonagy & Roth, 2004a,b); ST for somatic illness (Campbell & Patterson, 1995; Eccleston, Palermo, Williams, Lewandowski, & Morley, 2009; Ersser, Latter, Sibley, Satherley, & Welbourne, 2007; Glasscoe & Quittner, 2008; Huertas-Ceballos, Logan, Bennett, & Macarthur, 2008a, 2008b; King, De Silva, Stein, & Patel, 2009; Kröger, Hendrischke, Schweitzer, & Herzog, 1998; Oude Luttekuis et al., 2009; Ranmal, Prictor, & Scott, 2008; Scott et al., 2003; Waters et al., 2011; Yorke,

Fleming, & Shuldham, 2005; Yorke & Shuldham, 2005), and for specific disorders in children and adolescents, including affective disorders (Cotrell, 2003; Henken, Huibers, Churchill, Restifo, & Roelofs, 2007; Justo, Soares, & Calil, 2007; Lane, Millane, & Lip, 2003; Merry et al., 2011), anxiety disorders and obsessive-compulsive disorders (James, Soler, & Weatherall, 2005; O'Kearney, Anstey, von Sanden, & Hunt, 2006), eating disorders (Fisher, Hetrick, & Rushford, 2010; Hay, Bacaltchuk, Stefano, & Kashyap, 2009; Hay, Claudino, & Kaio, 2001; Le Grange, Lock, & Dymek, 2003; Lock, 2011; Pratt & Woolfenden, 2002), enuresis (Glazener & Evans, 2004; Glazener, Evans, & Peto, 2004), and fecal incontinence (Brazzelli, Griffiths, Cody, & Tappin, 2011); sexually abused children (Macdonald, Higgins, & Ramchandani, 2006), child and adolescent psychotherapy in general (Döpfner, 2003; Döpfner & Lehmkuhl, 2002; Heekerens, 2002; Kazdin & Weisz, 1998; Weisz, Huey, & Weersing, 1998), interventions for enhancing medication adherence (Haynes, Ackloo, Sahota, McDonald, & Yao, 2008), alternatives to inpatient mental health care for children and young people (Shepperd et al., 2009), psychoeducation (Lucksted, McFarlane, Downing, Dixon, & Adams, 2012), and resource orientation as a therapeutic technique (Grawe & Grawe-Gerber, 1999).

Selection of the Trials

Selection criteria with regard to the research methodology applied

All randomized (or parallelized/matched)[2] controlled trials published in English, German, Korean, Mandarin, or Spanish by December 2011 on the efficacy of systemic therapies with DSM-IV or ICD-10 diagnosed child and adolescent index patients (or clinically relevant conditions such as suicide attempts, conduct disorders, bullying, self-harming behavior, child abuse and neglect) were analyzed. We excluded unpublished dissertations and trials which presented treatment results on relational outcomes only.

Selection criteria with regard to the systemic interventions

The idiosyncratic use of terms and labels has been an obstacle for the evolution of systems oriented therapies (Eisler, 2007). In most reviews and meta-analyses "systemic therapy" is used as a name for a major psychotherapy school which can reliably be differentiated from other major orientations (Grawe et al., 1994; Justo et al., 2007; Kazdin & Weisz, 1998; Shadish et al., 1993). Like most reviews, we use "systemic therapy" synonymously with "systems oriented therapy" as a general term for a major therapy orientation (as defined above). According to the criteria applied in other meta-analyses and reviews, ST was operationalized as any individual, family, group, or multi-family group focused therapeutic intervention either referring to one of the systems oriented authors (including *T. Anderson, Boszormeny-Nagy, de Shazer, Haley, Minuchin, Satir, Selvini-Palazzoli, Stierlin, Watzlawick, White, Zuk*) or specifying the intervention through at least one of the following terms: *systemic, structural, strategic, triadic, Milan, functional, solution focused, narrative, resource/strength oriented, McMaster model* (Asen, 2002; Cotrell & Boston, 2002; Grawe et al., 1994; Justo et al., 2007; Kazdin & Weisz, 1998; Shadish et al., 1993). Integrative systemic approaches were included, as long as they were described as predominantly systemic, which means that they defined themselves as systems based. Trials which relied on predominantly behavioral, cognitive-behavioral, psychodynamic, or psychoeducative interventions without a systems orientation were excluded, even if they were conducted in a family setting.

For example, if the treatment condition was described as being based primarily on behavior therapy, learning and social learning theory, and mentioned techniques such as

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[2]As in only one of 38 trials the sample was matched instead of randomized (Table 1), we generally speak of "randomized" studies.

TABLE 1

Primary studies (RCT) on the efficacy of systemic therapy for child and adolescent index patients (38 Trials)

Authors (Year) – Country	Sample (N-IP)				Interventions			Study design			Results at the end of intervention (posttest)	Follow-up results	Evaluation
	Treated	pt	Age IP (years)	Sex IP	Number of sessions	Duration (weeks/ years)	Treatment and control groups / Type of disorders researched	ITT-analysis	Manual	PT-integrity			
1. Mixed disorders – 4 RCT													
1.1 Garrigan and Bambrick (1977) – USA	14 14 (28)	12 14 (26)	14.4 (11–17.7)	36%	10 —	16 week 16 week	1. **Systems oriented FT (G. Zuk)** 2. Untreated CG *"Attending classes for emotionally disturbed adolescents"*	n/i	— n/a	— n/a	Problem behavior (observational data in school): 1 < 2 Return to normal classes: 1 > 2 Marital communication: 1 > 2	—	+
1.2 Ro-Trock et al. (1977) – USA Wellisch et al. (1980)	14 14 (28)	14 14 (28)	16.5 (13–22) 18.4	36%	10 10	10 week 10 week	1. **Systems oriented FT (inpatient)** 2. Eclectic IT (inpatient) *Schizophrenic reactions, adjustment & substance disorder*	— —	— —	— —	3-months; reintegration: relapses: 1 < 2 Family communication: 1 > 2	3-year (N = 24): Inpatient after-care necessary: 1 > 2 (!) BUT: more schizophrenia in 1	+/–
1.3 Rowland et al. (2005) – USA	26 29 (55)	25 26 (51)	14	42%	n/i	24 week n/i	1. **MST** 2. TAU: youth services	—	x —	x —	Externalizing and internalizing symptoms: 1 < 2 Minor criminal activity: 1 < 2 Out-of-home-placements: 1 < 2	—	+
1.4 Chen and Tang (2004) – China	169 169 (338)	169 169 (338)	0–3	n/i	33	3 year n/a	1. **Systemic FT** 2. No treatment (TAU)	—	n/i n/a	n/i n/a	Behavior problems (CBCL): 1 < 2	—	+

(continued)

Table 1 (continued)

Authors (Year) – Country	Sample (N-IP)			Interventions				Study design				Results at the end of intervention (posttest)	Follow-up results	Evaluation
	Treated	pt	Age IP (years)	Sex IP	Number of sessions	Duration (weeks/ years)	Treatment and control groups Type of disorders researched	ITT-analysis	Manual	PT-integrity				

2. Mood disorders & suicidality (ICD-10: F 30 – 39; DSM-IV: 296, 300.4) – 6 RCT

2.1 Brent et al. (1997) – USA

Authors	Treated	pt	Age IP	Sex IP	Number of sessions	Duration	Treatment and control groups	ITT	Manual	PT-integrity	Results at the end of intervention (posttest)	Follow-up results	Evaluation
2.1 Brent et al. (1997) – USA	37	30	13–18	76%	12.1	12–16 week	1. CBT (IT: Beck)	x	x	x	Dropout:	2-year:	+?
	35	24			10.7	12–16 week	2. Systemic-behavioral FT (SBFT) = FFT + BSFT		x	x	1 = 2 = 3	Depression improved by 80%,	
	35	24			11.2	12–16 week	3. Nondirective supportive therapy (NST IT)		x	x	Functional impairment:	1 = 2 = 3	
	(107)	(78)			(12–16)	(12–16 week)	+ all 3 groups: psychoeducation				1 = 2 = 3 all improved	Family functioning:	
Brent et al. (1998)							*DSM-III-R: major depression, outpatients*				MDD present:	2 > 1	
Brent et al. (1997)											1 = 2 = 3	Anxiety symptoms:	
Renaud et al. (1998)											Remission: 1 > 2,3	1, 3 < 2	
Birmaher et al. (2000)											Symptom reduction: 1 = 2, but 1 more rapidly	53% received additional PT:	
Kolko, Brent, Baugher, Bridge, and Birmaher (2000)											Suicidality reduction: 1 = 2 = 3	1 = 2 = 3	
											Dropout acute suicidal:	- acute phase:	
Brent, Birmaher, Kolko, Baugher, and Bridge (2001)											1 (8%) = 2 (6%) = 3 (9%)	1 (11%) = 2 (11%) = 3 (14%)	
Stein et al. (2001)											Maternal depression moderates treatment success:	- follow-up phase:	
Gaynor et al. (2003)											- mother not depressed:	1 (49%)	
Barbe et al. (2004)											1 > 2, 3	= 2 (37%)	
											- mother depressed (BDI):	= 3 (40%)	
											2 > 3 > 1	Recurrence predicted by depressive symptom severity & family difficulties at end of treatment.	

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Table 1 (*continued*)

Authors (Year) – Country	Sample (N-IP)				Interventions			Study design			Results at the end of intervention (posttest)	Follow-up results	Evaluation
	Treated	pt	Age IP (years)	Sex IP	Number of sessions	Duration (weeks/years)	Treatment and control groups Type of disorders researched	ITT-analysis	Manual	PT-integrity			
2.2 Diamond et al. (2002) – USA Diamond, Siqueland, and Diamond (2003)	16 16 (32)	16 16 (32)	14.9 (13–17)	78%	8(3–12) n/a	12 week 6 week	**1. ABFT + 1 telephone/week** 2. CG (waiting list): 1 telephone/week *MDD (K-SADS) & delinquency (47%) parent-BSI: depression (42%), anxiety (47%), hostility (37%)*	—	x n/a	x n/a	MDD remitted: 1 (81%) >2 (56%) Depressive symptoms: 1 < 2 Trait anxiety: 1 < 2 Family conflict: 1 < 2 Bond IP-M: 1 > 2 Suicidality IP: 1 < 2	6-month (1 & treated out of CG in the meantime): 87% remitted MDD	+
2.3 Trowell et al. (2007) – **Finland, UK, Greece** Garoff, Heinonen, Pesonen, and Almqvist (2011)	35 37 (72)	35 37 (72)	11.7 (9–15)	38%	24.7 + 12 11	36 week 36 week	1. Psychodynamic Therapy + parent support group 2. **Systemic Therapy**	x	x x	n/i n/i	Depressive symptoms: 1 > 2 (dosage of treatment in 1 was up to 2× larger than in 2) Symptom reduction in patients who completed treatment: 1 = 2 Reduction of comorbid disorders: 1 = 2 Family functioning (FAD, BICS) 1 = 2	6-month: Depressive symptoms: 1 > 2 (dosage of treatment in 1 was up to 2× larger than in 2)	+
Suicidality – 3 RCT													
2.4 Harrington et al. (1998) - UK Harrington et al. (2000) Byford et al. (1999)	85 77 (162)	n/i n/i (149)	14.5 (10–16)	90%	3.2 + 4 3.6	n/i n/i	1. **Routine care + FT (theoretical background unclear)** 2. Routine treatment after suicide attempt	—	x —	— —	Posttest-, 2-, 6-month follow-up: - suicidal thoughts, hopelessness: 1 = 2 - compliance: 1 > 2 - parental satisfaction: 1 > 2	6-month: Outcome: 1 = 2 Cost-effectiveness: 1 = 2 Suicidal ideation in subgroup without MDD: 1 < 2	+/–

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Table 1 (*continued*)

Authors (Year) – Country	Sample (N-IP)				Interventions			Study design			Results at the end of intervention (posttest)	Follow-up results	Evaluation
	Treated	pt	Age IP (years)	Sex IP	Number of sessions	Duration (weeks/years)	Treatment and control groups Type of disorders researched	ITT-analysis	Manual	PT-integrity			
2.5 Henggeler et al. (1999) – USA Schoenwald, Ward, Henggeler, and Rowland (2000) Henggeler et al. (2003) Huey et al. (2004) Sheidow et al. (2004)	57 56 (113)	57 56 (113)	12.9 (10–17)	35%	92 h	16 week 1–2 week	1. **MST + medication (64-77%)** 2. Inpatient hospitalization (CBT based milieu program) + medication (69-76%) *Candidates for psychiatric emergency care (suicidality, homicidal, psychoses)* 96% ≥ 1 *DSM-III-R diagnosis*	–	x –	x –	Reduction of external symptoms: 1 > 2 Family functioning (structure): 1 > 2 School attendance: 1 > 2 Improving IP's self-esteem: 1 < 2 Consumer satisfaction: 1 > 2 Hospitalized days: 1 (44%, mean length 3.8 days) <2 PT-costs: 1 (5954 $) = 2 (6174 $) PT- & out-of-home-placement-costs: 1 (8017 $) = 2 (7878 $)	4-month: Cost-effectiveness: 1 (MST: 1617 $) more favorable than 2 12-month: Cost-effectiveness: 1 = 2 Suicide attempts: 1 < 2 Generally larger effects in 1 & 2; 1 had more rapid effects than 2, but 1 year later effects of 1 = 2 (approx.)	+
2.6 Diamond et al. (2010) – USA	35 31 (66)	35 31 (66)	15.1 (12–17)	83	(9.7) (2.8)	24 week 24 week	1. **ABFT** 2. Enhanced usual care	x	x n/i	n/i n/i	Reduction of suicidal ideation: 1 > 2 Retention in treatment:1 > 2	6-month: Suicidal ideation: 1 < 2	+
3. Anxiety disorders (ICD-10: F 40 – F42; DSM-IV: 300, 293.89) – 1 RCT													
3.1 Siqueland et al. (2005) – USA	6 5 (11)	6 5 (11)	14.9 (12–17)	27%	14 (–16) 15(13–16)	16 week 16 week	1. CBT 2. **CBT + ABFT (CBT-ABFT)** *DSM-IV generalized AD, separation AD*	–	x x	(x) (x)	Anxiety disorder remitted: 1 (67%) > 2 (40%)	6-month: Anxiety disorder remitted: 1 (100%) > 2 (80%)	–

(continued)

Table 1 (continued)

Authors (Year) – Country	Sample (N-IP)			Sex IP	Interventions			Study design			Results at the end of intervention (posttest)	Follow-up results	Evaluation
	Treated	pt	Age IP (years)		Number of sessions	Duration (weeks/ years)	Treatment and control groups Type of disorders researched	ITT-analysis	Manual	PT-integrity			
3.2 Bao and Yang (2011) – **China**	31 31 (62)	31 31 (62)	15,9 (12–18)	69%	10 –	20 week 20 week	1. SFT & medication 2. Medication	–	–	–	Reduction of anxiety (SAS) 1 > 2 Generic Quality of Life 1 > 2 Quality of child rearing (EMBU) 1 > 2	–	+
4. Eating disorders (ICD-10: F 50; DSM-IV: 307) – 12 RCT **Anorexia nervosa – 10 RCT**													
4.1 Hall and Crisp (1987) – **UK**	15 15 (30)	15 15 (30)	19.6 (13–27)	100%	12 12	12–24 week 12–24 week	1. **Combined psychodynamic IT & FT (Palazzoli, Minuchin)** 2. Dietary advice (+ partially family counseling) *Anorexia nervosa*	n/a	–	–	–	1-year: Both groups improved Weight: 1 = 2 Sexual & social adjustment: 1 > 2 Cured: 1 (4 women) > 2 (0 women) – all others needed further treatment	+
4.2 Russell et al. (1987) – **UK** Eisler et al. (1997) Dare, Eisler, Russell, and Szmukler (1990)	41 39 (80)	36 37 (73)	21.8 (14–55)	91%	10.5 15.9	48 week 48 week	1. **Maudsley Approach FT** 2. Supportive IT *Anorexia nervosa (N = 57) & bulimia (N = 23) (DSM III-R)* *Outpatient treatment after inpatient therapy*	–	(x)	–	Weight:1 > 2 (only in anorexia) 1 more effective than 2 in <19 years & not chronic Otherwise 2 more effective than 1 Only 28% of anorectic patients recovered	5-year: Outcome: 1 > 2 in young, not chronified patients All anorectic patients improved. Less positive in bulimia.	+? only young only AN

(continued)

Table 1 (continued)

Authors (Year) – Country	Sample (N-IP)				Interventions			Study design			Results at the end of intervention (posttest)	Follow-up results	Evaluation
	Treated	pt	Age IP (years)	Sex IP	Number of sessions	Duration (weeks/years)	Treatment and control groups / Type of disorders researched	ITT-analysis	Manual	PT-integrity			
4.3 Le Grange et al. (1992) – UK	n/i n/i (18)	n/i n/i (18)	15.3 (12–17)	89%	8.6 9.3	24 week 23 week	1. **Maudsley Approach conjoint FT** 2. **Maudsley separated FT: IP & parental couple treated separately** *anorexia nervosa* DSM-III-R	—	(x) (x)	(x) (x)	Weight: both improved 1 = 2 IP psychological symptoms: both improved 1 = 2 Family interaction: mostly 1 = 2, but parental criticism 1 > 2 (!)	n/i	(+)
4.4 Robin, Siegel, Koepke, Moye, and Tice (1994) – USA Robin et al. (1995) Robin et al. (1999)	19 18 (37)	11 11 (22)	14 (11–20)	100%	n/i n/i	64 week 4 week	1. **Behavioral Family Systems Therapy (BFST)** 2. Ego-oriented IT (EOIT) & parent sessions *anorexia nervosa* DSM-III-R 1/3 additional inpatient weight program	—	x x	x x	Post-treatment: 1 > 2 (weight, BMI, menstruation) 1 = 2 (attitudes, depression, ego-function, family relations)	12-month: BMI: 1 > 2 (both improved) Clinically improved (menstruation & target weight achieved): 1 (82%) = 2 (50%)	+
4.5 Eisler et al. (2000) – UK Eisler et al. (2007)	20 20 (40)	18 18 (36)	15.5 (11–17)	98%	16.4 15.5	48 week 48 week	1. **Maudsley Approach conjoint FT** 2. Separated FT: IP & parent treated separately *anorexia nervosa* DSM-IV or ICD-10 Outpatient treatment PT after 10 weeks inpatient treatment	—	— —	— —	Both improved: 1 = 2 2 > 1 with high degree of maternal criticism of IP Symptom reduction: 2 > 1 Mood, psychosexual adjustment: 1 > 2	5-year: 1 = 2 No deaths, 75% free from eating disorder symptoms	(+)

(continued)

Table 1 (*continued*)

| Authors (Year) – Country | Sample (N-IP) | | | | Interventions | | | | Study design | | | Results at the end of intervention (posttest) | Follow-up results | Evaluation |
	Treated	pt	Age IP (years)	Sex IP	Number of sessions	Duration (weeks/ years)	Treatment and control groups Type of disorders researched	ITT-analysis	Manual	PT-integrity			
4.6 Geist et al. (2000) – Canada	n/i n/i (86)	n/i n/i (25)	14.3 (12–17) 14.9 (12–17)	100%	8 8	16 week 16 week	1. **FT** (**theoretical orientation not clear**) 2. Family group psychoeducation *Restrictive eating disorders (DSM-IV) requiring hospitalization Treated first as in-, than as outpatients*	— —	— n/i	— n/i	Both successful: Weight: 1 = 2 No psychological changes with regard to eating pathology in both groups Family psychopathology/ conflict increased posttreatment in both groups! More than half of patients were readmitted to inpatient treatment during or after therapy	n/i	+
4.7 Lock et al. (2005) – USA Lock et al. (2006)	44 42 (86) (71)	42 35 (77)	(15.2)	90%	10 20	24 week 48 week	1. **Short-term SFT** 2. **Long-term SFT**	x	x x	x x	Weight and eating disorder symptoms: 1 = 2 IP with obsessive symptoms and nonintact families may profit more from longer SFT.	4-year: 1 = 2; 89% above 90% of ideal body weight 74% with eating disorder examination in normal range	+
4.8 Rausch Herscovici (2006) – Argentina	6 6 (12)	6 6 (12)	17.5 (12–20)	98%	n/i n/i	24 week 24 week	1. **SFT** 2. SFT with family lunch intervention	n/i	x x	n/i n/i	1 = 2	n/i	+
4.9 Rhodes et al. (2008) – UK	10 10 (20)	10 10 (20)	13.7 (12–16)	100%	20 20 & 2	6 week 6.3 week	1. **Systemic Therapy** 2. **Systemic Therapy with parents as consultants**	—	x x	x x	Weight restoration: 1 < 2	—	+

(continued)

Table 1 (*continued*)

Authors (Year) – Country	Sample (N-IP)				Interventions			Study design			Results at the end of intervention (posttest)	Follow-up results	Evaluation
	Treated	pt	Age IP (years)	Sex IP	Number of sessions	Duration (weeks/years)	Treatment and control groups Type of disorders researched	ITT-analysis	Manual	PT-integrity			
4.10 Lock et al. (2010) – USA	60 61 (121)	52 51 (103)	14.1 (12–18)	91%	21 (21 h) 32 (24 h)	48 week 48 week	1. SFT 2. Adolescent-Focused Therapy	x	x x	x (supervision) x	Full remission: 1 = 2 Partial remission (BMI): 1 > 2 Scores at end-of-treatment: 1 < 2	6-month & 12-month: Full remission: 1 > 2 Partial remission (BMI): 1 = 2 Scores at end-of-treatment: 1 = 2	+
Bulimia nervosa – 2 RCT													
4.11 Schmidt et al. (2007) – UK	44 41 (85)	44 41 (85)	13–20	98%	13 13	24 week 24 week	1. CBT-guided self-care 2. Systemic therapy	x	x x	x (x)	Binge attacks: 1 < 2 Cost of treatment: 1 < 2	12-month: Binge attacks: 1 = 2	+/−
4.12 Le Grange et al. (2007) – USA	41 39 (80)	41 39 (80)	(16.1) 12–19	n/i ("most were female")	20 20	24 week 24 week	1. SFT *IP had bulimia (50%) or met at least half of the required DSM symptoms, 38% had additional symptoms* 2. Individual CBT	x	x x	X x	Binge and purge remission/ frequency: 1 > 2 Fully remitted patients: 2× higher in 1 > 2 Reduction of additional symptoms: 1 > 2 No differences between patients with BN and with	6 months fully remitted patients: 3× higher in 1 > 2	+
5. Psychological factors affecting medical condition (ICD-10: F 54; DSM-IV: 316) – 12 RCT Asthma – 4 RCT													
5.1 Lask and Matthew (1979) – UK	21 16 (37)	18 11 (29)	4–14	n/i	6 5	16 week 16 week	1. FT (focus: family system) 2. Standard medical treatment (control group) *Asthma (grade C or D: McNichol & William (1973); the 21 children came from 16 families)*	—	(x) —	— —	—	1-year: Respiratory function: 1 > 2 (partially) No information on psychological or family data	+

(continued)

Table 1 (continued)

Authors (Year) – Country	Sample (N-IP)				Interventions			Study design			Results at the end of intervention (posttest)	Follow-up results	Evaluation
	Treated	pt	Age IP (years)	Sex IP	Number of sessions	Duration (weeks/years)	Treatment and control groups Type of disorders researched	ITT-analysis	Manual	PT-integrity			
5.2 Gustafsson et al. (1986) – Sweden	9 / 8 / (17 + 1 pilot case)	12 / 6 / (18)	9 (6–15)	n/i	8.8 (2–21) / n/a	24–32 week / 24 week	1. FT (Minuchin) & medical routine treatment / 2. Medical routine treatment / *Asthma: after 24 months overcross-design*	—	— / n/i	— / —	General pediatric assessment: 1 > 2 / Daily functioning: 1 > 2	1-year: Success in group 1 maintained then overcross-design	+
5.3 Onnis et al. (2001) – Italy	10 / 10 / (20)*	10 / 10 / (20)	9 (2–15)	50%	10–15 / n/a	20–28 week / n/i	1. Systemic Structural FT & medical routine treatment / 2. Medical routine treatment / *Severe, chronic asthma (min. 5 inpatient admissions/year)*	n/a	— / —	(x) / —	Number of asthma attacks: 1 < 2 / Medication: 1 < 2 / Family conflicts: 1 < 2	Success in intervention group maintained over 2 years stable (no stat. test)	+
5.4 Ng et al. (2008) – Hong Kong/China	23 / 23 / (46)	20 / 17 / (37)	9.2 (7–12)	35%	11 / n/i	11w / n/i	1. SFT & asthma education / 2. Asthma education	—	n/i / n/i	n/i / n/i	Somatic condition: 1 > 2 / Psychological adjustment: 1 > 2	11 weeks improvements were maintained	+
Insulin dependent diabetes mellitus – 5 RCT													
5.5 Ryden et al. (1994) – Sweden	9 / 6 / 10 / (25)	9 / 2 / n/i / n/i	12.8 / 14.0 / 12.6	67% / 67% / 70%	7 / 7 / n/i	24 week / 24 week / n/i	1. Structural/strategic FT (Minuchin) & conventional treatment / 2. Pediatric support: education / 3. CG: medical routine care / *Diabetes mellitus*	—	— / — / —	(x) / — / —	Diabetes control: 1 > 2 / Behavioral symptoms: 1 < 2 / Dropout-Rate: 1 < 2	—	+

(continued)

Table 1 (continued)

Authors (Year) – Country	Sample (N-IP)				Interventions			Study design			Results at the end of intervention (posttest)	Follow-up results	Evaluation
	Treated	pt	Age IP (years)	Sex IP	Number of sessions	Duration (weeks/years)	Treatment and control groups Type of disorders researched	ITT-analysis	Manual	PT-integrity			
5.6 Wysocki et al. (2000) – USA	38 40 41 (119)	35 39 41 (115)	14.5 (12–17) 14.1 14.3	61% 62% 51%	10 10 n/i	12 week 12 week	**1.BFST + Medical treatment** 2. Educational support + medical treatment 3. CG (medical standard treatment) *Insulin-dependent diabetes mellitus*	—	x n/i n/a	(x) n/a n/a	Baseline: big group differences! (100 $ per family for completion of evaluation) (1 + 2: together 100 $ per participant for attending 10 sessions) Post-therapy: Familial relationships: 1 better 2, 3 Diabetic control: 1 better 2, 3 only in boys & young girls; older girls in 1 did worse	—	+/–
5.7 Ellis et al. (2005) – USA **Ellis et al. (2007b)** **Ellis et al. (2008)** Ellis et al. (2007c)	64 63 (127)	64 63 (127)	13.2 (10–17)	51%	48 n/a	24 week 24 week	**1. Home-based MST and medical care** 2. Medical care	n/i	x n/a	x n/a	Hospitalization rate: 1 < 2 Improvement HbA₁c: 1 > 2 Improvement BGT: 1 > 2	24-month: Hospitalization rate: 1 < 2 HbA₁c: 1 = 2 BGT improvement maintained only in 2-parent families	+

(continued)

Table 1 (*continued*)

Authors (Year) – Country	Sample (N-IP)				Interventions			Study design			Results at the end of intervention (posttest)	Follow-up results	Evaluation
	Treated	pt	Age IP (years)	Sex IP	Number of sessions	Duration (weeks/ years)	Treatment and control groups Type of disorders researched	ITT-analysis	Manual	PT-integrity			
5.8 Wysocki et al. (2006) – USA Wysocki et al. (2007) Wysocki et al. (2008)	36 36 32 (104)	36 36 32 (104)	(11–16)	45%	12 12 n/i	24 week 24 week 24 week	1. **BFST for diabetes** 2. Educational support 3. Standard care	x	x x n/i	x n/i n/i	Family conflicts: reduced in 1, increased in 2 & 3 Diabetes management: 1 > 2, 3 Improvement of HbA1c: 1, 2 > 3	6- and 18-month: Adherence and family conflicts: 1 > 2	+
5.9 Cakan et al. (2007) – USA	64 63 (127)	64 63 (127)	(10–17)	51%	n/i n/a	24 week n/i	1. **MST** 2. Standard Care	x	x n/a	n/i n/a	Frequency of BGT: 1 > 2 HbA1c: decreased in 1 > in 2, but only in normal weight youths	24-month	+
Obesity – 2 RCT **5.10 Flodmark et al. (1993)** – Sweden	25 19 (44)	23 19 (42)	(10–11)	52%	6 + 5.5 5.5	56–72 week n/i	1. **Structural/ strategic FT + conventional treatment (2.)** 2. Conventional treatment (dietary counseling + medical check-ups) *BMI = 25.1+/− 2.0 SD*	x	— —	(x) n/a	BMI-Increase: 1 (0.66%) < 2 (2.31%) Subscapular skinfold thickness: 1 (+16.8%) > 2 (+6.8%)	1-year: Mean BMI: 1 (25.8) < 2 (27.1) BMI-Increase: 1 (+5.1%) < 3 (+12.0%) – other differences not significant Severe obesity (BMI > 30): 1 < 3	+

(continued)

Table 1 (continued)

Authors (Year) – Country	Sample (N-IP)				Interventions			Study design			Results at the end of intervention (posttest)	Follow-up results	Evaluation
	Treated	pt	Age IP (years)	Sex IP	Number of sessions	Duration (weeks/ years)	Treatment and control groups Type of disorders researched	ITT-analysis	Manual	PT-integrity			
5.11 Ellis et al. (2010) – USA	24 25 (49)	20 22 (42)	14.5 (12–17)	77%	48-72 10 + 3	24 week 24 week	1. **MST** 2. (Group weight loss program)	—	x x	x x	Reduction of weight and body fat: 1 > 2	—	+
6. Pervasive developmental disorders (ICD-10: F 84; DSM-IV: 299) – 1 RCT Asperger-syndrome													
6.1 Lu (2009) – China	5 5 (10)	5 5 (10)	5.4	20%	20 n/i	10 n/i	1. **SFT & behavior training** 2. Behavior training	—	— n/i	— n/i	Autistic symptoms: 1 < 2	2-month: Parent interview: reported maintenance of improvements	+
7. Other clinically relevant symptoms – 2 RCT **Physical abuse or neglect of children by parents – 2 RCT**													
7.1 Brunk et al. (1987) – USA	21 22 (43)	16 17 (33)	n/i	76%	8 8	8 week 8 week	1. **MST** 2. Behavioral parent training (group T)	—	(x) (x)	— —	Both showed improvement Parental symptoms, stress & family-stress: 1 = 2 Improvement of family problems & parent-child-interaction (assessment by therapists & behavioral rating): 1 > 2 Social problems: 1 > 2	—	+

(continued)

Table 1 (*continued*)

Authors (Year) – Country	Sample (N-IP)				Interventions					Study design				Results at the end of intervention (posttest)	Follow-up results	Evaluation
	Treated	pt	Age IP (years)	Sex IP	Number of sessions	Duration (weeks/ years)	Treatment and control groups Type of disorders researched			ITT-analysis	Manual	PT-integrity				
7.2 Swenson et al. (2010) – USA	44 42 (86)	43 40 (83)	13.9 (6–18)	56%	n/a n/a	16–24 week n/a	1. MST for child abuse and neglect (MST-CAN) 2. Enhanced outpatient treatment			x	(x) (x)	(x) (x)		Youth mental health symptoms: 1 < 2 Parent psychiatric distress: 1 < 2 Parenting behavior associated with maltreatment: 1 < 2 Youth out-of-home-placements: 1 < 2 Social support for parents: 1 > 2 Re-abuse: 1 = 2	–	+

Note. x = yes; — = no; n/a =not applicable; n/i = no information given.
Sample (N-IP) = sample size/number of index patients: treated = n that was treated; * = parallelized sample; PT = n of which posttest data are presented.
Age = average age or age range of index patients.
Sex = sex/gender of index patients, rate of female index patients in%.
Number of sessions = number of therapy sessions.
Duration (weeks/years) = duration of intervention in weeks or years.
Systemic interventions are printed in bold letters.
ITT-analysis = intent-to-treat-analysis (X = yes, realized; (X) = not necessary because sample was fully retained (no drop out); F = no/not mentioned).
Manual = manual mentioned (X = yes; (X) = publication about intervention mentioned, not clear if it is a "real" manual; F = no/not mentioned).
PT-integrity: Was the manual fidelity/adherence to the planned interventions systematically evaluated (X = yes, systematic evaluation; (X) = yes, only through supervision; F = no evaluation mentioned).
Evaluation (of the trials and its results): 1 < 2 treatment 2 had significantly stronger effects than treatment 1; 1 > 2 treatment 1 had significantly stronger effects than treatment 2; 1 = 2 there was no significant difference between the effects of treatment 1 and treatment 2.
=: no significant difference between the effect of the two interventions.
+: trial with positive results for the efficacy of systemic therapy (ST) (ST more efficacious than alternative interventions or control groups without interventions).
+?: trial with predominantly positive results for the efficacy of ST.
+/−: trial with mixed (positive and negative results) for the efficacy of ST.
−: trial with negative results for the efficacy of ST (ST less efficacious than alternative interventions of control group).
ABFT = Attachment-based Family Therapy; AD = anxiety disorder; BDI = Beck Depression Inventory; BFST = Behavioral Family Systems Therapy; BSFT = Brief Strategic Family Therapy; BSI = Brief Symptom Inventory; CBT = cognitive behavioral therapy; CG = control group; FFT = Functional Family Therapy; FT = family therapy; IT = individual therapy; K-SADS = Kiddie-Schedule for Affective Disorders and Schizophrenia; MDD = major depressive disorder; MST = Multisystemic Therapy; PT = psychotherapy; SFT = systemic family therapy; TAU = treatment as usual.

TABLE 2
Summary

Type of disorder	Number RCT	ST successful
Mixed disorders	**4**	**3**
Mood disorders and suicidality	**6**	**5**
Anxiety disorders	2	1
Eating disorders	**12**	**11**
Psychosocial factors in somatic illness	**11**	**10**
Pervasive developmental disorders	1	1
Others relevant: child neglect	2	2
SUM	**38**	**33**

Note. Number RCT: Number of controlled, randomized (or parallelized) primary studies. ST successful: Number of RCT in which systemic therapy was more efficacious than other established interventions (e.g. psychodynamic IT, CBT IT, nondirective IT, family psychoeducation, group therapy, antidepressant medication) or significantly more efficacious than control groups without treatment, or more efficacious than routine treatment (including antipsychotic medication). Successful studies are marked in with "+" or "+?".

Boldface type: disorders with good empiric evidence (3+ trials in which ST was successful).

operant techniques, training of social skills, communication and problem-solving skills, cognitive training, exposure techniques, modeling, systematic desensitization, and self instruction training control techniques without referring to a systems orientation, the trial was not included. Psychoeducation is a very general intervention used across different schools of psychotherapy and was therefore not included as specifically systemic. While we believe that the combination of ST with psychoeducative or behavioral elements often constitutes good clinical practice, in this review we were interested in evidence for the efficacy of "pure" ST not combined with other approaches.

Trials identified in our searches were always classified by two members of our research group. If there was a disagreement or an uncertainty, we checked additional descriptions of the intervention, to find out what it relies on (e.g., family psychoeducation, a base in learning theory, etc.). If we were still in doubt, we e-mailed the corresponding author of the trial and asked for further information. Trials were only included if all raters agreed that they qualified for inclusion. Evaluation of treatment effects was also performed by two members of the research group.

The Final Sample of the Analyzed RCT Studies

We identified a total of 38 RCTs on ST with child and adolescent patients, suffering from internalizing and other (non-externalizing) disorders. In this article we present a systematic review of these studies. The analysis of the remaining trials on externalizing disorders will be presented in another article (Sydow et al., in press).

RESULTS

First, results of general meta-analyses across diagnostic groups are presented, then, results of meta-analyses and primary studies for specific disorders follow. Table 1 provides a methodological overview and results for each single trial we analyzed. Trials are presented by diagnostic groups as well as by date of publication. Table 2 provides a summary of the efficacy data of ST for the various diagnostic groups.

General Meta-analyses

Many of the existing meta-analyses on the general effectiveness of child and adolescent psychotherapy do not allow any inferences about the effectiveness of ST: Only the most

comprehensive and methodologically rigorous meta-analysis by Shadish et al. (1993; $n = 163$ controlled trials) on the general efficacy of couple ($n = 62$) and family therapy ($n = 101$) was considered relevant. A direct comparison of different therapy orientations showed no significant differences in the efficacy of behavior therapy and ST. When all potential confounding methodological aspects were taken into account all school differences disappeared in the regression analyses (Shadish et al., 1993, 1995).

Studies on Mixed Disorders

Two older RCTs examined the effectiveness of ST in the treatment of samples with mixed diagnoses. Systemic treatment of schoolchildren from classes for "emotionally disturbed adolescents" with their parents had a positive effect, compared with an untreated control group. After the systemic treatment, the problem behavior of the index patients decreased more strongly, more schoolchildren could return to normal classes, and parents' marital communication improved significantly (Garrigan & Bambrick, 1977).

In another, older study on a sample of adolescents with mixed disorders (including adjustment disorders, substance abuse disorders, and schizophrenia spectrum disorders) who received inpatient treatment, systemic family therapy had superior treatment effects at end of treatment than eclectic individual therapy. But at 3-year follow-up, more patients of the systemic family therapy condition needed additional outpatient treatment (Ro-Trock, Wellisch, & Schoolar, 1977; Wellisch, Ro-Trock, & Kelton, 1980). This result is somewhat skewed as the systemic family therapy condition included more patients with schizophrenic disorders than the individual therapy condition.

Rowland et al. (2005) compared the effectiveness of MST with routine treatment in a sample of adolescents with behavioral and/or emotional disorders (according to DSM-IV). Six months after termination of treatment, patients in the experimental group showed a significantly larger reduction of externalizing and internalizing symptoms and a significant reduction of criminal behavior. Patients undergoing MST had significantly fewer placements in residential settings, incarcerations, and in-patient treatments.

A Chinese study (Chen & Tang, 2004) investigating the effects of systemic family therapy with infants, who received either systemic family therapy with their parents or routine care in the first 3 years of life, showed positive effects of systemic family therapy.

Efficacy for Specific Disorders

Mood disorders and suicidality

Brent et al. (1997) demonstrated that CBT was more effective than Systemic Behavioral Family Therapy (SBFT) or supportive individual therapy at end of treatment — but contrary to the hypotheses of the researchers, at the 2-year follow-up there were no differences in the effectiveness of the different forms of treatment. The most important predictor of persistent depression and necessity of continued treatment was a high initial level of depressive symptoms and high self-reported parent-child conflict (Birmaher et al., 2000; Brent, Kolko, Birmaher, Baugher, & Bridge, 1999).

Attachment Based Family Therapy (ABFT) resulted in a clinically significant improvement rate of 82% in the intervention group, compared to a 56% rate in the waiting list control group. Effects were stable at 6-month follow-up (Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002).

A multi-center study compared the effectiveness of ST and individual psychodynamic psychotherapy for children with major depression or dysthymia (Trowell et al., 2007). Unfortunately, there was a marked difference in the therapy doses applied (max. 14 systemic sessions vs. 30 individual sessions plus a parent support group). Both interventions,

carried out over a period of 9 months, were effective. Treatment effects both at termination of therapy and at the 6-month follow-up were significantly larger in the psychodynamic condition than in the systemic treatment condition, which also had a higher drop-out rate. When only therapy completers were compared, both conditions were equally effective, even though patients in the psychodynamic condition had received nearly twice as many therapy sessions. There was a comparable reduction of comorbid disorders in both groups. Both groups continued to improve after termination of therapy, and there were no relapses within 6 months after end of treatment. The systemic treatment condition was more effective in younger children and in patients without a diagnosis of both major depression and dysthymia (Garoff, Heinonen, Pesonen, & Almqvist, 2011).

Depression is a frequent correlate of suicide, attempted suicide, and suicidal ideation. Adolescents with depression and acute or lifetime suicidality have a poorer treatment prognosis and more frequently drop out of treatment than nonsuicidal patients with depression. In a study by Barbe, Bridge, Birmaher, Kolko, and Brent (2004), suicidality was not a moderating factor for treatment response to CBT or SBFT. But nondirective supportive individual therapy did not result in a significant improvement in lifetime suicidality. A 3–4 session intervention did not differ significantly in the reduction of suicidality in youths that had attempted suicide, compared with routine treatment (Harrington et al., 1998, 2000). However, intensive MST (92 sessions) in suicidal youths was more rapidly effective than inpatient treatment and was equally effective at 1-year follow-up. In youths in psychiatric crises with externalizing behaviors, it reduced the number of subsequent suicide attempts (Huey et al., 2004).

Diamond et al. (2010) conducted a randomized study with depressed adolescents having suicidal thoughts. The treatment condition consisted of ABFT or an intense form of routine care (referral to a treatment center, weekly phone contacts, and a 24/7 crisis hotline). Significantly, more patients in the ABFT condition met criteria for clinical recovery for suicidal ideation at end of treatment and at follow-up. Patterns of depressive symptoms were similar, as were results for the subsample of patients with diagnosed depression. After ABFT, suicidal ideations were significantly reduced and depressive symptoms were reduced more rapidly. Retention in ABFT was higher than in routine treatment.

Anxiety disorders

Anxiety disorders of children and adolescents are routinely treated by systemic therapists, and numerous techniques have been developed (Madanes, 1981; Nardone, 1977; White & Epston, 1990). Surprisingly, the efficacy of ST has been evaluated only twice, once as a supplement to CBT: Both CBT and CBT combined with ABFT were successful. However, "pure" CBT was somewhat more effective than the combined treatment (primary anxiety disorder remitted at the 6-month follow-up: CBT: 100%, CBT-ABFT: 80%). However, index patients' and parents' satisfaction was the highest in the family therapy condition, and the retention rate was somewhat higher in CBT-ABFT than in CBT (Table 1; Siqueland, Rynn, & Diamond, 2005). In the treatment of adolescents with anxiety disorders, the combination of systemic family therapy with medication resulted in a larger reduction of symptoms and a larger improvement of quality of life and child rearing than medication alone (Bao & Yang, 2011). However, no follow-up data were provided in this study (Bao & Yang, 2011).

Eating disorders

Krautter and Lock (2004) identified nine RCTs on anorexia, with seven on ST and only two on CBT. Systemic therapy with structural techniques had higher treatment effects than CBT, psychodynamic therapy, or cognitive-analytical therapy. Especially for young patients (under age 18) with duration of anorectic symptoms of less than 3 years, ST was

superior to individual therapy. About 65% of adolescent patients with anorexia can be cured by ST (Lock, Le Grange, Agras, & Dare, 2001). In a Cochrane Review of family based approaches for the treatment of anorexia nervosa, 12 of 13 trials evaluated systems oriented approaches (Fisher et al., 2010). The authors found some evidence suggesting that family therapy might be more effective than treatment as usual (TAU) for symptom remission in the short term. But they called for caution in generalizing any conclusions of the value of family therapy in the treatment of Anorexia nervosa because of the small number of trials and small sample sizes. In their view, the evidence of treatment effectiveness remains inconclusive.

The first uncontrolled study on ST for Anorexia nervosa was conducted by Minuchin (1974), and most subsequent trials largely rely on concepts of structural family therapy. Russell, Szmukler, Dare, & Eisler (1987) showed that systemic family therapy is particularly effective for patients whose anorectic (and bulimic) symptoms started at age 19 or younger. Robin, Siegel, & Moye (1995) and Robin et al. (1999) demonstrated the success of a similar systemic intervention. Hall & Crisp (1987) compared the effect of individual psychodynamic therapy with family therapy, which included some individual sessions. The description of the systemic condition is very succinct; the treatment was described as a form of systemic family therapy including work on family and individual commitment to weight gain. Both conditions led to weight improvement, though psychosocial adjustment was better in the systemic condition. Similarly, in a study by Geist, Heinmaa, Stephens, Davis, & Katzmann (2000), both treatments led to weight gain (though the systemic treatment was not well described), but readmission rate in both treatment groups was high. A brief format of ST with ten sessions in 6 months can be as effective as a longer format with 20 sessions in 12 months (Lock, Agras, Bryson, & Kraemer, 2005; Lock, Coutrier, & Agras, 2006), but index patients with nonintact families and obsessive symptoms may profit more from the longer form of therapy.

While it is important to involve the family of anorectic index patients, it is not mandatory to do so in a conjoint setting — parallel treatment of index patients and family members can also be effective (Le Grange, Eisler, Dare, & Russell, 1992). In a study with a 5-year follow-up (Eisler, Simic, Russell, & Dare, 2007; Eisler et al., 2000), there were few differences between conjoint and separated family therapy conditions. However, patients from families with high maternal criticism profited less from conjoint family treatment.

In a small Argentinian study of ST with and without the family lunch intervention (Rausch Herscovici, 2006), both conditions led to a significant improvement of somatic indices, depressive symptoms, general psychological symptoms, and eating behavior. The family lunch intervention did not result in a general additional weight gain. The results indicate a specific beneficial effect of the family lunch intervention in therapy resistant patients with distinct psychopathology. Systemic therapy supplemented by parents of previous patients as consultants is significantly more efficacious than ST alone (Rhodes, Bailee, Brown, & Madden, 2008).

In a study of systemic family-based therapy and adolescent-focused therapy (AFT), both were equally successful in achieving full remission at end of treatment. However, at the 6- and 12-month follow-up, the systemic condition showed superior weight restoration (Lock et al., 2010). Partial remission at end of treatment was more frequent in the systemic condition, but these differences did not persist at follow-up.

Fewer trials exist on the efficacy of ST for *Bulimia nervosa*. A Spanish study demonstrated that ST in a sample of both adult and adolescent patients was more effective than the combination of group therapy for index patients and support groups for parents (Espina Eizaguirre, Ortego Saenz de Cabezon, & Ochoa de Alda Martinez de Appellaniz, 2000, 2002; see Sydow et al., 2010). Schmidt et al. (2007) compared the effectiveness and cost-effectiveness of a brief, manualized systemic treatment condition with a manualized

form of CBT. At the end of treatment, CBT patients had significantly fewer binge attacks compared with systemic patients. Frequency of vomiting, other symptoms, and general well-being did not differ significantly. At 12-month follow-up, there was no significant difference in binge attacks between the two conditions.

Le Grange, Crosby, Rathouz, & Leventhal (2007) compared the effectiveness of a form of systemic family therapy with supportive manualized individual CBT for bulimic patients. Criteria for affective disorders were met by 38% of patients. At end of treatment, the number of binge-and-purge abstinent patients was more than twice as high in the systemic condition as in the supportive CBT condition, and at follow-up the number of binge-and-purge abstinent patients was three times higher in the systemic condition.

Psychosocial factors related to medical conditions and physical illness

A Cochrane Review on the efficacy of family based interventions in childhood *asthma* (Panton & Barley, 2004) identified only two randomized studies. Both compared ST with routine medical treatment to routine treatment alone. The results cannot be summarized statistically because of methodological differences. One study shows that the addition of a systemic intervention led to a significant improvement in patients' gas volume, peak exploratory flow rate, and daytime wheeze (Lask & Matthew, 1979). The other study showed that the systemic condition was followed by advantages in general clinical assessment (assessed by blind raters) and in reduced number of days with functional impairment (Gustafsson, Kjellman, & Cederblad, 1986). In another study by Onnis et al. (2001), the systemic treatment group showed advantages in clinical measures and in family functioning when compared with routine treatment. Ng et al. (2008) investigated the effect of adding systemic family therapy to psychoeducational asthma training. In the group with an additional systemic treatment component, symptom related measures, individual management of the illness, and parent ratings were significantly better.

In adolescence, adjustment to *insulin-dependent diabetes mellitus* can become a problem both for youths afflicted with the illness and for their parents. Because family conflicts are associated with insufficient treatment regime compliance and reduced diabetic control, family interventions are a key factor for the improvement of diabetic adolescents' health situation (Wysocki et al., 2000). Behavioral Family Systems Therapy (BFST) improved the relationship between adolescents and their parents and decreased diabetes-related conflicts, both at treatment end and at 6- and 12-month follow-up (Wysocki, Greco, Harris, Bubb, & White, 2001). In addition, there was delayed improvement on treatment adherence with no effects on adjustment to diabetes or diabetic control.

A US trial evaluated the influence of home-based MST on treatment adherence, metabolic control, and hospitalization rate of adolescents with instable diabetes type 1 and diabetic ketoacidosis. Hospitalization rate for diabetic ketoacidosis (DKA) in the MST-condition was significantly lowered, both at treatment termination and at follow-up. Improvement in glycosylated hemoglobin HbA_{1c} was lost at follow-up and increases in blood glucose testing (BGT) were moderated by family composition: only two parent families maintained improvements at follow-up (Ellis, Naar-King, Templin, Frey, & Cunningham, 2007a; Ellis et al., 2005, 2007b, 2008).

Similarly, in a study with families of adolescents with instable diabetes type 1 (Wysocki et al., 2006, 2007) a positive effect was found for an adapted form of Behavioral Family Systems Therapy for Diabetics (BFST-D) when compared with standard care or multifamily educational support. In the BFST-D group, HbA_{1c} was significantly improved at treatment end and at 6- and 18-month-follow-up. A significantly larger number of patients undergoing BFST-D condition showed a moderate or high improvement of treatment adherence and a reduction of family conflicts.

Cakan, Ellis, Templin, Frey, and Naar-King (2007) investigated the development of weight status during the treatment of youths with type 1 diabetes and poor metabolic control, with treatment conditions being MST versus standard medical care. Intention-to-treat analysis showed a significant increase of blood glucose testing and a trend to significant improvement of adolescents' HbA_{1c} in the MST condition, but only in normal weight youths. This implies that young diabetic patients with severe overweight profit less and need a focus on weight loss before a focus on diabetic related behaviors.

In adolescents with *obesity*, ST was more effective than routine pediatric and dietetic treatment, compared to an untreated control group. It resulted in a reduced — but still elevated — body mass index (Flodmark, Ohlsson, Ryden, & Sveger, 1993). In a trial comparing MST with a group weight loss intervention, MST increased family support for behavior changes of index patients, which were directly related to weight status on body fat (Ellis et al., 2010; Naar-King et al., 2009).

Pervasive developmental disorders

In China, children with Asperger disorder were randomly assigned to either a standard treatment behavioral program (TEACH) or TEACH plus systemic family therapy. At the end of treatment, scores on the Autism Behavior Check List had improved significantly more in the family therapy group than in the control group (Lu, 2009).

Other clinically relevant symptoms

We identified two studies on abuse and neglect by parents, which are clinically relevant problems though not a DSM- or ICD-diagnosis. Behavioral parent training and MST both showed similar improvement of parental symptoms. Multisystemic therapy improved parent–child interaction (rated by external observers) more than behavioral parent training, while behavior therapy resulted in a larger reduction of families' social problems (Brunk, Henggeler, & Whelan, 1987). In a second trial, MST for child abuse and neglect (MST-CAN) was more efficacious at end-of-treatment than enhanced outpatient treatment with regard to youth mental health symptoms, parent psychiatric distress, parental behaviors associated with maltreatment and out-of-home placements of youths. The rate of abuse was similar in both conditions, but instances were rare to begin with (Swenson, Schaeffer, Henggeler, Faldowski, & Mayhew, 2010).

No studies were found on the systemic treatment of personality disorders, psychosis, or intellectual disabilities in children and adolescents.

DISCUSSION

How Efficacious is Systemic Therapy with Internalizing Disorders?

In 33 of the studies found, ST was either significantly more efficacious than control groups without a systems oriented intervention, or ST was more efficacious than other evidence-based interventions (individual CBT, psychodynamic therapy, behavioral family therapy/parent-training, family psychoeducation, group therapy, or inpatient treatment). Systemic therapy with child and adolescent patients is particularly efficacious — defined by more than three independent RCTs with positive outcomes — in the treatment of affective disorders and suicidality, eating disorders, and psychosocial factors related to medical conditions.

Research on the efficacy of ST for children and adolescents has focused on certain diagnostic groups, while other important disorders like anxiety and adjustment disorders have been neglected (Retzlaff, Beher, Rotthaus, Schweitzer, & Sydow, 2009).

Methodological recommendations have been presented in an earlier publication (Sydow et al., 2010).

According to the guidelines for classifying evidence-based treatments in couple and family therapy proposed by Sexton et al. (2011), 19 of the trials are on Level I (evidence-informed treatments clearly based on psychological research), as they do not provide a clear description of the treatment; 17 trials can be classified as Level II treatments (promising preliminary results), and only three studies (4.7; 4.10; 2.5) can be classified as "evidence-based treatments" (Level III), as (a) all three specify the content of the treatment model and use treatment manuals; (b) all apply measures of treatment fidelity; (c) all clearly identify client problems; (d) describe service delivery contexts; and (e) use valid measures of clinical outcome. With regard to the levels-of-evidence proposed by Sexton et al. (2011) only a few trials on mixed disorders evaluated the absolute evidence (Category 1: treatment compared to no treatment, s. Tab. 1: trial 1.1, 1.4). Most trials are relative efficacy studies comparing systemic interventions either to treatment as usual (TAU), or to various — specified or unspecified — individual, group, or other family therapies, sometimes to evidence-based, manualized interventions (e.g., individual or group CBT). Category 2, "Efficacious models with verified mechanisms," is not fulfilled by any of the trials reviewed here. With regard to category 3, "Effective models with contextual efficacy," only the trials on MST demonstrate clinical effectiveness with different specific problems (emotional problems, diabetes, and obesity) in different service contexts, but there are only a few trials on any of these conditions and at this time there have been no replications of trials within the diagnostic groups. The Maudsley approach to eating disorders has been applied in various sites and with two conditions (anorexia and bulimia), and also with adult patients (Sydow et al., 2010).

In contrast to other reviewers (Carr, 2000, 2009; Kaslow et al., 2012; Sprenkle, 2002), we focused on trials which investigated systems-oriented treatments rather than family therapy as a setting, and therefore we include a smaller base of trials. The separation into an article on trials on externalizing and one on internalizing disorders does not imply that entirely different systemic approaches are needed. Making a conceptual distinction between trials with a systemic orientation from trials working with behavioral, cognitive, psychodynamic, and other approaches in a family setting complies with the way in which regulations of health care provision are organized in some European countries and long standing traditions in the psychotherapy field. With today's tendency towards psychotherapy integration, one might question the utility of this approach. Yet, currently, psychotherapy regulations in several European countries are still based on the concept of psychotherapy schools. This makes it mandatory to compile evidence on the effectiveness of ST. Otherwise, treatments that have been proven to be highly effective could not be legally provided to youths and their families in need. A possible advantage for this approach could be that the specific merits of a systems perspective in contrast to other approaches might show more clearly.

Within the German health system, only ST and CBT have been acknowledged as scientifically validated treatments for children and adolescents (Wissenschaftlicher Beirat Psychotherapie, 2009). Systemic therapy is particularly effective in the treatment of eating disorders (Lock, 2011), psychological factors effecting somatic illness and affective disorders, conduct disorders and substance use disorders (see Sydow et al., submitted).

Readers should be aware of some limitations of this review. Although considerable effort was made to involve trials in a number of languages, RCT searches in other languages, such as Japanese, might yield additional studies. By including trials across a wide time span (from the 1970s till today), trials with different qualities of methodology are presented in our review, and one should be aware that generally some of the older studies

may not meet more modern research standards. We tried to minimize publication bias in our review by asking experts, with the help of the *American Academy of Family Therapy* (AFTA) and the *European Federation of Family Therapy* (EFTA), about any relevant publications, but we cannot rule out the possibility that unpublished studies were not identified.

While we regard the inclusion of RCTs from a large number of countries as a strength, this might also be considered as a weakness. Delivery of health care interventions and treatment as usual differs considerably from country to country, and it might make a considerable clinical difference if therapy was conducted with only one ethnic group or a variety of patients from various ethnic groups. Therapy approaches need to take into account issues of gender, developmental age, culture, and ethnicity, as well as the larger socio-cultural and health care system of the country in which an RCT is carried out. Treatment programs must be adapted to the specific needs of different cultural groups (Robbins, Horigian, & Szapocznik, 2008). Due to limits of space, we were not able to provide data on the above mentioned categories, and information was not always provided in the description of the trials. In recent years, multi-centered studies in different countries have been carried out. In our reviews, we found evidence that systemic approaches work across many nations, that is, the Maudsley approach has been successfully applied in the UK and the USA. In the trial of Trowell et al. (2007), the systemic intervention was successful in diverse countries (Finland, Great Britain, and Greece). Systemic therapy, as a treatment orientation, has been successfully employed in a wide range of countries with internalizing disorder in the USA, Canada, Argentina, China and Hong Kong, Finland, Greece, Italy, Sweden, and the UK; with externalizing disorders in the USA, Germany, the Netherlands, Norway, Sweden, the UK; and China (Sydow et al., in press); with adult patients in the USA, Belgium, Finland, Germany, Italy, the Netherlands, Spain, UK, Turkey, and China (Sydow et al., 2010). One might demand that a manualized treatment should be tested for different ethnic groups and levels of society. This might work if there is a small number of fairly large ethnic groups in a country, but this demand might be hard to fulfill if a country has a large number of ethnic groups with a small number of members. Broad categories such as Black, Asian, Caucasian might blur differences within these groups, because of religion, different family histories, socio-economic, migration, or regional differences. Before the rise of manualized treatments, psychotherapy and ST were supposed to be tailored to the individual needs of each family; therapists were requested to adapt their approach to the specific culture of the family, including their social status and ethnicity (Fraenkel, 1995) — to be meaningful, psychotherapies might need both sound evidence from standardized treatments as well as an ideographic approach which takes into account the individuality of families. Future research and analyses should allow for a more fine-grained analysis of the role of ethnicity, race, socioeconomic group, and nationality and its possible relation to outcome.

Excluding combinations of approaches (e.g., of ST with family psychoeducation) might present a somewhat skewed picture, giving the impression that effective treatments for conditions such as bipolar disorders, obsessive-compulsive disorders, or anxiety disorders are wanting. However, we focused on trials with systemic treatments, and much more research is needed for the combination of systems-oriented treatment with other forms of interventions such as psychoeducation.

Results of this systematic review show that ST in its different settings (family, group, multi-family group, individual therapy) is an efficacious approach for the treatment of children and adolescents suffering from internalizing psychological disorders, such as mood and eating disorders and psychological factors affecting physical illness.

Based on prior reviews by our research team (Sydow, Beher, Retzlaff, & Schweitzer, 2007b; Sydow et al., 2006, 2007a), ST has been granted the status of an evidence-based treatment approach for children and adolescents as well as for adults by the federal *German Scientific Approval Board for Psychotherapy* (Wissenschaftlicher Beirat Psychotherapie, 2009). In the light of current evidence, ST is qualified as one of the major evidence-based treatments. Considerable further research is needed on the treatment of diagnostic groups such as anxiety disorders, somatoform disorders, and the processes that lead to substantive change.

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**Meta-analysis (including Cochrane Reviews): described in the results section.

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