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The evidence base for family therapy and systemic interventions for child-focused problems

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This review updates similar articles published in the *Journal of Family Therapy* in 2001 and 2009. It presents evidence from meta-analyses, systematic literature reviews and controlled trials for the effectiveness of systemic interventions for families of children and adolescents with various difficulties. In this context, systemic interventions include both family therapy and other family-based approaches such as parent training. The evidence supports the effectiveness of systemic interventions either alone or as part of multi-modal programmes for sleep, feeding and attachment problems in infancy; child abuse and neglect; conduct problems (including childhood behavioural difficulties, attention deficit hyperactivity disorder, delinquency and drug misuse); emotional problems (including anxiety, depression, grief, bipolar disorder and self-harm); eating disorders (including anorexia, bulimia and obesity); somatic problems (including enuresis, encopresis, medically unexplained symptoms and poorly controlled asthma and diabetes) and first episode psychosis.

Introduction

This article summarizes the evidence base for systemic practice with child-focused problems and updates previous similar articles (Carr, 2000, 2009). It is also a companion article to a review of research on systemic interventions for adult-focused problems (Carr, 2014). In this article a broad definition of systemic practices has been used, covering family therapy and other family-based interventions such as parent training or multisystemic therapy, which engage family members or members of the families' wider networks in the process of resolving problems for young people from birth up to the age of 18 years. One-to-one services (such as home visiting for vulnerable mothers of young children) and complex interventions (such as multi-component care packages for people with intellectual and developmental disabilities), which are arguably systemic interventions but which differ in

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many practical ways from family therapy, were excluded from this review.

Sprenkle (2012) edited a special issue of the *Journal and Marital and Family Therapy* on research and concluded that a large and growing evidence base now supports the effectiveness of systemic interventions. This work updates previous special issues of the *Journal and Marital and Family Therapy* (Pinsof and Wynne, 1995; Sprenkle, 2002). Shadish and Baldwin (2003) reviewed twenty meta-analyses of systemic interventions for a wide range of child and adult-focused problems. The average effect size across all meta-analyses was 0.65 after therapy and 0.52 at 6–12-months follow up. These results show that, overall, the average treated family fared better after therapy and at follow up than over 71 per cent of families in control groups.

If there is little doubt now about the fact that family therapy works, the next key question to address is its cost-effectiveness. In an important series of US studies, Crane and Christenson (2012) showed that family therapy reduces health service usage, especially for frequent service users, and that family therapy is associated with greater benefits than individual therapy. The medical cost offset associated with family therapy covers the cost of providing therapy and in many cases leads to overall cost savings. Crane drew these conclusions from studies of a US health maintenance organization with 180,000 subscribers, the Medicaid system of the State of Kansas, CIGNA Behavioural Health which is a division of a health insurance company with nine million subscribers, and a US family therapy training clinic.

While evidence for the overall efficacy, effectiveness and cost-effectiveness of systemic interventions is vital for healthcare policy development and management, detailed research findings on what works for whom are required by family therapists who wish to engage in research-informed practice. The remainder of this article focuses on precisely this issue. As with previous versions of this review, extensive computer and manual literature searches were conducted for systemic interventions with a wide range of problems of childhood and adolescence. For the present review the search extended to July 2013. Major databases, family therapy journals and child and adolescent mental health journals were searched, as well as key textbooks on evidence-based practice. Where available, meta-analyses and systematic review articles were selected for review, since these constitute the strongest form of evidence. If such articles were unavailable, controlled trials, which constitute the next highest level of evidence, were selected. Only in the absence of such trials were uncontrolled studies

selected. It was intended that this article be primarily a review of the reviews, with a major focus on substantive findings of interest to practicing therapists rather than on methodological issues. This overall review strategy was adopted to permit the strongest possible case to be made for systemic evidence-based practices for a wide range of child-focused problems and to offer useful guidance for therapists, within the space constraints of a single article. Below, the results of the review are presented under the following headings: problems of infancy, child abuse and neglect, conduct problems, emotional problems, eating disorders, somatic problems and psychosis.

Problems of infancy

Family-based interventions are effective for a proportion of families in which infants have sleeping, feeding and attachment problems. These difficulties occur in about one- quarter to one-third of infants and are of concern because they may compromise family adjustment and later child development (Zennah, 2012).

Sleep problems

Family-based behavioural programmes are an effective treatment for settling and night waking problems, which are the most prevalent sleep difficulties in infancy (Hill, 2011). In these programmes parents are coached in reducing or eliminating children's daytime naps, developing positive bedtime routines, reducing parent–child contact at bedtime or during episodes of night waking and introducing scheduled waking where children are awoken 15–60 minutes before the child's spontaneous waking time and then resettled. A systematic review of 52 studies of family-based behavioural programmes for sleep problems in young children by Mindell *et al*. (2006), and of nine randomized controlled trails of family-based and pharmacological interventions by Ramchandani *et al*. (2000) indicate that both family-based and pharmacological interventions are effective in the short term but only systemic interventions have positive long-term effects on children's sleep problems.

Feeding problems

Severe feeding problems in infancy, which may be associated with a failure to thrive, include self-feeding difficulties, swallowing problems,

frequent vomiting and, in the most extreme cases, food refusal. With food refusal there is refusal to eat all or most foods, resulting in dependence on supplemental tube feeds or a failure to meet caloric needs. Family-based behavioural programmes are particularly effective in addressing food refusal (Kedesdy and Budd, 1998; Sharp *et al.,* 2010). Such programmes involve parents prompting, shaping and reinforcing successive approximations to appropriate feeding behaviour while concurrently preventing children from escaping from the feeding situation, ignoring inappropriate feeding responses and making the feeding environment pleasant for the child. Small spoonfuls of preferred foods are initially used in these programmes. Gradually, bite sizes are increased and non-preferred nutritious food is blended with preferred food. In a systematic review of forty-eight controlled single case and group studies, Sharp *et al*. (2010) concluded that such programmes were effective in ameliorating severe feeding problems and improving weight gain in infants and children, particularly those with developmental disabilities.

Attachment problems

Infant attachment insecurity is a risk factor for internalizing (Madigan *et al.,* 2013) and externalizing (Fearon *et al.,* 2010) problems in childhood and adult psychological difficulties (Dozier *et al.,* 2008). A range of short-term and long-term evidence-based family interventions, each supported by a series of controlled trials, has been developed to foster attachment security in families with varying degrees of vulnerability (Berlin *et al.,* 2008; Zeanah *et al.,* 2011). For high-risk families in which parents have histories of childhood adversity and whose current families are characterized by high levels of stress, low levels of support and domestic violence or child abuse, intensive longer term interventions have been shown to be effective in improving attachment security. These involve weekly clinical sessions or home visiting and span 1–2 years. For example, child–parent psychotherapy involves weekly dyadic sessions with mothers and children for about a year (Lieberman and Van Horn, 2005). Child–parent psychotherapy helps mothers resolve ambivalent feelings about their infants by linking them to their own adverse childhood experiences and current life stresses in the context of a supportive long-term therapeutic alliance. For less vulnerable families, briefer interventions involving a few carefully structured home-visiting sessions and video feedback on parent–child interaction have been shown to be effective in improving

attachment security. For example, with Juffer *et al*.'s (2007) video feedback intervention to promote positive parenting, in four home visits parents are given feedback on videotapes of their interactions with their infants, written materials on attachment, and an opportunity to discuss the impact of their own family of origin experiences on the way they interact with their infants.

The results of this review suggest that in developing services for families of infants with sleeping and feeding problems only relatively brief outpatient programmes are required involving up to fifteen sessions over 3–4 months for each episode of treatment. For attachment problems, the intensity of intervention needs to be matched to the level of family vulnerability.

Child abuse and neglect

Systemic interventions are effective in a proportion of cases of child abuse and neglect. These problems have devastating effects on the psychological development of children (Myers, 2011). In a series of meta-analyses of international studies Stoltenborgh *et al*. (2011, 2012, 2013a, 2013b) found prevalence rates based on self-reports of 22.6 per cent for physical abuse, 12.7 per cent for contact sexual abuse, 36.3 per cent for emotional abuse, 16.3 per cent for physical neglect and 18.4 per cent for emotional neglect.

Physical abuse and neglect

Systematic narrative reviews concur that for physical child abuse and neglect, effective therapy is family-based and structured. It extends over periods of at least 6 months and addresses specific problems in relevant subsystems, including children's post-traumatic adjustment problems; parenting skills deficits and the overall supportiveness of the family and social network (Chaffin and Friedrich, 2004; Edgeworth and Carr, 2000; MacDonald, 2001; MacLeod and Nelson, 2000; Skowron and Reinemann, 2005; Tolan *et al*., 2005). Cognitive behavioural family therapy (Kolko, 1996; Kolko and Swenson, 2002; Rynyon and Deblinger, 2013), parent–child interaction therapy (Chaffin *et al*., 2004; Hembree-Kigin and McNeil, 1995; Timmer *et al*., 2005), and multisystemic therapy (Brunk *et al*., 1987; Henggeler *et al*., 2009) are manualized approaches to family-based treatment that have been shown in randomized controlled trials to reduce the risk of further physical child abuse.

Cognitive behavioural family therapy for physical abuse. In a controlled trial Kolko (1996) found that at 1-year follow up conjoint cognitive behavioural family therapy and concurrent parent and child cognitive behavioural therapy were both more effective than routine services in reducing the risk of further abuse in families of schoolaged children in which physical abuse had occurred. The sixteen-session programme involved helping parents and children develop skills for regulating angry emotions, communicating and managing conflict and developing alternatives to physical punishment as a disciplinary strategy (Kolko and Swenson, 2002).

Parent–child interaction therapy for physical abuse. In a controlled trial of parent–child interaction therapy, Chaffin *et al*. (2004) found that at 2-years follow up only 19 per cent of parents who participated in parent–child interaction therapy had a re-report for physical abuse compared with 49 per cent of parents assigned to standard treatment. Parent–child interaction therapy involved sessions that aimed to enhance parents' motivation to engage in parent training; seven sessions devoted to the live coaching of parents and children in positive child-directed interactions and seven sessions devoted to the live coaching of parents and children in the behavioural management of discipline issues, using time-out and related procedures.

Multisystemic therapy for physical abuse and neglect. Brunk *et al*. (1987) compared the effectiveness of multisystemic therapy and group-based behavioural parent training in families where physical abuse or neglect had occurred. Families who received multisystemic therapy showed greater improvements in family problems and parent–child interactions after treatment than those who engaged in group-based behavioural parent training. Multisystemic therapy involved joining with family members and members of their wider social and professional network, reframing interaction patterns and prescribing tasks to alter problematic interaction patterns within specific subsystems (Henggeler *et al*., 2009). Therapists designed intervention plans on a per-case basis in light of family assessments. They used individual, couple, family and network meetings in these plans and received regular supervision to facilitate this process, carrying small caseloads of four to six families.

Sexual abuse

For child sexual abuse, trauma-focused cognitive behavioural therapy for both the abused young people and their non-abusing parents has

been shown to reduce the symptoms of post-traumatic stress disorder and improve overall adjustment (Deblinger and Heflinger, 1996). In a systematic review of thirty-three trials, twenty-seven of which evaluated trauma-focused cognitive behavioural therapy, Leenarts *et al*. (2012) found that patients treated with this approach fared better than those who received standard care. The results of this review suggest that trauma-focused cognitive behavioural therapy is the best supported treatment for children following childhood maltreatment. Trauma-focused cognitive behavioural therapy involves concurrent sessions for abused children and their non-abusing parents in group or individual formats, with periodic conjoint parent–child sessions, Where intra-familial sexual abuse has occurred it is essential that offenders live separately from victims until they have completed a treatment programme and been assessed as being at low risk for re-offending (Doren, 2006). The child-focused component involves exposure to abuse-related memories to facilitate habituation to them; relaxation and coping skills training; learning assertiveness and safety skills and addressing victimization, sexual development and identity issues. Concurrent work with non-abusing parents and conjoint sessions with abused children and non-abusing parents focus on helping parents develop supportive and protective relationships with their children and develop support networks for themselves.

The results of this review suggest that in developing services for families in which abuse or neglect has occurred, programmes that begin with a comprehensive network assessment and include, along with regular family therapy sessions, the option of parent-focused and child-focused interventions should be prioritized. Programmes should span at least 6 months, with the intensity of input matched to families' needs. Therapists should carry small caseloads of fewer than ten cases.

Conduct problems

Family-based systemic interventions are effective for a proportion of cases of childhood behaviour problems (or oppositional defiant disorder), attention deficit hyperactivity disorder (ADHD), pervasive adolescent conduct problems and drug misuse. All these difficulties are of concern because they may lead to comorbid academic, emotional and relationship problems and, in the long-term, to adult adjustment difficulties (Pliszka, 2008). They are also relatively common. In a review of community surveys, Merikangas *et al*. (2009)

found that the median prevalence rate for disruptive behaviour disorders (including oppositional defiant disorder and conduct disorder) was 6 per cent; for ADHD it was 3–4 per cent and for adolescent substance use disorders it was 5 per cent. Prevalence rates for these types of problems ranged from 1–24 per cent across studies and were all more common in boys.

Childhood behaviour problems

Childhood behaviour problems are maintained by both personal attributes (such as self-regulation problems) on the one hand, and contextual factors (such as problematic parenting practices) on the other. Treatment programmes have been developed to target each of these sets of factors. Many meta-analyses and systematic reviews covering an evidence base of over 100 studies conclude that behavioural parent training is particularly effective in ameliorating childhood behaviour problems, leading to improvement in 60–70 per cent of children, with gains maintained at a 1-year follow up, particularly if periodic review sessions are offered (Barlow *et al.,* 2002; Behan and Carr, 2000; Brestan and Eyberg, 1998; Burke *et al.,* 2002; Comer *et al.,* 2013; Coren *et al.,* 2002; Farrington and Welsh, 2003; Kazdin, 2007; Leijten *et al.,* 2013; Lundahl, *et al.,* 2008; Michelson *et al.,* 2013; Nixon, 2002; Nock, 2003; Nowak and Heinrichs, 2008; Serketich and Dumas, 1996). Behavioural parent training also has a positive impact on parental adjustment problems. For example, in meta-analyses of parent training studies Serketich and Dumas (1996) found an effect size of 0.44 and McCart *et al*. (2006) found an effect size of 0.33 for parental adjustment. Thus, the average participant in parent training fared better than 63–65 per cent of control group cases. Behavioural parent training is far more effective than individual therapy. For example, in a meta-analysis of thirty studies of behavioural parenting training and forty-one studies of individual therapy, McCart *et al*. (2006) found effect sizes of 0.45 for parent training and 0.23 for individual therapy. Meta-analyses also show that behavioural parent training is as effective in routine community settings as it is in specialist programme development clinics (Michelson *et al.,* 2013). Furthermore, the inclusion of fathers in parent training leads to greater improvement in child behaviour problems and parenting practices (Lundahl *et al.,* 2008) and the more intensive programmes are more effective (Nowak and Heinrichs, 2008).

A critical element of behavioural parent training, which derives from Gerald Patterson's seminal work at the Oregon Social Learning Centre, is helping parents develop skills for increasing the frequency of children's prosocial behaviour (through attending, reinforcement and engaging in child-directed interactions) and reducing the frequency of antisocial behaviour (through ignoring, time-out, contingency contracts and engaging in parent directed interactions) (Forgatch and Paterson, 2010).

Immediate feedback, video feedback and video modelling have been used in effective behavioural parent training programmes. With video feedback, parents learn child management skills by watching videotaped episodes of themselves using parenting skills with their own children. With immediate feedback, parents are directly coached in child-management skills through a 'bug in the ear' while the therapist observes their interaction with their children from behind a one-way mirror. Eyberg's parent–child interaction therapy for parents of preschoolers is a good example of this approach (Zisser and Eyberg, 2010). With video modelling, parents learn child management skills through viewing video clips of actors illustrating successful and unsuccessful parenting skills. Webster-Stratton's Incredible Years programme is an example of this type of approach (Webster-Stratton and Reid, 2010).

The effectiveness of behavioural parent training programmes may be enhanced by concurrently engaging children in therapy that aims to remediate deficits in self-regulation skills, such as managing emotions and social problem-solving (Kazdin, 2010; Webster-Stratton and Reid, 2010).

In a meta-analysis of thirty-one studies, Reyno and McGrath (2006) found that parents with limited social support, high levels of poverty-related stress, and mental health problems derived the least benefit from behavioural parent training. To address these barriers to effective parent training, adjunctive interventions that address parental vulnerabilities have been added to standard parent training programmes, with positive incremental benefits. For example, Thomas and Zimmer-Gembeck (2007) found that enhanced versions of the parent–child interaction therapy (Zisser and Eyberg, 2010) and triple-P (Sanders and Murphy-Brennan 2010) programmes, which included additional sessions on parental support and stress management, were far more effective than standard versions of these programmes.

The results of this review suggest that in developing services for families where childhood behaviour problems are a central concern,

behavioural parent training should be offered, with the option of additional child-focused and parent-focused interventions being offered where the assessment indicates particular vulnerabilities in these subsystems. Programmes should span at least 6 months, with the intensity of input matched to families' needs. Each aspect of the programme should involve about ten to twenty sessions, depending on need.

Attention and overactivity problems

ADHD is currently the most commonly used term for a syndrome, usually present from infancy, characterized by persistent overactivity, impulsivity and difficulties sustaining attention. Available evidence suggests that vulnerability to attentional and overactivity problems, unlike the oppositional behavioural problems discussed in the section above, is largely constitutional (Thapar *et al.,* 2013).

The results of meta-analyses suggest that a proportion of preschool children with ADHD show significant improvement in response to behavioural parent training (Lee *et al.,* 2012; Rajwan *et al.,* 2012). For children who do not respond to systemic interventions alone, systematic reviews concur that systemic interventions for ADHD are best offered as elements of multi-modal programmes involving stimulant medication (Anastopoulos *et al.,* 2005; DuPaul *et al.,* 2012; Friemoth, 2005; Hinshaw *et al.,* 2007; Jadad *et al.,* 1999; Klassen *et al.,* 1999; Nolan and Carr, 2000; Schachar *et al.,* 2002). For example, Hinshaw *et al*. (2007) in a review of fourteen randomized controlled trials, concluded that about 70 per cent of children with ADHD benefited from multi-modal programmes. Multi-modal programmes typically include stimulant treatment of children with drugs such as methylphenidate combined with family therapy or parent training; school-based behavioural programmes and coping skills training for children. Family therapy for ADHD focuses on helping families develop patterns of organization conducive to effective child management (Anastopoulos *et al.,* 2005). Such patterns of organization include a high level of parental co-operation in problem-solving and child management; a clear intergenerational hierarchy between parents and children; warm supportive family relationships; clear communication and clear, moderately flexible, rules, roles and routines. School-based behavioural programmes involve the extension of home-based behavioural programmes into the school setting through home–school, parent–teacher liaison meetings (DuPaul *et al.,* 2012).

Coping skills training focuses on coaching children in the skills required for managing their attention, impulsivity, aggression and overactivity (Hinshaw, 2005).

Medicated children with ADHD show a reduction in symptomatology and an improvement in both academic and social functioning, although the positive effects dissipate when medication ceases if systemic interventions to improve symptom control, such as those outlined above, have not been provided concurrently with the medication. One of the most remarkable findings of the multi-modal treatment study of ADHD (MTA) – the largest ever long-term controlled trial of stimulant medication for ADHD involving over 500 patients – is that stimulant medication ceased to have a therapeutic effect after 3 years (Swanson and Volkow, 2009). It also led to a reduction in height gain of about 2 cm and a reduction in weight gain of about 2 kg. Furthermore, it did not prevent adolescent substance misuse as expected. The MTA trial showed that tolerance to medication used to treat ADHD occurs and this medication has negative side effects. These findings underline the importance of using medication to reduce ADHD symptoms to manageable levels for a time-limited period, while children and their parents engage in systemic interventions to develop skills to manage symptoms.

These results suggest that in developing services for families where children have attention and overactivity problems, multi-modal treatment which includes family, school and child-focused interventions combined with stimulant therapy, spanning at least 6 months in the first instance, is the treatment of choice. For effective long-term treatment, infrequent but sustained contact with a multidisciplinary service over the course of the child's development should be made available so that at transitional points in each yearly cycle (such as entering a new school classes each autumn) and at transitional points within the life cycle (such as entering adolescence, changing school or moving house) increased service contact may be offered.

Pervasive conduct problems in adolescence

About one-third of children with childhood behaviour problems develop conduct disorder, which is a pervasive and persistent pattern of antisocial behaviour that extends beyond the family into the community. Adolescent self-regulation and skills deficits, problematic parenting practices and extra-familial factors such as deviant peer group membership, high stress and low social support maintain conduct

disorder and are targeted by effective treatment programmes (Murrihy *et al.,* 2010).

In a meta-analysis of twenty-four studies Baldwin *et al*. (2012) evaluated the effectiveness of brief strategic family therapy (Robbins *et al.,* 2010), functional family therapy (Alexander *et al.,* 2013), multisystemic therapy (Henggeler and Schaeffer, 2010) and multidimensional family therapy (MDTF) (Liddle, 2010). They found that all four forms of family therapy were effective compared with non-treatment control groups (with an effect size of 0.7) and somewhat more effective than treatment as usual or alternative treatments (where the effect sizes were about 0.2). These results showed that the average case treated with family therapy fared better than 76 per cent of untreated patients and 58 per cent of patients who engaged in alternative treatments. These results are consistent with those from a previous meta-analysis of eight family-based treatment studies of adolescent conduct disorder conducted by Woolfenden *et al*. (2002). They found that family-based treatments, including functional family therapy, multisystemic therapy and treatment foster care were more effective than routine treatment. These family-based treatments significantly reduced time spent in institutions, the risk or re-arrest and recidivism 1–3 years following treatment. For each of these approaches, organizations to facilitate the large-scale transport of treatments to community settings have been developed along with quality assurance systems to support treatment fidelity in these settings (Henggeler and Sheidow, 2012). These effective family-based interventions for adolescent conduct disorder fall on a continuum of care which extends from functional family therapy and brief strategic therapy through more intensive multisystemic therapy to very intensive treatment foster care. What follows are brief outlines of three of these models.

Functional family therapy. This model was developed initially by James Alexander at the University of Utah and more recently by Tom Sexton at the University of Indiana (Alexander *et al.,* 2013; Sexton, 2011). It is a manualized model of systemic family therapy for adolescent conduct disorder. It involves distinct stages of engagement where the emphasis is on forming a therapeutic alliance with family members, behaviour change, where the focus is on facilitating competent family problem-solving and generalization, where families learn to use new skills in a range of situations and to deal with setbacks. Whole family sessions are conducted on a weekly basis. Treatment spans eight to thirty sessions over 3–6 months. In a systematic review of twenty-seven clinical trials of

functional family therapy, Alexander *et al*. (2013) concluded that this approach is effective in reducing recidivism by up to 70 per cent in adolescent offenders with conduct disorders from a variety of ethnic groups over follow-up periods of up to 5 years, compared with those receiving routine services. It also leads to a reduction in conduct problems in the siblings of offenders. In a review of a series of large-scale effectiveness studies, Sexton and Alexander (2003) found that functional family therapy was $5,000–12,000 less expensive per case than juvenile detention or residential treatment and led to cost savings for victims and the criminal justice system of over $13,000 per case. The same review concluded that in a large-scale effectiveness study the drop-out rate for functional family therapy was about 10 per cent compared to the usual drop-out rates of 50–70 per cent in the routine community treatment of adolescent offenders.

Multisystemic therapy. This model was developed at Medical University of South Carolina by Scott Henggeler and his team (Henggeler *et al*., 2009). Multisystemic therapy combines intensive family therapy with individual skills training for adolescents and intervention in the wider school and inter-agency network. Multisystemic therapy involves helping adolescents, families and involved professionals understand how adolescent conduct problems are maintained by recursive sequences of interaction within the youngsters' family and social network. It uses individual and family strengths to develop and implement action plans and new skills to disrupt these problem maintaining patterns. Furthermore, it supports families to follow through on action plans, helping them use new insights and skills to handle new problem situations and monitoring progress in a systematic way.

Multisystemic therapy involves regular, frequent home-based family and individual therapy sessions with additional sessions in school or community settings over 3 to 6 months. Therapists carry low caseloads of no more than five cases and provide 24-hour, 7-day availability for crisis management. In a meta-analysis of eleven studies evaluating the effectiveness of multisystemic therapy, Borduin *et al*. (2004) found a post-treatment effect size of 0.55, which indicates that the average treated case fared better than 72 per cent of control group cases receiving standard services. Positive effects were maintained up to 4 years after treatment.

Multisystemic therapy had a greater impact on improving family relations than on improving individual adjustment or peer relations. In a systematic review of eighteen studies Henggeler and

Schaeffer (2010) concluded that, compared with treatment-as-usual, multisystemic therapy led to significant improvements in individual and family adjustment, which contributed in turn to significant reductions in conduct problems, psychological adjustment, drug use, school absence, out-of home placement and recidivism. Improvements were found to be sustained at long-term follow up for up to 14 years and entailed significant savings in placement, juvenile justice and crime victim costs.

Multidimensional treatment foster care. This model was developed at the Oregon Social Learning Centre by Patricia Chamberlain and her team (Chamberlain, 2003). Multidimensional treatment foster care combines procedures similar to multisystemic therapy, with specialist foster placement in which foster parents use behavioural principles to help adolescents modify their conduct problems. Treatment foster-care parents are carefully selected and before an adolescent is placed with them they undergo intensive training. This focuses on the use of behavioural parenting skills for managing antisocial behaviour and developing positive relationships with antisocial adolescents. They also receive ongoing support and consultancy throughout placements that last 6–9 months. Concurrently, the young person or their biological family engage in weekly family therapy with a focus on parents developing behavioural parenting practices and families developing communication and problem-solving skills. Adolescents also engage in individual therapy, and wider systems consultations are carried out with the youngsters' teachers, probation officers and other involved professionals, to ensure all relevant members of youngsters' social systems are cooperating in ways that promote their improvement. About 85 per cent of adolescents return to their parents' home after treatment foster care. In a review of three studies of treatment foster care for delinquent male and female adolescents Smith and Chamberlain (2010) found that, compared with care in a group home for delinquents, multidimensional treatment foster care significantly reduced running away from placement as well as the re-arrest rate and self-reported violent behaviour. The benefits of multidimensional treatment foster care were due to the improvement in the parents' skills in managing adolescents in a consistent, fair and non-violent way, and reductions in the adolescents' involvement with deviant peers. These positive outcomes of multidimensional treatment foster care entailed cost savings of over $40,000 per case in juvenile justice and crime victim costs (Chamberlain and Smith, 2003).

From this review it may be concluded that, in developing services for families of adolescents with conduct disorder, it is most efficient to offer services on a continuum of care. Less severe cases may be offered up to thirty sessions of functional family therapy over a 6-month period. Moderately severe cases and those that do not respond to circumscribed family interventions may be offered up to 20 hours per month of multisystemic therapy over a period of up to 6 months. Extremely severe cases and those who are unresponsive to intensive multisystemic therapy may be offered treatment foster care for a period of up to year and this may then be followed with ongoing multisystemic intervention. It is essential that such a service involves high levels of supervision and low caseloads for front-line clinicians because of the high stress load that these cases entail and the consequent risk of therapist burnout.

Drug misuse in adolescence

In a systematic narrative review of forty-five trials of treatments for adolescent drug users, Tanner-Smith *et al*. (2013) concluded that family therapy is more effective than other types of treatment including cognitive behavioural therapy, motivational interviewing, psychoeducation and various forms of individual and group counselling. A series of systematic reviews and meta-analyses support the effectiveness of family therapy programmes in the treatment of adolescent drug misuse (Austin *et al.,* 2005; Baldwin *et al.,* 2012; Becker and Curry, 2008; Rowe, 2012; Vaughn and Howard, 2004; Waldron and Turner, 2008). Effective programmes include MDTF (Liddle, 2010), brief strategic family therapy (Robbins *et al.,* 2010), functional family therapy (Waldron and Brody, 2010) and multisystemic therapy (Henggeler and Schaeffer, 2010). These programmes also lead to the amelioration of conduct problems (mentioned in the previous section), family functioning and school performance, as well as leading to a reduction in contact with deviant peers (Rowe, 2012). Brief outlines of MDTF and brief strategic family therapy are given below to indicate the type of clinical practices associated with these evidence-based models.

MDTF. This model was developed by Howard Liddle and his team at the Centre for Treatment Research on Adolescent Drug Abuse at the University of Miami (Liddle, 2010). MDTF involves assessment and intervention in four domains: including (i) adolescents, (ii) parents, (iii) interactions within the family and (iv) family interactions with other agencies such as schools and courts. Three distinct phases

characterize MDFT and these include engaging families in treatment; working with themes central to recovery and consolidating treatment gains and disengagement. MDFT involves between sixteen and twenty-five sessions over 4–6 months. Treatment sessions may include adolescents, parents, whole families and involved professionals and may be held in the clinic, home, school, court or other relevant agencies. Rowe and Liddle (2008) conducted a thorough review of the evidence base for MDFT and concluded that it is effective in reducing alcohol and drug misuse, behavioural problems, emotional symptoms, negative peer associations, school failure and family difficulties associated with drug misuse.

Brief strategic family therapy. This model was developed at the Centre for Family Studies at the University of Miami by Josè Szapocznik and his team (Robbins *et al.,* 2010). Brief strategic family therapy aims to resolve adolescent drug misuse by improving family interactions that are directly related to substance use. This is achieved within the context of conjoint family therapy sessions by coaching family members to modify such interactions when they occur and to engage in more functional interactions. The main techniques used in brief strategic family therapy are engaging with families, identifying maladaptive interactions and family strengths and restructuring maladaptive family interactions. The model was developed for use with minority ethnicity families, particularly Hispanic families, and therapists facilitate healthy family interactions based on appropriate cultural norms. Where there are difficulties engaging with whole families, the therapists work with motivated family members to engage less motivated family members in treatment. Where parents cannot be engaged in treatment, a one-person adaptation of brief strategic family therapy has been developed. Brief strategic family therapy involves twelve to thirty sessions over 3–6 months, with treatment duration and intensity being determined by problem severity. In a thorough review of research on this approach, Santisteban *et al*. (2006) concluded that it was effective in engaging adolescents and their families in treatment, reducing drug abuse and recidivism and improving family relationships. There is also empirical support from controlled trials for the efficacy of its strategic engagement techniques for inducting resistant family members in treatment, and for one-person family therapy in cases where parents resist engagement in treatment.

This review suggests that services for adolescent drug misuse should involve an intensive family engagement process and thorough

assessment, followed by regular family sessions over a 3–6 month period, coupled with direct work with youngsters and other involved professionals. The intensity of therapy should be matched to the severity of the youngster's difficulties. Where appropriate, medical assessment, detoxification or methadone maintenance should also be provided.

Emotional problems

Family-based systemic interventions are effective for a proportion of cases with anxiety disorders, depression, grief following parental bereavement, bipolar disorder and self-harm. All these emotional problems cause youngsters and their families considerable distress and in many cases prevent young people from completing developmental tasks such as school attendance and developing peer relationships. In a review of community surveys, Merikangas *et al*. (2009) found that the median prevalence rate for anxiety disorders was 8 per cent, with a range of 2–24 per cent; the median prevalence rate for major depression was 4 per cent, with a range of 0.2–17 per cent and the prevalence of bipolar disorder in young people was under 1 per cent. Between 1.5 and 4 per cent of children under the age of 18 lose a parent by death, and a proportion of these show complicated grief reactions (Black, 2002). Community-based studies show that about 10 per cent of adolescents report having self-harmed; for some of these teenagers suicidal intent motivates their self-harm; and self-harm is more common among girls, while completed suicide is more common among boys (Hawton *et al.*, 2012).

Anxiety

Anxiety disorders in children and adolescents include separation anxiety, selective mutism, phobias, social anxiety disorder, generalized anxiety disorder, obsessive compulsive disorder (OCD) and post-traumatic stress disorder (American Psychiatric Association, 2013; World Health Organization, 1992). All are characterized by excessive fear and avoidance of particular internal experiences or external situations. Systematic reviews of the effectiveness of family-based cognitive behavioural therapy for child and adolescent anxiety disorders show that it is at least as effective as individual cognitive behavioural therapy; more effective than individual therapy in cases where parents also have anxiety disorders and more effective than individual

interventions in improving the quality of family functioning (Barmish and Kendall, 2005; Creswell and Cartwright-Hatton, 2007; Diamond and Josephson, 2005; Drake and Ginsburg, 2012; Kaslow *et al.,* 2012; Reynolds *et al.,* 2012; Silverman *et al.,* 2008). Barrett's *FRIENDS* programme is the best validated family-oriented cognitive behavioural therapy intervention for childhood anxiety disorders (Barrett and Shortt, 2003; Pahl and Barrett, 2010). In this programme children attend ten weekly group sessions and parents join these 90-minute sessions for the last 20 minutes to become familiar with the programme content. There are also a couple of dedicated family sessions and 1-month and 3-month follow-up sessions for relapse prevention. Both children and parents engage in psycho-education about anxiety, which provides a rationale for anxious children to engage in gradual exposure to feared stimuli, which is essential for effective treatment. Children and parents also engage in communication and problem-solving skills training to enhance the quality of parent–child interaction.

In the child-focused element of the programme youngsters learn anxiety management skills such as relaxation, cognitive coping and using social support, and use these skills to manage anxiety associated with gradual exposure to feared stimuli. In the family-based component, parents learn to reward their children's use of anxiety management skills when facing feared stimuli, ignore their children's avoidant or anxious behaviour and manage their own anxiety.

School refusal. School refusal is usually due to separation anxiety disorder where children avoid separation from parents as this leads to intense anxiety. Systematic reviews have concluded that behavioural family therapy leads to recovery for more than two-thirds of patients and this improvement rate is significantly higher than that found for individual therapy (Elliott, 1999; Heyne and Sauter 2013; King and Bernstein, 2001; King *et al.,* 2000; Pina *et al.,* 2009). Effective therapy begins with a careful systemic assessment to identify anxiety triggers and obstacles to anxiety control and school attendance. Children, parents and teachers are helped to collaboratively develop a return-to-school plan, which includes coaching children in relaxation, coping and social skills to help them deal with anxiety triggers. Parents and teachers are then helped to support and reinforce children for using anxiety management and social skills to deal with the challenges which occur during their planned return to regular school attendance.

OCD. With OCD children compulsively engage in repetitive rituals to reduce anxiety associated with cues such as dirt or lack of symmetry.

In severe cases, children's lives become seriously constricted due to the time and effort they invest in compulsive rituals. Family life comes to be dominated by other family member's attempts to accommodate to or prevent these rituals. A series of trials has shown that family-based cognitive behavioural exposure and response-prevention treatment is effective in alleviating symptoms in 50–70 per cent of cases of paediatric OCD. The best treatment response occurs where such interventions are combined with selective serotonin re-uptake inhibitors (SSRI) such as sertraline and that family-based cognitive behavioural therapy is more effective than SSRI alone (Franklin *et al.,* 2010; Moore *et al.,* 2013; Watson and Rees, 2008). Treatment is offered on an individual or group basis to children with concurrent family sessions over about 4 months. Family intervention involves psychoeducation about OCD and its treatment through exposure and response prevention, externalizing the problem, monitoring symptoms and helping parents and siblings support and reward the child for completing exposure and response-prevention homework exercises. Family therapy also helps parents and siblings avoid inadvertently reinforcing children's compulsive rituals. Exposure and response prevention is the principal child-focused element of the programme. With this, children construct hierarchies of anxiety-providing cues (such as increasingly dirty stimuli) and are exposed to the cues that elicit anxiety-provoking obsessions (such as ideas about contamination), commencing with the least anxiety provoking, while not engaging in compulsive rituals (such as hand washing) until habituation occurs. They also learn anxiety management skills to help them cope with the exposure process.

This review suggests that in developing services for children with anxiety disorders, family therapy of up to sixteen sessions should be offered, which allows children to enter into anxiety-provoking situations in a planned way and to manage these through the use of coping skills and parental support.

Depression

Major depression is an episodic disorder characterized by low or irritable mood, loss of interest in normal activities and most of the following symptoms: psychomotor agitation or retardation, fatigue, low self-esteem, pessimism, inappropriate excessive guilt, suicidal ideation, impaired concentration and sleep and appetite disturbance (American Psychiatric Association, 2013; World Health Organization,

1992). Episodes may last from a few weeks to a number of months and recur periodically over the life cycle with inter-episode intervals varying from a few months to a number of years. Integrative theories of depression propose that episodes occur when genetically vulnerable individuals find themselves involved in stressful family systems in which there is limited access to socially supportive relationships (Abela and Hankin, 2008). Family-based therapy aims to reduce stress and increase support for young people in their families. But other factors also provide a rationale for family therapy. Not all young people respond to antidepressant medication (Goodyer *et al.,* 2007). Moreover, some young people do not wish to take medication because of its side effects and in some instances parents or clinicians are concerned that medication may increase the risk of suicide. Finally, research on adult depression has shown that relapse rates in the year following pharmacotherapy are about double those following psychotherapy (Vittengl *et al.,* 2007).

Stark *et al*. (2012) reviewed twenty-five trials of family-based treatment programmes for child and adolescent depression. In these studies a variety of formats was used, including conjoint family sessions; for example, Diamond's (2005) attachment-based family therapy; child-focused cognitive behavioural therapy (Stark *et al*., 2010) or interpersonal therapy (Jacobson and Mufson, 2010) sessions combined with some family or parent sessions; and concurrent group-based parent and child training sessions (such as Lewinsohn's coping with depression course (Clark and DeBar, 2010). Stark *et al*. (2012) concluded that family-based treatments for child and adolescent depression were as effective as well-established therapies such as individual cognitive behavioural therapy or interpersonal therapy and led to remission in two-thirds to three-quarters of cases at 6-months follow up. They were also more effective than individual therapy in maintaining post-treatment improvement. Effective family-based interventions aim to decrease the family stress to which youngsters are exposed and enhance the availability of social support within the family context. Core features of effective family interventions include psycho-education about depression; the relational reframing of depression-maintaining family interaction patterns; the facilitation of clear parent–child communication; the promotion of systematic family-based problem-solving and of secure parent–child attachment; the disruption of negative critical parent–child interactions and helping children develop skills for managing negative mood states and changing their pessimistic belief systems. With respect to clinical

practice and service development, family therapy for episodes of adolescent depression is relatively brief, requiring about twelve sessions. Because major depression is a recurrent disorder, services should make long term re-referral arrangements so that intervention is offered promptly in further episodes. Systemic therapy services should be organized so as to permit the option of multi-modal treatment with family therapy and antidepressant medication in cases unresponsive to family therapy.

Grief

A number of single group outcome studies and controlled trials show that effective therapy for grief reactions following parental bereavement may include a combination of family and individual interventions (Black and Urbanowicz, 1987; Cohen *et al*., 2006; Kissane and Bloch, 2002; Kissane *et al.,* 2006; Rotheram-Borus *et al.,* 2004; Sandler *et al*., 1992, 2003, 2010). Family intervention involves engaging families in treatment, facilitating family grieving and family support, decreasing parent–child conflict and helping families to reorganize so as to cope with the demands of daily living in the absence of the deceased parent. The individual component of treatment involves exposure of the child to traumatic grief-related memories and images until a degree of habituation occurs. This may be facilitated by viewing photos, audio and video recordings of the deceased and developing a coherent narrative with the child about their past life with the deceased and a way to preserve a positive relationship with the memory of the deceased parent. With respect to clinical practice and service development, family therapy for grief following the loss of a parent is relatively brief, requiring about twelve sessions.

Bipolar disorder

Bipolar disorder is a recurrent episodic mood disorder with a predominantly genetic basis, characterized by episodes of mania or hypomania, depression and mixed mood states (American Psychiatric Association, 2013; World Health Organization, 1992). The primary treatment for bipolar disorder is pharmacological and involves the initial treatment of acute manic, hypomanic, depressive or mixed episodes and the subsequent prevention of further episodes with mood-stabilizing medication such as lithium (Kowatch *et al.,* 2009). Bipolar disorder typically first occurs in late adolescence or early adulthood and its course, even

when treated with mood-stabilizing medication, is significantly affected by stressful life events and family circumstances on the one hand, and family support on the other. The high frequency of relapses among young people with bipolar disorder provides the rationale for the development of relapse-prevention interventions.

Psycho-educational family therapy aims to prevent relapses by reducing family stress and enhancing family support for youngsters with bipolar disorder who are concurrently taking mood-stabilizing medication such as lithium (Miklowitz, 2008). Family therapy for bipolar disorder typically spans twelve to twenty-one sessions and includes psycho-education about the condition and its management, and family communication and problem-solving skills training. The results of a series of studies suggest that psycho-educational family therapy may be helpful in adolescent bipolar disorder in increasing knowledge about the condition, improving family relationships and ameliorating symptoms of depression and mania (Fristad, 2006: Fristad *et al.,* 2002, 2003, 2009; Miklowitz *et al.,* 2004; Pavuluri *et al.,* 2004; West *et al.,* 2009). With respect to clinical practice and service development, family therapy for bipolar disorder in adolescence is relatively brief, requiring up to twenty-one sessions, and should be offered as part of a multi-modal programme that includes mood-stabilizing medication such as lithium.

Self-harm

A complex constellation of risk factors has been identified for self-harm in adolescence. They include the characteristics of the young person (such as the presence of psychological disorder) and features of the social context (such as family difficulties) (Hawton *et al.,* 2012; Ougrin *et al.,* 2012). Both sets of factors are targeted in family-based treatment for self-harm in adolescence. A series of studies has found that a range of specialized family therapy interventions improves the adjustment of adolescents who have self-harmed, although family interventions are not always more effective than alternative treatments in reducing the recurrence of self-harm (Asarnow *et al.,* 2011; Diamond *et al.,* 2010, Harrington *et al.,* 1998; Huey *et al.,* 2004; Katz *et al.,* 2004; King *et al.,* 2006, 2009; Rathus and Miller 2002; Rotheram-Borus *et al.,* 2000). Family-based approaches that improve adjustment share a number of common features. They begin by engaging the young people and their families in an initial risk-assessment process and proceed to the development of a clear plan for risk reduction that includes individual

therapy for adolescents combined with systemic therapy for members of their family and social support networks. Attachment-based family therapy, multisystemic therapy, dialectical behaviour therapy combined with multi-family therapy, and nominated support network therapy are well developed protocols with some or all of these characteristics.

Attachment-based family therapy. Attachment-based family therapy was originally developed for adolescent depression, as noted above, but it has been adapted for use with self-harming teenagers (Diamond *et al.*, 2013). This approach aims to repair ruptures in adolescent–parent attachment relationships. Re-attachment is facilitated by first helping family members to access their longing for greater closeness and commit to rebuilding trust. In individual sessions adolescents are helped to articulate their experiences of attachment failures and agree to discuss these experiences with their parents. In concurrent sessions parents explore how their own intergenerational legacies affect their parenting style. This helps them to develop greater empathy for their adolescents' experiences. When the adolescents and parents are ready, conjoint family therapy sessions are convened in which the adolescents share their concerns, receive empathic support from their parents and usually become more willing to consider their own contributions to family conflict. This respectful and emotional dialogue serves as a corrective attachment experience that rebuilds trust between adolescents and parents. As conflict decreases, therapy focuses on helping adolescents pursue developmentally appropriate activities to promote their competency and autonomy. In this context, parents serve as the secure base from which the adolescents receive support, advice and encouragement in exploring these new opportunities. In a controlled trial of adolescents at risk for suicide, Diamond *et al*. (2010) found that 3 months of attachment-based family therapy was more effective than routine treatment in reducing suicidal ideation and depressive symptoms at 6-months follow up.

Multisystemic therapy. Multisystemic therapy was originally developed for adolescent conduct disorder, as noted above, but it has been adapted for use with adolescents who have severe mental health problems, including attempted suicide (Henggeler *et al.*, 2002). Multisystemic therapy involves assessment of suicide risk, followed by intensive family therapy to enhance family support combined with individual skills training for adolescents to help them develop mood

regulation and social problem-solving skills, and intervention in the wider school and inter-agency network to reduce stress and enhance support for the adolescent. It involves regular, frequent home-based family and individual therapy sessions with additional sessions in the school or community settings over 3–6 months. Huey *et al*. (2004) evaluated the effectiveness of multisystemic therapy for suicidal adolescents in a randomized controlled study of 156 African-American adolescents at risk for suicide referred for emergency psychiatric hospitalization. Compared with emergency hospitalization and treatment by a multidisciplinary psychiatric team, Huey *et al*. found that multisystemic therapy was significantly more effective in decreasing rates of attempted suicide at a 1-year follow up.

Dialectical behaviour therapy and multi-family therapy. Dialectical behaviour therapy, which was originally developed for adults with borderline personality disorder, has been adapted for use with adolescents who have attempted suicide (Miller *et al*., 2007). This adaptation involves individual therapy for adolescents combined with multi-family psycho-educational therapy. The multi-family psycho-educational therapy helps family members understand self-harming behaviour and develop skills for protecting and supporting self-harming adolescents. The individual therapy component includes modules on mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness skills to address problems in the areas of identity, impulsivity, emotional liability and relationship problems, respectively. Evidence from two controlled outcome studies support the effectiveness of dialectical behaviour therapy with adolescents who have attempted suicide. In a study of suicidal adolescents with borderline personality features, Rathus and Miller (2002) compared the outcome for twenty-nine patients who received dialectical behaviour therapy plus psycho-educational multi-family therapy and eighty-two patients who received psychodynamic therapy plus family therapy. In each programme the participants attended therapy twice weekly. Both programmes led to reductions in suicidal ideation. Significantly more patients completed the dialectical behaviour therapy programme and significantly fewer were hospitalized during treatment. In a further study of sixty-two suicidal adolescent in-patients, Katz *et al*. (2004) found that both dialectical behaviour therapy and routine in-patient care led to significant reductions in self-harming behaviour, depressive symptoms and suicidal ideation but dialectical behaviour therapy led to significantly greater reductions in behaviour problems.

Youth-nominated support team. The youth-nominated support team is a manualized systemic intervention for adolescents who have attempted suicide, in which adolescents nominate a parent or guardian and three other people from their family, peer group, school or community to be members of their support team (King *et al*. 2000). For each patient, support team members receive psycho-education explaining how the adolescent's psychological difficulties led to the suicide attempt, the treatment plan and the role that support team members can play in helping the adolescent towards recovery and managing situations where there is a risk of further self-harm. Support team members are encouraged to maintain weekly contact with the adolescent and are contacted regularly by the treatment team to facilitate this process. King *et al*. (2006) evaluated the youth-nominated support team programme in a randomized controlled trial of 197 girls and eighty-two boys who had attempted suicide and been hospitalized. They found that, compared with routine treatment with psychotherapy and antidepressant medication, the youth-nominated support team programme led to decreased suicidal ideation and mood-related functional impairment in girls at 6-months follow up but had no significant impact on boys.

Systemic services for young people who self-harm should involve prompt intensive initial individual and family assessment followed by systemic intervention, including both individual and family sessions to reduce individual and family-based risk factors. Such therapy may involve regular session over a 3–6 month period. Systemic therapy services for youngsters at risk for suicide should be organized so as to permit the option of brief hospitalization or residential placement in circumstances where families are assessed as lacking the resources for immediate risk reduction on an outpatient basis.

Eating disorders

An excessive concern with the control of body weight and shape along with an inadequate and unhealthy pattern of eating are the central features of anorexia nervosa and bulimia nervosa. The former is characterized primarily by weight loss and the latter by a cyclical pattern of bingeing and purging (American Psychiatric Association, 2013; World Health Organization, 1992). The average prevalence rates for anorexia nervosa and bulimia nervosa among young women are about 0.3–0.5 per cent and 1–4 per cent, respectively (Hoek, 2006; Keel, 2010). Childhood obesity occurs where there is a body mass

index above the 95th percentile with reference to age-specific and sex-specific growth charts (Reilly, 2010). In Europe the prevalence of obesity among children and adolescents is about 5 per cent and in the USA it is about 15 per cent (Wang and Lim, 2012). Anorexia, bulimia and obesity are of concern because they lead to long-term physical or mental health problems. Family therapy is effective for a proportion of children and adolescents with eating disorders.

Anorexia nervosa

A series of systematic reviews and meta-analyses covering a total of seven controlled and six uncontrolled trials allow the following conclusions to be drawn about the effectiveness of family therapy for anorexia nervosa in adolescents (Couturier *et al.,* 2013; Eisler, 2005, Lock, 2011; Robin and Le Grange, 2010; Smith and Cook-Cottone, 2011; Stuhldreher *et al.,* 2012; Wilson and Fairburn, 2007). After treatment, between half and two-thirds of patients achieve a healthy weight. At 6-months to 6-years follow up, 60–90 per cent have fully recovered and no more than 10–15 per cent are seriously ill. In the long term the negligible relapse rate following family therapy is superior to the moderate outcomes for individually oriented therapies. The outcome for family therapy is also far superior to the high relapse rate following in-patient treatment, which is 25–30 per cent following first admission and 55–75 per cent for second and further admissions. Outpatient family-based treatment is also more cost-effective than in-patient treatment. Evidence-based family therapy for anorexia can be effectively disseminated and implemented in community-based clinical settings. In the Maudsley model for treating adolescent anorexia, which is the approach with the strongest empirical support, family therapy for adolescent anorexia progresses through three phases (Lock and Le Grange, 2013). The first involves helping parents work together to refeed their youngster. This is followed in the second phase with facilitating family support for the youngster in developing an autonomous, healthy eating pattern. In the final phase the focus is on helping the young person develop an age-appropriate lifestyle. Treatment typically involves between ten and twenty one-hour sessions over a 6–12-month period.

Bulimia nervosa

Two trials of family therapy for bulimia in adolescence, using the Maudsley model, show that it is more effective than supportive therapy

(Le Grange and Lock, 2010) and as effective as cognitive behavioural therapy (Schmidt *et al.,* 2007), which is considered to be the treatment of choice for bulimia in adults, due its strong empirical support (Wilson and Fairburn, 2007). In both trials, at 6-months follow up, over 70 per cent of cases treated with family therapy showed partial or complete recovery. Family therapy for adolescent bulimia involves helping parents work together to supervise the young person during mealtimes and afterwards, to break the binge-purge cycle. As with anorexia, this is followed by helping families support their youngsters in developing autonomous, healthy eating patterns, and age appropriate lifestyles (Le Grange and Locke, 2007).

Obesity

Systematic narrative reviews and meta-analyses of controlled and uncontrolled trials of treatments for obesity in children converge on the following conclusions (Epstein, 2003; Feng, 2011; Jelalian and Saelens, 1999; Jelalian *et al.,* 2007; Kitzmann and Beech, 2011; Kitzmann *et al.,* 2010; Nowicka and Flodmark, 2008; Seo and Sa, 2010; Young *et al.,* 2007). Family-based behavioural weight reduction programmes are more effective than dietary education and other routine interventions. They lead to a 5–20 per cent reduction in weight after treatment and at a 10-year follow up 30 per cent of patients are no longer obese. Childhood obesity is due predominantly to lifestyle factors including poor diet and lack of exercise and so family-based behavioural treatment programmes focus on lifestyle change. Specific dietary and exercise routines are agreed and implemented and parents reinforce young people for adhering to these routines (Jelalian *et al.,* 2007). An important development in the treatment of obesity is the standardized obesity family therapy in Malmo in Sweden. It is based on systemic and solution-focused theories and has had a positive effect on the degree of obesity, physical fitness, self-esteem and family functioning in several studies (Nowicka and Flodmark, 2011).

In planning systemic services for young people with eating disorders it should be expected that treatment of anorexia or bulimia will span 6–12 months, with the first ten sessions occurring weekly and the later sessions occurring fortnightly and then monthly. For obesity, therapy may span ten to twenty sessions followed by periodic, infrequent review sessions over a number of years to help youngsters maintain weight loss.

Somatic problems

Family-based interventions are helpful in a proportion of cases for the following somatic problems: enuresis, encopresis, recurrent abdominal pain and both poorly controlled asthma and diabetes.

Enuresis

In a systematic review and a meta-analysis of randomized controlled trials, Glazener *et al.,* (2004, 2009) found that family-based urine alarm programmes were an effective treatment for childhood nocturnal enuresis (bed-wetting). These programmes involve coaching the child and parents to use an enuresis alarm, which alerts the child as soon as micturition begins. Family-based urine alarm programmes, if used over 12–16 weeks, are effective in about 60–90 per cent per cent of patients (Brown *et al.,* 2011; Houts, 2010). With a urine alarm the urine wets a pad that closes a circuit and sets off the urine alarm, waking the child, who gradually learns over multiple occasions by a conditioning process to wake before voiding the bladder. In family sessions, parents and children are helped to understand this process and plan to implement the urine alarm-based programme at home. In family-based urine alarm programmes, parents reinforce children for success in maintaining dry beds using star-charts.

Encopresis

In a narrative review of 42 studies, McGrath *et al*. (2000) found that for childhood encopresis (soiling), multi-modal programmes involving medical assessment and intervention followed by behavioural family therapy were effective for 43–75 per cent of patients. Initially a paediatric medical assessment is conducted and if a faecal mass has developed in the colon, this is cleared with an enema. A balanced diet containing an appropriate level of roughage and regular laxative use are arranged. Effective behavioural family therapy involves psychoeducation about encopresis and its management, coupled with a reward programme, where parents reinforce appropriate daily toileting routines. There is some evidence that a narrative approach may be more effective than a behavioural approach to family therapy for encopresis. Silver *et al*. (1998) found success rates of 63 and 37 per cent for narrative and behavioural family therapy, respectively. With narrative family therapy the soiling problem was externalized and

referred to as 'sneaky poo'. Therapy focused on parents and children collaborating to outwit this externalized personification of encopresis (White, 2007).

Recurrent abdominal pain

Results of 4 trials have shown that behavioural family therapy is effective in alleviating recurrent abdominal pain, often associated with repeated school absence, and for which no biomedical cause is evident (Finney *et al.,* 1989; Robins *et al*. 2005; Sanders *et al.,* 1989, 1994). Such programmes involve family psycho-education about recurrent abdominal pain and its management, relaxation and coping skills training to help children manage stomach pain, which is often anxiety-based, and contingency management implemented by parents to motivate their children to engage in normal daily routines, including school attendance. This conclusion is consistent with those of other systematic narrative reviews (Banez and Gallagher, 2006; Sprenger *et al*., 2011; Spirito and Kazak, 2006; Weydert *et al.,* 2003).

Poorly controlled asthma

Asthma, a chronic respiratory disease with a prevalence rate of about 10 per cent among children, can lead to significant restrictions in daily activity, repeated hospitalization. If it is very poorly controlled, asthma is potentially fatal (Currie and Baker, 2012). The course of asthma is determined by the interaction between abnormal physiological processes of the respiratory system, to which some youngsters have a predisposition, physical environmental triggers and psychosocial processes. In a systematic review of twenty studies, Brinkley *et al*. (2002) concluded that family-based interventions for asthma spanning up to eight sessions were more effective than individual therapy. These included psycho-education to improve their understanding of the condition, medication management and environmental trigger management, relaxation training to help young people reduce physiological arousal, skills training to increase adherence to asthma management programmes and conjoint family therapy sessions to empower family members to work together to manage asthma effectively. These conclusions have been supported by results of some (for example, Ng *et al.,* 2008) but not all (for example, Celano *et al.,* 2012) recent trials.

Poorly controlled diabetes

Type 1 diabetes is an endocrine disorder characterized by complete pancreatic failure (Levy, 2011). The long-term outcome for poorly controlled diabetes may include blindness and leg amputation. For youngsters with diabetes normal blood glucose levels are achieved through a regime involving a combination of insulin injections, balanced diet, exercise and the self-monitoring of blood glucose. In a systematic review of eleven studies Farrell *et al*. (2002) found that family-based programmes of ten to twenty sessions were effective in helping young people control their diabetes, and that different types of programmes were appropriate for young people at different stages of the life cycle. For youngsters newly diagnosed with diabetes, psycho-educational programmes that helped families understand the condition and its management were particularly effective. Family-based behavioural programmes, where parents rewarded youngsters for adhering to their diabetic regimes, were particularly effective with pre-adolescent children, whereas family-based communication and problem-solving skills training programmes were particularly effective for families with adolescents, since these programmes gave families skills for negotiating diabetic management issues in a manner appropriate for adolescents. In a meta-analysis of fifteen trials of various types of interventions, Hood *et al*. (2010) concluded that those that targeted emotional, social or family processes that facilitate diabetes management were more effective in promoting glycaemic control than interventions just targeting a direct, behavioural process, such as increasing the frequency of blood glucose monitoring. Behavioural family systems therapy has the strongest empirical support as a family-based intervention for treating families of poorly controlled diabetic adolescents (Harris *et al*. 2009).

This review suggests that family therapy may be incorporated into multi-modal, multidisciplinary paediatric programmes for a number of somatic conditions including enuresis, encopresis, recurrent abdominal pain and both poorly controlled asthma and diabetes. Systemic intervention for these conditions should be offered following thorough paediatric medical assessment, and typically interventions are brief, ranging from eight to twelve sessions.

First episode psychosis

First episode psychosis is a condition characterized by positive symptoms (such as delusions and hallucinations), negative symptoms (such

as lack of goal-directed behaviour and flattened affect), and disorganized thinking, behaviour and emotions (American Psychiatric Association, 2013; World Health Organization, 1992). First episode psychosis typically occurs in late adolescence. It is exceptionally distressing for the young person and the family. Complete recovery may occur for a proportion of young people, especially if they receive early intervention and if their families are supportive. However, where psychosis persists or a chronic relapsing pattern develops eventually a diagnosis of schizophrenia may be given. Antipsychotic medication is the primary treatment for the symptoms of first episode psychosis. Pharmacological interventions may be combined with family interventions in which the primary aim is to facilitate a supportive family environment and so prevent the development of a chronic relapsing condition. Reviews of controlled trials show that combining antipsychotic medication with psycho-educational family therapy (Kuipers *et al.,* 2002) reduces relapse rates in first episode psychosis and that multi-family psycho-educational therapy (McFarlane, 2002) is particularly effective (Bird *et al.,* 2010; McFarlane *et al.,* 2012; Onwumere *et al.,* 2011).

Psycho-educational family therapy for schizophrenia involves psycho-education, based on the stress-vulnerability or bio-psychosocial models of psychosis (McFarlane *et al.,* 2012), with a view to helping families understand and manage the condition, antipsychotic medication, related stresses and early warning signs of relapse. Psycho-educational family therapy also aims to reduce negative family processes associated with relapse, specifically high levels of expressed emotion, stigma, communication deviance and stresses related to transitions in the life cycle. Emphasis is placed on blame reduction and the positive role that family members can play in supporting the young person's recovery. Psycho-educational family therapy also helps families develop communication and problem-solving skills. Skills training commonly involves modelling, rehearsal, feedback and discussion. Effective interventions typically span 9–12 months and are usually offered in a phased format, with initial sessions occurring more frequently than later sessions and crisis intervention as required.

From this review it may be concluded that systemic therapy services for families of people with first episode psychosis should be offered within the context of multi-modal programmes that include antipsychotic medication. Because of the potential for relapse, services should make re-referral arrangements, so intervention is offered promptly in later episodes.

Discussion

A number of comments may be made about the evidence reviewed in this article. For a wide range of child-focused problems systemic interventions are effective. These interventions are brief, rarely involving more than twenty sessions, and may be offered by a range of professionals on an outpatient basis. Treatment manuals have been developed for many systemic interventions and these may be flexibly used by clinicians in treating individual patients. Moreover, most evidence-based systemic interventions have been developed within the cognitive -behavioural, structural and strategic traditions. The implications of these findings are discussed in the final section of the companion article in this issue (Carr, 2014).

The results of this review are broadly consistent with the important role accorded to family involvement in the treatment of children and young people in authoritative clinical guidelines such as those published by the UK National Institute for Clinical Excellence (NICE) for a range of problems, including conduct disorder (NICE, 2013a), ADHD (NICE, 2013b), drug misuse (NICE, 2007), some anxiety disorders (for example, NICE, 2005a), mood disorders (NICE, 2005b, 2006), eating disorders (NICE, 2004), certain somatic problems (for example, NICE, 2009, 2010) and psychosis in adolescence (NICE, 2013c).

A broad definition of systemic intervention has been adopted in this article, in comparison with that taken in other reviews of the field of family therapy for child-focused problems (for example, Kaslow *et al.,* 2012; Retzlaff, *et al.,* 2013). There are pros and cons to adopting a broad definition. On the positive side, it provides the widest scope of evidence on which to draw in support of systemic practice. This is important in a climate where there is increasing pressure to point to a significant evidence base to justify funding family therapy services. It also offers the family therapists reading this review guidance on family-based treatment procedures that may usefully be incorporated into their systemic practice. However, the broad definition of systemic intervention used in this article potentially blurs the unique contribution of the practices developed within the tradition of systemic family therapy, as distinct from interventions in which parents are included in an adjunctive role to facilitate individually focused therapy, or family-based approaches that integrate distinctly systemic ideas and practices with those of other therapeutic traditions, notably cognitive behavioural therapy.

The findings of this review have implications for research, training and practice. With respect to research, more studies are needed on the effectiveness of distinctly systemic interventions for child abuse, problems of early childhood and emotional problems in young people. More research is also required on social constructionist and narrative approaches to systemic practice which, though widely used, have rarely been evaluated. With respect to training, the systemic evidence-based interventions reviewed in this article should be incorporated in family therapy training programmes and continuing professional development short courses for experienced systemic practitioners. This argument has recently been endorsed in the UK and the USA in statements of the core competencies of systemic therapists (Northey, 2011; Stratton *et al.,* 2011). With respect to routine practice, family therapists should work towards incorporating the types of practices described in this article and in the treatment resources listed below when working with families of children and adolescents with the types of problems considered in this article.

Treatment resources

Sleep problems

Mindell, J. and Owens, J. (2009) *A Clinical Guide to Paediatric Sleep: Diagnosis and Management of Sleep Problems* (2nd edn). Philadelphia: Lippincott Williams and Wilkins.

Feeding problems

Kedesdy, J. and Budd, K. (1998) *Childhood Feeding Disorders: Behavioural Assessment and Intervention*. Baltimore: Paul. H. Brookes.

Attachment problems

Berlin, L. and Ziv, Y. (2005) *Enhancing Early Attachments. Theory, Research, Intervention and Policy*. New York: Guilford.

Physical abuse

Kolko, D. and Swenson, C. (2002) *Assessing and Treating Physically Abused Children and Their Families: A Cognitive Behavioural Approach*. Thousand Oaks: Sage.

Rynyon, M. and Deblinger, E. (2013) *Combined Parent–child Cognitive Behavioural Therapy. An Approach to Empower Families At-Risk for Child Physical Abuse*. New York: Oxford University Press.

Child sexual abuse

Deblinger, A. and Heflinger, A. (1996) *Treating Sexually Abused Children and their Non-offending Parents: A Cognitive Behavioural Approach*. Thousand Oaks: Sage.

Childhood behaviour problems

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