journal of family therapy

Journal of Family Therapy (2018) **00**: 00–00
doi: 10.1111/1467-6427.12226

Family therapy and systemic interventions for child-focused problems: the current evidence base

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This review updates previous similar papers published in JFT in 2000, 2009 and 2014. It presents evidence from meta-analyses, systematic literature reviews, narrative literature reviews and controlled trials for the effectiveness of systemic interventions for families of children and adolescents with common mental health problems and other difficulties. In this context, systemic interventions include both family therapy and other family-based approaches such as parent training or parent implemented behavioural programmes. The evidence supports the effectiveness of systemic interventions either alone or as part of multimodal programmes for sleep, feeding and attachment problems in infancy; recovery from child abuse and neglect; conduct problems, emotional problems, eating disorders, somatic problems, and first episode psychosis.

Keywords: family therapy research; systemic therapy research; effectiveness of family therapy; efficacy of family therapy.

Introduction

This paper summarizes the evidence base for systemic practice with child-focused problems, and updates previous reviews (Carr, 2000, 2009, 2014). It is also a companion paper to a research review on systemic interventions for adult-focused problems (Carr, 2018). A broad definition of systemic practice has been taken in this paper. This covers family therapy and other family-based interventions such as parent training, parent implemented behavioural programmes, multisystemic therapy and treatment foster care, which engage family members or members of families' wider networks in the process of resolving problems for young people from birth to the age of 18 years. One-to-one services (such as supportive parent counselling) and complex interventions (such as multi-component care packages

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for people with intellectual and developmental disabilities), which are arguably systemic interventions, but which differ in many practical ways from family therapy, were excluded from this review.

Lebow (2016) recently edited a special issue of *Family Process* on couple and family therapy research. He concluded that there is now a significant number of well-defined empirically supported systemic interventions for specific problems. This special issue of *Family Process* updates previous special issues of the *Journal and Marital and Family Therapy* on systemic therapy research (Pinsof and Wynne, 1995; Sprenkle, 2002, 2012), and complements other important major recent reviews of the evidence base for family therapy, for example, Stratton *et al*. (2015), Stratton (2016), Sexton *et al*. (2013), Retzlaff *et al*. (2013) and von Sydow *et al*. (2013). However, it is noteworthy that as far back as the 1970s there have been promising reviews of evidence base for couple and family therapy (e.g. Gurman and Kniskern, 1978).

Meta-analyses provide a particularly important type of evidence to support the effectiveness of family therapy, because they statistically synthesize the results of many outcome studies in a relatively unbiased way. The first meta-analyses of systemic therapy outcome studies were published in the late 1980s and early 1990s (Hazelrigg *et al*., 1987; Markus *et al*., 1990; Shadish *et al*., 1993). These showed conclusively that systemic therapy worked for a range of problems and was as effective, or in some cases more effective than individual therapy. 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 six to twelve months follow up. These results show that, overall, the average treated family fared better after therapy and at follow up than in excess of 71 per cent of families in control groups and this is equivalent to a success rate of 61–64 per cent. In a recent meta-analysis of fifty-six studies of family therapy for child-focused problems, Riedinger *et al*. (2017) found that systemic therapy showed small to medium effects in comparison with waiting-list control groups after treatment ($g = .59$) and at follow up ($g = .27$). It was also more effective than alternative interventions after treatment ($g = .32$) and at follow up ($g = .28$). At follow up, longer interventions produced larger effect sizes. In a vast meta-analysis of 447 studies of family and individual interventions for common emotional and conduct problems in childhood and adolescence, Weisz *et al*. (2017) found an overall effect size of 0.46 after treatment and 0.36 at

an average of eleven months follow up. There was no significant difference between the effectiveness of systemic and individual therapy. In a series of twenty-two studies conducted over twenty years, using four large databases, Crane and his team showed that systemic therapy is more cost-effective than individual therapy and systemic therapy leads to significant medical cost-offsets (Crane and Christenson, 2014).

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 paper focuses on precisely this issue. As with previous versions of this review, extensive computer and manual literature searches were conducted for studies of the outcome of systemic interventions with a wide range of problems of childhood and adolescence. For the present review, the search extended from the earliest available year to January 2018. Major databases (e.g. PsycINFO, PubMed), family therapy journals (e.g. *Family Process, Journal of Family Therapy, Journal of Marital and Family Therapy*), and child and adolescent mental health journals were searched, as well as major textbooks on evidence-based systemic practice. Using appropriate Boolean logical operators (e.g. AND, OR) in these searches, terms denoting systemic interventions (e.g. family therapy, parent training) were combined with terms denoting specific problem types (e.g. depression, anxiety), limited to children and adolescents. Where available, meta-analyses and systematic review papers were selected, since these constitute the strongest form of evidence. If such papers were unavailable, controlled trials, which constitute the next highest level of evidence, were selected. Where there were so many papers that it would have been impractical within the space constraints of a single article to cite them all, a sample of the most comprehensive and methodologically robust papers representative of older and more recent publications were cited. Thus, the current review paper both incorporates and updates earlier versions of this article (Carr, 2000, 2009, 2014). It was intended that this paper should be primarily a 'review of the reviews', with a major focus on substantive findings of interest to practising therapists, rather than on methodological issues. This overall review strategy was adopted to permit the strongest possible case to be made for systemic evidence-based practices with a wide range of child-focused problems, and to offer useful guidance for therapists, within the space constraints of a

single paper. The results of the review are presented below 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 a quarter to a third of infants and are of concern because they may compromise family adjustment and later child development (Bryant-Waugh and Watkins, 2015; Harvey and McGlinchey, 2015; Zeanah and Smyke, 2015).

Sleep problems

Family-based behavioural programmes are the main systemic intervention for settling and night waking problems, which are the most prevalent sleep difficulties in infancy (Harvey and McGlinchey, 2015). 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, managing children's anxiety, and introducing scheduled waking where children are awoken fifteen to sixty minutes before the child's spontaneous waking time and then resettled. A systematic review and meta-analysis of sixteen controlled trials and a qualitative analysis of twelve within-subject studies of family-based behavioural programmes for sleep problems in young children by Meltzer and Mindell (2014), and a systematic review 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

Feeding problems in infancy include self-feeding difficulties, swallowing problems, frequent vomiting and, in the most extreme cases, food refusal and failure to thrive. With food refusal, there is refusal to eat all or most foods, resulting in a failure to meet caloric needs or dependence on supplemental tube feeds. Family-based behavioural

programmes are the main systemic intervention for addressing food refusal and other infant feeding difficulties (Kedesdy and Budd, 1998). Such programmes involve parents prompting, shaping and reinforcing successive approximations to appropriate feeding behaviour in a non anxiety-provoking way, 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. In a systematic review of thirteen controlled and uncontrolled trials, Lukens and Silverman (2014) found that family-based behavioural programmes were particularly effective in addressing food refusal and other infant feeding difficulties.

Attachment problems

Infant attachment insecurity is a risk factor for psychological difficulties across the lifespan (Cassidy and Shaver, 2016). In a systematic review and meta-analysis of sixteen studies, Facompré *et al*. (2017) found that a range of systemic interventions were effective in reducing rates of disorganized child-parent attachment in at-risk families. Interventions covered in this meta-analysis and in a narrative review by Berlin *et al*. (2016) included child-parent psychotherapy (Lieberman and Van Horn, 2005), attachment and bio-behavioural catch-up (Dozier *et al*., 2005), video-feedback intervention to promote positive parenting (Juffer *et al*., 2008) and circle of security (Powell *et al*., 2014). Meta-analyses focusing on specific systemic interventions have supported the effectiveness of child-parent psychotherapy (Barlow *et al*., 2016) and circle of security (Yaholkoski *et al*., 2016). Child-parent psychotherapy involves weekly dyadic sessions with mothers and children for about a year. It helps mothers resolve ambivalent feelings about their infants by linking these to their own adverse childhood experiences and current life stresses within the context of a supportive long-term therapeutic alliance. This intensive systemic intervention is probably most appropriate 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. Attachment and bio-behavioural catch-up, video-feedback intervention to promote positive parenting, and circle of security are less intensive interventions and probably more appropriate for less vulnerable families. In these three programmes across four to twenty sessions, parents receive psychoeducation about attachment and video-feedback and coaching to improve child-parent interactions associated with attachment security. Parents are also helped to develop strategies for avoiding replicating problematic family-of-origin parenting practices.

Service implications for sleeping, feeding and attachment problems

The results of this review suggest that in developing services for families of infants with sleeping and feeding problems, only relatively brief out-patient programmes are required, involving up to fifteen sessions over three to four months for each episode of treatment. For attachment problems, the intensity of intervention needs to be matched to the level of family vulnerability, with highly vulnerable families being offered more intensive interventions.

Child abuse and neglect

Systemic interventions are effective in promoting child recovery and better family adjustment in a proportion of cases of child abuse and neglect. These problems have devastating effects on the psychological development of children (Kilka and Conte, 2017). In a series of meta-analyses of international studies Stoltenborgh *et al*. (2015) found prevalence rates based on self-report 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 and meta-analyses concur that for physical child abuse and neglect, effective therapy is family-based, structured, extends over periods of at least six months, is often conducted on a home-visiting basis, and addresses specific problems in relevant subsystems including parenting skills deficits, children's post-traumatic adjustment problems, and the overall supportiveness of the

family and social network (Henggeler and Schaeffer, 2016; Kennedy *et al*., 2016; Levey *et al*., 2017; Skowron and Reinemann, 2005; Timmer and Urquiza, 2014; Vlahovicova *et al*., 2017). Cognitive behavioural family therapy (Kolko *et al*., 2014; Kolko and Swenson, 2002; Rynyon and Deblinger, 2013), parent-child interaction therapy (Kennedy, 2016; McNeil and Hembree-Kigin, 2011), and multisystemic therapy for child abuse and neglect (Henggeler and Schaeffer, 2016; Swenson and Schaeffer, 2014) are manualized approaches to family-based treatment which 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 series of controlled trials Kolko *et al*., (2014) found that cognitive behavioural family therapy was more effective than routine services in reducing the risk of further abuse in families of school-age children and adolescents in which physical abuse had occurred. The sixteen-session alternatives for families CBT programme involves 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). Separate sessions with parents and children and conjoint family sessions are used to achieve these aims.

Parent-child interaction therapy for physical abuse. In a meta-analysis of six controlled trials, Kennedy *et al*. (2016) found that parent-child interaction therapy led to significantly fewer physical abuse recurrences and greater reductions in parenting stress than routine services or other control conditions for families in which physical abuse had occurred. Parent-child interaction therapy involves conjoint parent-child sessions in which parents are coached in how to engage in child-directed interactions to strengthen parent-child attachment, and how to engage in parent-directed interactions to address oppositional behaviour to prevent the development of conduct problems (McNeil and Hembree-Kigin, 2011). Coaching is conducted from behind a one-way mirror and therapists communicate with parents though a 'bug in the ear'. Typically therapy spans fourteen to sixteen sessions. For parents who are ambivalent about treatment, additional preliminary sessions may be incorporated into the standard protocol to enhance parents' motivation to engage in therapy.

Multisystemic therapy for child abuse and neglect. In a series of three studies, multisystemic therapy for child abuse and neglect has been compared with alternative treatments for families where physical abuse or neglect had occurred (Henggeler and Schaeffer, 2016). After treatment, families who received multisystemic therapy showed greater improvements in parenting, individual adjustment and family functioning, and a lower rate of out-of-home placements. Multisystemic therapy for child abuse and neglect involves joining with family members and members of their wider social and professional networks, reframing interaction patterns, focusing on family strengths, and prescribing tasks to alter problematic interaction patterns within specific subsystems, especially the parent-child subsystem (Swenson and Schaeffer, 2014). Therapists design intervention plans on a per-case basis in light of family assessment; they use individual, couple, family and network meetings in these plans, receive regular supervision to facilitate this process, and carry small case-loads of four to six families.

Sexual abuse

For child sexual abuse, trauma-focused cognitive behaviour therapy for both abused young people and their non-abusing parents has been shown to reduce symptoms of post-traumatic stress disorder and improve overall adjustment (Deblinger *et al*., 2015). In a systematic review of thirty-three trials, twenty-seven of which evaluated trauma-focused cognitive behaviour therapy, Leenarts *et al*. (2013) found that cases 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 behaviour therapy involves concurrent sessions for abused children and their non-abusing parents, in group or individual formats, with periodic conjoint parent-child sessions. Where intrafamilial 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 reoffending (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.

Service implications for child abuse and neglect

The results of this review suggest that for families in which abuse and/or neglect has occurred, intervention should begin with a comprehensive network assessment. Treatment should include regular family therapy sessions, as well as individual parent-focused and child-focused sessions. Programmes should span at least six months, with the intensity of input matched to families' needs. Therapists should carry small case-loads of less than ten cases.

Conduct problems

Childhood behaviour problems (or oppositional defiant disorder), attention deficit hyperactivity disorder, pervasive adolescent conduct problems, and drug misuse are of concern because they may lead to co-morbid academic, emotional and relationship problems and, in the long term, to significant adult adjustment difficulties (Crowley and Sakai, 2015; Scott, 2015; Sonuga-Barke and Taylor, 2015). They are also relatively common. In a meta-analysis of forty-one studies from seventeen countries, Polanczyk *et al*. (2015) found that the pooled prevalence rate for disruptive behaviour disorders was 5.7 per cent. In a systematic review and meta-analysis of seventeen randomized controlled trials of children and adolescents with disruptive behaviour disorders, Bakker *et al*. (2017) found that most studies evaluated systemic interventions, either parent training or family therapy. Compared to the outcomes for alternative treatments or waiting-list control groups, systemic interventions led to small but significant overall effect sizes (ranging from 0.26 to 0.36) on rating scales completed by parents, teachers, or researchers. In a wide-ranging narrative review Kazdin (2015) reached similar conclusions, identifying systemic interventions, especially parent training and family therapy, as particularly effective for disruptive behaviour disorders. Research on systemic interventions for preadolescent behaviour problems has focused predominantly on parent training. In contrast, family therapy has been the primary focus of research on systemic interventions for pervasive adolescent conduct problems and substance misuse.

Childhood behaviour problems

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 one year follow up, particularly if periodic review sessions are offered (Brestan and Eyberg, 1998; Comer *et al*., 2013; Coren *et al*., 2002; Furlong *et al*., 2012; Leijten *et al*., 2013; Lundahl *et al*., 2008; Maughan *et al*., 2005; Michelson *et al*., 2013; Serketich and Dumas, 1996). Systematic reviews and meta-analyses also support the effectiveness of a number of specific evidence-based parent training programmes including the Oregon model of parent management training (Forgatch and Gewirtz, 2017; Forgatch and Kjøbli, 2016), Parent-Child Interaction Therapy (Thomas *et al*., 2017; Ward *et al*., 2017; Zisser-Nathenson *et al*., 2017), the Incredible Years Programme (Menting *et al*., 2013; Webster-Stratton and Reid, 2017), the Triple-P positive parenting programme (Sanders *et al*., 2017; Sanders and Turner, 2017), the Parents Plus programme (Carr *et al*., 2017), and Kazdin's (2017) parent management training and social problem solving skills programmes.

Parent training programme similarities. All of the empirically supported programmes mentioned in the previous paragraph hold the following features in common. They are all systemic interventions which aim to address children's behaviour problems by changing relationships between family members, notably parent-child relationships, but also co-parenting relationships, and relationships between parents and involved professionals, such as teachers. The underlying assumption is that both conduct problems and prosocial behaviour are maintained by repetitive relational patterns, and associated behaviours, beliefs, and affective states. They draw on multiple theories, especially behaviourism, social learning theory, attachment theory, and ecological social systems theory. They include two main sets of interventions. The first of these aims to enhance the quality of parent-child relationships, and increase children's prosocial behaviour by coaching parents in how to engage in child-directed play and positively reinforce prosocial behaviour. The second aims to reduce antisocial behaviour by improving the consistency and efficiency with which parents address this type of behaviour, and also by improving children's self-regulation skills. Active skills training is used in all

evidence-based parenting programmes. This involves in-session psychoeducation, modelling, rehearsal, and feedback, and between session practice followed by in-session review. In a meta-analysis of seventy-seven studies, Kaminski *et al*. (2008) found that active skills training, teaching parents skills to enhance parent-child relationships, and teaching skills for managing antisocial behaviour were the three components of parent training programmes consistently associated with larger treatment effects.

Parent training programme differences. There are distinct differences between widely disseminated parent training programmes. Some programmes were primarily designed for group administration (for example, the Incredible Years and Parents Plus programmes), some for individual family administration, (for example, the Oregon parent management training programme or Parent-Child Interaction Therapy), while others were developed to be offered in multiple formats within the context of a stepped-care service delivery model (for example, the Triple-P programme). Video modelling is a key element of some programmes (for example the Incredible Years and Parents Plus programmes). With video modelling, parents learn child management skills through viewing video clips of actors illustrating successful and unsuccessful parenting skills. Both immediate feedback and video feedback have been used in empirically supported behavioural parent training programmes. With video feedback, parents are coached in how to improve their child management skills while watching videotaped episodes of themselves interacting with their children. For example, video feedback is used in the early years version of the Parents Plus programme. 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. This procedure is used in Parent-Child Interaction Therapy. Some evidence-based parent training programmes include a module for children which aims to enhance their self-regulation and social skills, and this module is offered to children, while their parents attend the parent training module. This approach is used in the Incredible Years programme and Kazdin's parent management training and social problem-solving skills programme.

Neurodevelopmental disabilities and disorders. Meta-analytic and systematic review results show that parent training programmes are effective in

alleviating behaviour problems in families of children who have both conduct problems and a comorbid neurodevelopmental disability or disorder such as intellectual disability (Skotarczak and Lee, 2015), autism spectrum disorder (Postorino *et al*., 2017), or attention deficit hyperactivity disorder (Daley *et al*., 2014, 2017; Mulqueen *et al*., 2015). For children with attention deficit hyperactivity disorder who do not respond to systemic interventions alone, systematic reviews concur that parent training is best offered as one element of a multimodal programme involving stimulant medication (Daly *et al*., 2017; Pfiffner and Haack, 2015).

Comparison with individual therapy. Behavioural parent training is 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.

Long-term effects. Parent training programmes have long-lasting effects. In a meta-analysis of seventy-eight studies, Piquero *et al*. (2016) found that parent training for families with pre-adolescent children prevented juvenile delinquency in adolescence. The effect size was 0.37. This corresponded to an offending rate of 32 per cent for young people from families where parent training occurred, compared with 50 per cent from families who did not receive parent training.

Contextual factors. Meta-analyses also show that behavioural parent training not only affects children's behaviour but also improves parental well-being (Colalillo and Johnston, 2016; Trivedi, 2017); it is as effective in routine community settings as it is specialist programme development clinics (Michelson *et al*., 2013); more intensive programmes are more effective (Nowak and Heinrichs, 2008); and computer-based parent training programmes can be effective for families with pre-adolescent children with clinically significant behaviour problems (Baumel *et al*., 2016).

Father involvement. The inclusion of fathers in parent training leads to greater improvement in child behaviour problems and parenting practices (Lundahs *et al*., 2008; Pruett *et al*., 2017a,b). The Supporting Father Involvement/Parents as Partners programme is a sixteen-session systemic group parent training intervention designed to

recruit and retain both fathers and mothers in treatment. A series of North American studies and a UK study show that it enhances both child and parent adjustment (Pruett *et al*., 2017a,b). Key features of the programme are facilitation by male/female co-therapy teams, engaging fathers in treatment though pre-group programme individual interviews with fathers and mothers, and helping parents build effective, mutually supportive co-parenting teams. The programme addresses personal wellbeing, couple relationship issues, parent-child relationships, relationships with partners' families of origin, and extrafamilial stresses and supports.

Dropout. Not all families engage with parent training, and of those that do, not all who engage derive benefits from the parent training process. In a systematic review of 262 parent training outcome studies, Chacko *et al*. (2016) found that 25 per cent of families identified as appropriate for parent training programmes did not engage, and of those that began treatment, 26 per cent dropped out. 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 least benefit from behavioural parent training. To address these barriers to effective parent training, adjunctive interventions which 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 and Triple-P programmes, which included additional sessions on parental support and stress management, were far more effective than standard versions of these programmes.

Service implications for childhood behaviour problems. 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 provided where assessment indicates particular vulnerabilities in these subsystems. Programmes should span three to six 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.

Pervasive conduct problems and substance misuse in adolescence

About a quarter 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 (Scott, 2016). Co-morbid substance misuse is present in 60–80 per cent of cases of conduct disorder (Crowley and Sakai, 2015). Family disorganization, problematic parenting, deviant peer group membership, high levels of family stress, low levels of social support, and skills deficits are targeted by effective systemic treatment programmes because these factors maintain both conduct disorder and substance misuse (Kazdin, 2015).

There is a large evidence base supporting the effectiveness of family therapy for adolescent conduct disorder and substance misuse. In a systematic narrative review of forty-five trials of treatments for adolescent drug misuse, Tanner-Smith *et al*. (2013) concluded that family therapy was more effective than other types of treatments including cognitive behaviour therapy, motivational interviewing, psychoeducation and various forms of individual and group counselling. In a meta-analysis of twenty-four studies, Baldwin *et al*. (2012) evaluated the effectiveness of brief strategic family therapy (Szapocznik *et al*., 2016), functional family therapy (Sexton, 2016), multisystemic therapy (Schoenwald *et al*., 2016), and multidimensional family therapy (Liddle, 2016a) in the treatment of conduct disorders and substance misuse. They found that all four forms of family therapy were effective compared with treatment as usual ($d = 0.21$) or alternative treatments ($d = 0.26$). In a more recent meta-analysis of twenty-eight studies of brief strategic family therapy, functional family therapy, multisystemic therapy, and the Oregon model of multidimensional treatment foster care (Buchanan *et al*., 2017), Dopp *et al*. (2017) found that all of these systemic therapy programmes were more effective than treatment as usual up to two and a half years after therapy had ended ($d = 0.24$). The results of the meta-analyses by Baldwin *et al*. and Dopp *et al*. showed that the average case treated with family therapy fared better than 58–59 per cent of cases who engaged in treatment as usual or alternative treatments in terms of a range of outcomes including recidivism, antisocial behaviour, drug use, scholastic achievement, family functioning, and deviant peer group contact. These results are consistent with those of other systematic reviews and meta-analyses of studies of systemic interventions for conduct problems (de Vries *et al*., 2015; Dowden and Andrews, 2003; Latimer, 2001; Woolfenden *et al*., 2002)

and substance misuse (Austin *et al*., 2005; Becker and Curry, 2008; Rowe, 2012; Vaughn and Howard, 2004; Waldron and Turner, 2008).

The family therapy models evaluated in studies included in the meta-analyses by Baldwin *et al*. (2012) and Dopp *et al*. (2017) hold a number of features in common. They are based on an ecological systemic conceptualization of the aetiology of adolescent conduct problems and substance misuse. Therapy practices are informed by classical structural and strategic models of family therapy, social learning theory and cognitive behaviour therapy. Treatment is guided by specific attainable goals, which include improving prosocial behaviour and reducing deviant behaviour. Treatment aims to change relational patterns involving adolescents and members of their families, peer groups, and wider social systems that maintain their difficulties. Treatment involves conjoint family therapy sessions, but also sessions with various subsystems of the family and wider network, including adolescents, parents, school staff and other involved professionals. Treatment moves through three main phases. In the preliminary engagement phase, the focus is on forming alliances with relevant family and network members, motivating them to engage in therapy, assessment, goal setting, and clarifying the treatment contract. In the middle phase, the emphasis is on changing relational patterns that maintain adolescent problems, and facilitating the development of supportive relationships within the family and wider system. There is a strong focus on strengthening the effectiveness of the parenting subsystem in managing adolescent conduct problems and drug misuse, and improving parent-adolescent communication and negotiation skills. In the closing phase, the process by which gains were made is reviewed, and plans are made for anticipating and managing potential relapses and setbacks. For each of the evidence-based family therapy models cited above, 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. Entire community agency teams are trained in model use. Treatment and supervision are guided by manuals. Therapists carry relatively small caseloads, are supervised regularly, and match the structure and intensity of therapy offered to case needs. What follows are brief outlines of these empirically supported family therapy models and reference to evidence bases specific to each of these models.

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 (Szapocznik *et al*., 2016). 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 families, particularly Hispanic families, and therapists facilitate healthy family interactions based on appropriate cultural norms. Where there are difficulties engaging with whole families, 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 three to six months, with treatment duration and intensity being determined by problem severity. In thorough reviews of research on this approach, conducted largely in the US, Horigian *et al*. (2016) and Santisteban *et al*. (2006) concluded that it was effective at engaging adolescents and their families in treatment, reducing drug misuse 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 into treatment, and for one-person family therapy, where parents resist treatment engagement.

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 (Robbins *et al*., 2016; Sexton, 2016; Waldron *et al*., 2017). It is a manualized model of systemic family therapy for adolescent conduct and substance use disorders. 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 three to six months. In a systematic review and meta-analysis of fourteen international clinical trials of functional family therapy, Hartnett *et al*. (2013) concluded that this approach was more

effective than well defined alternative treatments such as cognitive behaviour therapy, and individual and group counselling in reducing antisocial behaviour and drug misuse.

Multisystemic therapy. This model was developed at the Medical University of South Carolina by Scott Henggeler and his team (Schoenwald *et al*., 2016). Multisystemic therapy combines intensive family therapy with individual skills training for adolescents and intervention in the wider school and interagency 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; using individual and family strengths to develop and implement action plans and new skills to disrupt these problem maintaining patterns; supporting families to follow through on action plans; helping families 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 three to six months. Therapists carry low caseloads of no more than five cases and provide 24/7 availability for crisis management. In a meta-analysis of twenty-two international studies, van der Stouwe *et al*. (2014) found that compared with treatment as usual, multisystemic therapy led to small but significant treatment reductions in delinquency, substance use, psychopathology, out-of-home placement, family disorganization, and engagement with antisocial peers. Multisystemic therapy was most effective for young Caucasian adolescents under the age of 15, with severe problems and in which treatment led to improvement in parenting skills. The positive effects found in this recent large meta-analysis by van der Stouwe *et al*. (2014) were smaller than those found in previous meta-analyses of fewer studies of multisystemic therapy (Curtis *et al*., 2004, Littell, 2005). These meta-analytic findings are consistent with those from recent narrative reviews by Henggeler's group which showed that multisystemic therapy had positive effects in multiple domains including delinquency and drug misuse up to twenty years after treatment, and led to significant cost-saving in placement, juvenile justice and crime victim costs (Henggeler, and Schaeffer, 2016, 2017). However, multisystemic therapy is not more effective than treatment-as-usual in all contexts. In a large (N=684) UK independent randomized controlled trial, Fonagy *et al*. (2018) found that multisystemic therapy was

no more effective than treatment-as-usual in reducing out-of-home placements of delinquent youth at eighteen-months follow up.

Multidimensional Family Therapy (MDFT). 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, 2016a). Multidimensional Family Therapy involves assessment and intervention in four domains, including: (1) adolescents, (2) parents, (3) interactions within the family, and (4) family interactions with other agencies such as schools and courts. Three distinct phases characterize MDFT: 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 four to six 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. In a meta-analysis of nineteen studies (including one very large multi-country European study), van der Pol *et al*. (2017) found that compared with alternative treatments, Multidimensional Family Therapy led to small but significant reductions in antisocial behaviour, substance misuse, psychopathology and family disorganization. The effects were greatest for families of adolescents with severe problems. These meta-analytic results are consistent with those from previous meta-analyses and narrative reviews (Filges *et al*., 2015; Liddle, 2016b; Rowe and Liddle, 2008), notably that of Liddle (2016b), who concluded that Multidimensional Family Therapy has positive short- and long-term effects in multiple domains including delinquency and drug misuse, and leads to significant cost-savings.

Treatment Foster Care Oregon. This model, which was originally branded as Multidimensional Treatment Foster Care, was developed at the Oregon Social Learning Centre by Patricia Chamberlain and her team (Buchanan *et al*., 2017). Multidimensional Treatment Foster Care combines procedures similar to multisystemic therapy with specialist foster placement, in which trained 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 which last six to nine months. Concurrently, the young person and his or her birth family engage in weekly family therapy with a focus on parents developing behavioural parenting practices, and families developing communication and problem-solving skills. Adolescents engage in individual therapy and skills training, to help them develop self-regulation and social skills. Wider systems consultations are carried out with adolescents' school teachers, probation officers and other involved professionals, to ensure all relevant members of the youngsters' social systems are co-operating in ways that promote their improvement. Over a six to nine-month period the adolescent is phased from the foster family into the birth family as their antisocial behaviour decreases, and as birth family parents develop competence in using behavioural parenting skills to maintain improvements in the adolescent's behaviour. This model of Treatment Foster Care is delivered by a team that includes a team leader, trained foster parents, a family therapist for the birth family, an individual therapist and skills coach for the young person, a consultant psychiatrist, and a trainer who recruits and trains foster parents and collects daily data on the young person's prosocial and antisocial behaviour by phone. A team carries a caseload of up to ten families. About 85 per cent of adolescents return to their birth parents' home after Treatment Foster Care. There have been ten outcome studies of Treatment Foster Care, three of which were controlled studies of delinquent male or female adolescents (Buchanan *et al*., 2017). These showed that compared with care in a group home for delinquents, Multidimensional Treatment Foster Care significantly reduced antisocial behaviour, drug misuse, and re-arrest rates. It also led to reductions in running away from placement and teenage pregnancy (for girls), and improvements in educational and psychological adjustment. The benefits of Multidimensional Treatment Foster Care were due to the improvement in parents' skills for managing adolescents in a consistent, fair, non-violent way, and reductions in 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).

Service implications for pervasive conduct problems and substance misuse in adolescence. From this review, it may be concluded that in developing services for families of adolescents with conduct and substance use disorders, it is most efficient to offer services on a continuum of care.

The intensity of therapy should be matched to the severity of the youngster's difficulties. Cases with severe problems that do not respond to intensive brief strategic family therapy, functional family therapy, multidimensional family therapy, or multisystemic therapy may be offered intensive Treatment Foster Care Oregon. It is essential that such a service involves high levels of supervision and low caseloads for front-line clinicians because of the complexity of these cases. Where adolescents have conduct disorder and comorbid substance use disorder, where appropriate, medical assessment, detoxification, and other medical services 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 of 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 meta-analysis of forty-one studies from seventeen countries, Polanczyk *et al*. (2015) found that the pooled prevalence rate for anxiety disorders was 6.5 per cent and for depressive disorders was 2.6 per cent. Between 1.5 and 4 per cent of children under 18 lose a parent by death, and a proportion of these show complicated grief reactions (Black, 2002). Community-based studies show that about 13 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 females, while completed suicide is more common among males (Hawton *et al*., 2015).

Disorders where anxiety is a central feature

In children and adolescents, disorders where anxiety is a central feature include separation anxiety, selective mutism, phobias, social anxiety disorder, generalized anxiety disorder, obsessive compulsive disorder and post-traumatic stress disorder (American Psychiatric Association, 2013; World Health Organization, 1992). All are characterized by excessive fear of particular internal experiences or external situations, and avoidance of these. Cognitive behaviour therapy that involves young people being exposed to anxiety provoking stimuli and situations and learning to cope with the distress that this elicits is

a particularly effective intervention (Higa-McMillan *et al*., 2016). In a meta-analysis of eight controlled trials, Brendel and Maynard (2014) found that exposure-based cognitive behavioural family therapy was significantly more effective than individual cognitive behaviour therapy for children with anxiety disorders ($d = 0.26$). However, this finding was not supported by a meta-analysis of sixteen studies by Thulin *et al*. (2014) which found no difference between individual and family-based treatments. These conflicting meta-analytic findings were resolved in a large study with synthesized individual case data from eighteen separate trials. In this study Manassis *et al*. (2014) found that cognitive behavioural family therapy in which parents were helped to use contingency management to reinforce children's 'brave behaviour' for coping with exposure to anxiety-provoking stimuli or situations was particularly effective in helping young people maintain treatment gains a year after treatment had ended. This type of cognitive behavioural family therapy was significantly more effective in the long term than therapy where parents had limited involvement, or where they had extensive involvement which did not involve using contingency management to reinforce children's 'brave behaviour'. These recent findings extend those of previous systematic reviews of the effectiveness of cognitive behavioural family therapy for child and adolescent anxiety disorders, which showed that it was at least as effective as individual cognitive behaviour therapy, more effective than individual therapy in cases where parents also had anxiety disorders, and more effective than individual interventions in improving the quality of family functioning (Barmish and Kendall, 2005; Chorpita *et al*., 2011; Creswell and Cartwright-Hatton, 2007; Drake and Ginsburg, 2012; Reynolds *et al*., 2012; Silverman *et al*., 2008).

Barrett's *FRIENDS* programme is the best validated family-oriented cognitive behaviour 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 ninety-minute sessions for the last twenty minutes to become familiar with programme content. There are also a couple of dedicated family sessions and one and three-month follow-up sessions for relapse prevention. Both children and parents engage in psychoeducation about anxiety, which provides a rational for anxious children engaging 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 cases, and this improvement rate is significantly higher than that found for individual therapy (Elliott, 1999; Heyne *et al*. 2013; Kearney and Sheldon, 2017; 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.

Obsessive compulsive disorder (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. Also, family life comes to be dominated by other family members' attempts to accommodate to, or prevent these rituals. Meta-analyses and narrative reviews have shown that family-based, cognitive behavioural, exposure and response prevention treatment is effective in alleviating symptoms in 50 to 70 per cent of cases of paediatric OCD; that the best treatment response occurs where such interventions are combined with selective serotonin reuptake inhibitors (SSRI) such as Sertaline; and that family-based CBT is more effective than SSRIs alone (Franklin *et al*., 2017; McGuire *et al*., 2015; Moore *et al*., 2013; Rapoport and Shaw, 2015; Rosa-Alcázar *et al*., 2015; Sánchez-Meca *et al*., 2014; Thompson-Hollands

et al., 2014; Watson and Rees, 2008). Treatment is offered on an individual or group basis to children with concurrent family sessions over about four 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 inadvertent reinforcement of 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 these 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.

Post-traumatic stress disorder (PTSD). PTSD occurs following a catastrophic trauma which is perceived as potentially life-threatening to the self or others. In PTSD children have recurrent, intrusive, anxiety-provoking traumatic memories. These occur as flashbacks or engaging in repetitive trauma-related play while awake, or as nightmares when asleep. Young people try to avoid these experiences by suppressing memories and avoiding situations that remind them of the trauma. There may be an inability to remember aspects of the trauma, difficulty in experiencing positive emotions, extreme negative emotions or emotional numbing, and extremely negative beliefs about the self, others, and the dangerousness of the world in general. Meta-analyses and narrative reviews show that family-based, trauma-focused cognitive behaviour therapy is the systemic intervention for PTSD in young people with the strongest evidence base (Dorsey *et al*., 2017; Kowalik *et al*., 2011; Lenz and Hollenbaugh, 2015). This family-based intervention was described earlier in the section on child sexual abuse. In a recent meta-analysis of twenty-one trials, Lenz and Hollenbaugh (2013) found that young people who had experienced multiple types of trauma including war, terrorism, natural disasters, and maltreatment, who engaged in family-based trauma-focused cognitive behaviour therapy fared better than those who received alternative treatments ($d = 0.28$) or who were on waiting-lists ($d = 1.48$). Trauma-focused cognitive behaviour therapy spans sixteen weeks,

and involves concurrent sessions for traumatized children and their parents, in group or individual formats, with periodic conjoint parent-child sessions (Cohen *et al.*, 2006). The child-focused component involves exposure to abuse-related memories and cues through trauma narration and *in vivo* exposure, relaxation and coping skills training, and safety skills training. Concurrent work with parents and conjoint sessions with children and parents focus on psychoeducation, reframing trauma experiences, helping parents to develop supportive and protective relationships with their children, and to develop support networks for themselves.

Service implications for anxiety. This review suggests that in developing services for children with disorders where anxiety is a central feature, systemic interventions of up to sixteen sessions should be offered, which invite children to enter into increasingly anxiety-provoking situations in a planned way, to manage the distress associated with this by using coping skills, and to be reinforced and supported by their parents for doing so.

Depression

Major depressive disorder is an episodic condition characterized by low or irritable mood, loss of interest in normal activities, and most of the following symptoms: sleep and appetite disturbance, psychomotor agitation or retardation, fatigue, low self-esteem, inappropriate excessive guilt, pessimism, impaired concentration; and suicidal ideation (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 lifecycle, 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 (Brent and Maalouf, 2015). Family-based therapy aims to reduce stress and increase support for young people within their families. But other factors also provide a rationale for family therapy. Not all young people respond to antidepressant medication. Also, 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 of 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 (e.g. attachment-based family therapy (Diamond *et al*., 2016)); child-focused CBT (Klein *et al*., 2007) or interpersonal therapy (Pu *et al*., 2017) sessions combined with some family or parent sessions; and concurrent group-based parent and child training sessions (e.g. the Adolescent Coping with Depression programme (Rhode, 2017)). Stark *et al*. (2012) concluded that family-based treatments for child and adolescent depression were as effective as well-established therapies such as individual CBT or interpersonal therapy (Zhou *et al*., 2015), led to remission in two-thirds to three-quarters of cases at six months follow up, and were 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 psychoeducation about depression; relational reframing of depression-maintaining family interaction patterns; facilitation of clear parent-child communication; promotion of systematic family-based problem-solving; disruption of negative critical parent-child interactions; promotion of secure parent-child attachment; and helping children develop skills for managing negative mood states and changing 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 intervention is offered early in further episodes. Systemic therapy services should be organized so as to permit the option of multimodal treatment with family therapy and antidepressant medication in cases unresponsive to family therapy alone (Biernacki *et al*., 2015).

Grief

In a systematic review or outcome studies, Bergman *et al*. (2017) identified fourteen studies which evaluated family-based programmes for children whose parents had died. These programmes significantly reduced children's traumatic grief reactions, and parents' levels of

perceived social support and engagement in positive parenting behaviour. Effective systemic interventions which address grief reactions following parental bereavement share a number of features in common (Ayers *et al*., 2014; Cohen *et al*., 2006; Kissane and Bloch, 2002). Family intervention involves engaging families in treatment, facilitating family grieving, facilitating 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, 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 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 initial treatment of acute manic, hypomanic, or mixed episodes with second generation antipsychotic medication, and subsequent prevention of further episodes with mood-stabilizing medication, especially lithium (Leibenluft and Dickstein, 2015). 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, and the observation that relapse may be associated with high levels of parental expressed emotion, provides the rationale for the development of relapse prevention interventions (Miklowitz and Chung, 2016). Psychoeducational family therapy aims to prevent relapses by reducing family stress (including parental expressed emotion) and enhancing family support for youngsters with bipolar disorder who are concurrently taking mood-stabilizing medication (Miklowitz, 2008). Narrative

reviews of a series of outcome studies show that for paediatric bipolar disorder, psychoeducational family therapy ameliorates mood symptoms, increases knowledge about the condition, and improves family relationships (Fristad and MacPherson, 2014; Goldberg *et al*., 2015; Miklowitz and Chung, 2016). Family therapy for bipolar disorder typically spans about twelve to twenty-one sessions and includes psychoeducation about the condition and its management, and family communication and problem-solving skills training. 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 multimodal programme which includes mood-stabilizing medication such as lithium.

Self-harm

A complex constellation of risk factors has been identified for self-harm in adolescence which include characteristics of the young person (such as presence of psychological disorder), and features of the social context (such as family difficulties) (Hawton *et al*., 2015; 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 systemic interventions improved the adjustment of adolescents who had self-harmed (Asarnow *et al*., 2011; Diamond *et al*., 2010; Freeman *et al*., 2016; Harrington *et al*., 1998; Huey *et al*., 2004; King *et al*., 2006, 2009; Rotheram-Borus *et al*., 2000), although family interventions were not always more effective than alternative treatments in reducing recurrence of self-harm. For example, in a large (*N=832*) UK randomized controlled trial, Cottrell *et al*. (2018) found that family therapy was no more effective than treatment-as-usual in preventing repeated self-harm at eighteen months follow up. Family-based approaches that improve adjustment share a number of common features. They begin by engaging young people and their families in an initial risk assessment process, and proceed to the development of a clear plan for risk reduction which 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 family 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 was noted above, but 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 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 develop greater empathy for their adolescents' experiences. When adolescents and parents are ready, conjoint family therapy sessions are convened in which 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 competency and autonomy. In this context, parents serve as the secure base from which 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 three months of attachment-based family therapy was more effective than routine treatment in reducing suicidal ideation and depressive symptoms at six months follow up.

Multisystemic therapy. Multisystemic therapy was originally developed for adolescent conduct disorder as was noted above, but 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 interagency 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 three to six 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 one year follow up.

Dialectical behaviour therapy and 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 spans four months and involves individual therapy for adolescents combined with multifamily psychoeducational therapy and individual family therapy sessions as needed. The multifamily psychoeducational therapy helps family members to understand self-harming behaviour and to develop skills for protecting and supporting self-harming adolescents. Family therapy offers a forum within which families can support the adolescent and address issues that require more time than is available in multifamily sessions. The adolescent-focused therapy component includes modules on mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness skills to address problems in the areas of identity, impulsivity, emotional lability and relationship problems respectively. In a review of six controlled trials, Freeman *et al*. (2016) concluded that dialectical behaviour therapy and family therapy was an effective intervention for adolescents who had attempted suicide. It led to significant reductions in non-suicidal self-harming behaviour, suicidal ideation and depressive symptoms.

Service implications for self-harm. 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 sessions over a three- to six-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 to lack 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). In a national US survey, Swanson *et al*. (2011) found that the lifetime prevalence of eating disorders among adolescents was about 1 per cent. Childhood obesity occurs where there is a body mass index above the 95th percentile with reference to age 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 US it is about 15 per cent (Wang and Lim, 2012).

Anorexia nervosa

A series of systematic reviews and meta-analyses covering over a dozen trials and implementation studies allow the following conclusions to be drawn about the effectiveness of family therapy for anorexia nervosa in adolescents (Blessitt *et al*., 2015; Couturier *et al*., 2013; Couturier and Kimber, 2015; Downs and Blow, 2013; Eisler, 2005; Jewell *et al*., 2016; LeGrange and Robin, 2017; Lock, 2015; Murray *et al*., 2014; Pike *et al*., 2015; Smith and Cook-Cottone, 2011; Stuhldreher *et al*., 2012; Watson and Bulik, 2013). After treatment, between a half and two-thirds of cases achieve a healthy weight. At six months to six 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 inpatient 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 inpatient treatment. Evidence-based family therapy for anorexia can be effectively disseminated from specialist centres and implemented in community-based clinical settings. In the Maudsley model for treating adolescent anorexia, which is the approach with strongest empirical support, family therapy for adolescent anorexia progresses through four phases (Eisler *et al*., 2016a; Lock and Le Grange, 2013).

In the first phase the focus is on engaging with the family, conducting a multidisciplinary systemic, medical, and psychiatric assessment and developing a therapeutic alliance. The second phase involves helping parents work together to refeed their youngster. The parents are viewed as a resource to facilitate recovery rather than as a cause of the eating disorder. The eating disorder is externalized and viewed as a challenging problem which all family members, including the adolescent with the eating disorder, work together to resolve. This is followed, in the third phase, with facilitating family support for the youngster in developing an autonomous, healthy eating pattern, and exploration of issues of individual and family development. In the final phase the focus is on helping the young person develop an age-appropriate lifestyle, recovery review, and relapse prevention planning. Treatment typically involves ten to twenty one-hour sessions over a six- to twelve-month period.

A recent large effectiveness trial indicated that when individual family therapy was combined with intensive multi-family therapy, it was significantly more effective than single family therapy in the treatment of adolescent anorexia nervosa (Eisler *et al*., 2016b). Groups of five to seven families met with a co-therapy team over a period of five consecutive days, and then on five follow-up days over six to nine months. The four-stage Maudsley model was followed, coupled with a strong emphasis on facilitating mutual support and optimism, and reducing stigmatization. During the engagement phase, a family who had completed multi-family therapy described their experiences to programme participants. In multifamily therapy, families had their meals and snacks together and this provided multiple opportunities for *in vivo* learning and support. The results of this large trial are consistent with those from four small uncontrolled studies of multifamily therapy for adolescent anorexia (Jewell *et al*., 2016)

Bulimia nervosa

In a review of three trials of the Maudsley model of family therapy for bulimia in adolescence, Jewell *et al*. (2016) concluded that it was more effective than supportive therapy and led to more rapid initial increases in recovery than cognitive behaviour therapy. At six to twelve months follow up, binge-purge abstinence rates were 13 to 44 per cent for those who engaged in family therapy and 10 to 36 per cent for those who engaged in individual therapy. Family therapy for adolescent bulimia spans fifteen to twenty sessions. To motivate young

people to engage in therapy, and create a context that facilitates co-operative conjoint family sessions, separate sessions with adolescents and parents are scheduled prior to conjoint family sessions. Therapy 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 (Feng, 2011; Janicke *et al*., 2014; Jelalian and Saelens, 1999; Jelalian *et al*., 2007; Kitzmann and Beech, 2011; Kitzmann *et al*., 2010; Nowicka and Flodmark, 2008; Whitlock *et al*., 2010; Wilfley *et al*., 2007; 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 to 20 per cent reduction in weight after treatment, and at ten-year follow up 30 per cent of cases 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 goals are agreed and progress towards goals is monitored by parents and children. Stimulus control procedures are used, so eating cues are only present during mealtimes and only healthy food is available in the home. Parents model healthy eating and regular exercise, and reinforce young people for adhering to healthy eating and exercise routines. Better outcome occurs when therapy is offered to individual families rather than multi-family groups, and where therapy is of longer duration. Therapy may span one to twenty-four months, with most programmes spanning three to six months.

Service implications for eating disorders

In planning systemic services for young people with eating disorders, it should be expected that treatment of anorexia or bulimia will span six to twelve months, with the first ten sessions occurring weekly and later sessions occurring fortnightly, and then monthly. More rapid recovery may occur if this is supplemented with multifamily therapy.

For obesity, therapy may span three to six months of weekly 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, functional abdominal pain, and poorly controlled asthma and diabetes.

Enuresis

The prevalence of nocturnal enuresis, or bedwetting, is about 15 per cent in 6-year-olds and declines to 1 per cent among 18-year-olds (Mellon and Houts, 2017). Systematic reviews and meta-analyses of randomized controlled trials show family-based urine alarm programmes are an effective treatment for childhood nocturnal enuresis (bed-wetting); are as effective as medication (desmopressin) at the end of treatment; and are more effective than medication in the long term, because many children relapse when they stop taking desmopressin (Glazener *et al*., 2009; Perrin *et al*., 2015). Family-based urine alarm programmes, if used over twelve to sixteen weeks, are effective in about 70 to 90 per cent of cases (Mellon and Houts, 2017). These programmes involve coaching the child and parents to use an enuresis alarm, which alerts the child as soon as micturition begins. The urine wets a pad which closes a circuit, and sets off the urine alarm, which wakes 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

About 1.5–7.5 per cent of preschool and elementary school children have encopresis (Mellon and Houts, 2017). Systematic reviews and meta-analyses show that multimodal programmes involving medical assessment and intervention followed by behavioural family therapy are effective for 43–75 per cent of cases (Brazzelli *et al*., 2011; Freeman *et al*., 2014; McGrath *et al*., 2000). 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 per cent 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).

Functional abdominal pain

The lifetime prevalence of functional abdominal pain is 13.5 per cent (Korterink *et al*., 2015). Narrative reviews and meta-analyses show that cognitive behavioural family therapy is effective in alleviating recurrent functional abdominal pain, often associated with repeated school absence, and for which no biomedical cause is evident (Banez and Gallagher, 2006; Garralda and Rask, 2015; Sprenger *et al*., 2011; Weydert *et al*., 2003). Such programmes involve family psychoeducation about functional abdominal pain and its management, relaxation and coping skills training to help children manage abdominal pain which is often anxiety-based, and contingency management implemented by parents to motivate children to engage in normal daily routines, including school attendance.

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 and, if very poorly controlled, asthma is potentially fatal (Currie and Baker, 2012). The course of asthma is determined by the interaction between abnormal respiratory system physiological processes 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.

They included psychoeducation to improve 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 (e.g. Ellis *et al*., 2014; Naar-King *et al*., 2104; Ng *et al*., 2008) but not all (e.g. Celano *et al*., 2012) recent trials. The adaption of multisystemic therapy for treating high-risk families of asthmatic adolescents is an important recent development. In a randomized controlled trial, compared with family support, multisystemic therapy led to significant improvements in adolescents' asthma management and lung function, parental self-efficacy, and parental beliefs in the value of asthma-related positive parenting behaviours (Ellis *et al*., 2014; Naar-King *et al*., 2014).

Poorly controlled diabetes

Type 1 diabetes is an endocrine disorder characterized by complete pancreatic failure (Holt *et al*., 2017). 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 self-monitoring of blood glucose. Systematic reviews and meta-analyses of the impact of family-based, systemic, cognitive behavioural and psychoeducational programmes for families of adolescents with type 1 diabetes allow the following conclusions to be drawn (Farrell *et al*., 2002; Hilliard *et al*., 2016; Hood *et al*., 2010; Lohan *et al*., 2013; Savage *et al*., 2010). Effective family-based programmes spanned two to six months. Effective programmes led to improvements in a range of domains including family members' knowledge about diabetes and its management, adherence, glycaemic control, hospitalization, quality of family relationships, and wellbeing of children and parents. Different types of programmes were appropriate for families at different stages of the lifecycle. For families of young children newly diagnosed with diabetes, psychoeducational programmes which 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 adolescence. Behavioural family systems therapy (Wysocki *et al*., 2007, 2008) and multisystemic therapy adapted for families of adolescents with type 1 diabetes (Ellis *et al*., 2008, 2012) are particularly well supported systemic interventions for families of young people with poorly controlled diabetes.

Service implications for somatic problems

This review suggests that family therapy may be incorporated into multimodal, multidisciplinary paediatric programmes for a number of somatic conditions including enuresis, encopresis, functional 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 two to six months.

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). An attenuated psychosis syndrome for individuals with brief episodes of one or more psychotic symptoms and insight into these is included in DSM-5 as a schizophrenia spectrum condition deserving further study. This condition, often referred to as ARMS (which stands for 'at-risk mental states') is typically shown by those at high risk for developing psychosis (Tiffin and Welsh, 2013). First episode psychosis or ARMS typically occur in late adolescence. These conditions are exceptionally distressing for the young person and the family. Antipsychotic medication is the primary treatment for psychotic symptoms. Pharmacological interventions may be combined with psychoeducational family therapy in which the primary aim is to facilitate a supportive family environment, and so prevent the development of a chronic relapsing psychotic condition (McFarlane, 2015). Reviews and meta-analyses of over a dozen controlled trials of psychoeducational family therapy for

psychosis in adolescence, or young people at risk of psychosis lead to the following conclusions (Bird *et al*., 2010; Clazton *et al*., 2017; Ma *et al*., 2017; McFarlane, 2016; McFarlane *et al*., 2012; Onwumere *et al*., 2011). Combining antipsychotic medication with psychoeducational family therapy leads to significantly better outcomes than routine treatment with antipsychotic medication. For young people, better outcomes include a reduction in psychotic symptoms and relapse rates. For family members, better outcomes include improvement in carer wellbeing, reduction in carer burden, and reduction in patient-directed negative expressed emotion, particularly criticism and hostility. The reduction in patient-directed criticism and conflict may lead to young people experiencing less stress or more support, and this may facilitate recovery. Compared with single family therapy (Kuipers *et al*., 2002), multifamily psychoeducational therapy (McFarlane, 2002) may be particularly effective, possibly because it provides families with a forum within which to experience mutual support, shared learning, and a reduced sense of isolation and stigmatization. Outcomes for family therapy for childhood onset psychosis are less favourable than for adolescents, possibly because this is a more severe and debilitating condition (Hollis and Palaniyappan, 2015).

Psychoeducational family therapy for psychosis involves psychoeducation based on the stress-vulnerability or bio-psycho-social models of psychosis (McFarlane, 2015). It aims to help families understand and manage the condition, antipsychotic medication, related stresses, and early warning signs of relapse. Psychoeducational family therapy also aims to reduce negative family processes associated with relapse, specifically high levels of expressed emotion, stigma, communication deviance, and lifecycle-transition-related stresses. Emphasis is placed on blame reduction, the positive role family members can play in supporting the young person's recovery, and the importance of families building social support networks. Psychoeducational family therapy also helps families develop communication, problem-solving, coping, crisis management, and service accessing skills. Skills training commonly involves modelling, rehearsal, feedback and discussion. Effective interventions typically span nine to twelve months, and are usually offered in a phased format with 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 multimodal programmes that include

antipsychotic medication. Because of the potential for relapse, services should make re-referral arrangements, so intervention is offered early in later episodes.

Discussion

The evidence base for systemic therapy for child-focused problems has grown significantly since the previous version of this review (Carr, 2014). Greatest growth has occurred in research evaluating systemic interventions for disruptive behaviour disorders and psychosis. Important innovations have also been evaluated, including multifamily therapy for eating disorders and multisystemic therapy adapted for chronic health problems.

The evidence reviewed above supports the following conclusions. First, systemic interventions are effective, and cost-effective for a wide range of child-focused problems. Second, these interventions rarely involve more than twenty sessions over two to six months offered on an outpatient or home-visiting basis. Third, treatment manuals are available for many systemic interventions and these may be flexibly used in routine practice. Fourth, most evidence-based systemic interventions have been developed within the cognitive behavioural, structural and strategic family therapy traditions. In the final section of a companion paper the implications of these findings will be discussed (Carr, 2018).

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 Care and Health Excellence (NICE) for a range of problems including conduct disorder (NICE, 2013a), ADHD (NICE, 2013b), drug misuse (NICE, 2007, 2008), bipolar disorder (NICE 2017a), eating disorders (NICE, 2017b), and psychosis in adolescence (NICE, 2013c).

A broad definition of systemic intervention has been adopted in this paper, in comparison with the narrower definition taken in other similar reviews (e.g. Kaslow *et al*., 2012; Retzlaff *et al*., 2013; von Sydow *et al*., 2013). A broad definition entails both pros and cons. On the positive side, it provides a larger evidence base. A large evidence base may be more convincing when justifying funding family therapy services. A broad definition also offers family therapists a wide range of sources to consult when seeking guidance on family-based treatment procedures for specific problems that may usefully be

incorporated into routine systemic practice. However, the broad definition of systemic intervention taken here potentially blurs the unique contribution of systemic family therapy practices to positive outcomes, as distinct from the effects of enlisting the aid of parents in implementing individually-focused cognitive behavioural, psychodynamic or biomedical therapies.

The main limitation of the current paper is that it is not a systematic review. Rather, it is a narrative review, mainly of other reviews and meta-analyses. It is, therefore, subject to biases, especially positive biases, of both its author and of authors of the narrative reviews which it covers. Having said that, reference is made in our review to important studies which conclude that in certain contexts systemic therapy has been shown not to be more effective than treatment-as-usual (e.g. Cottrell *et al*., 2018; Fonagy *et al*., 2018). It is therefore difficult to state definitively the extent to which author biases affected our conclusions about the degree to which systemic therapy is effective.

Our findings have implications for research, training and practice. More research is needed on the effectiveness of distinctly systemic interventions for child maltreatment, problems of infancy, and emotional problems in young people. Family therapy development and evaluation studies are required for new emerging child-focused problems such as internet gaming addiction (Young, 2017). More research is also required on the effectiveness of social constructionist and narrative approaches to systemic practice. While popular, these approaches have rarely been evaluated. With respect to training, systemic evidence-based interventions should be incorporated into family therapy training programmes and continuing professional development courses for experienced systemic practitioners, a position endorsed in UK and US statements of core competencies for systemic therapists (Northey, 2011; Stratton *et al*., 2011). With respect to practice, family therapists may incorporate approaches described above and in the treatment resources listed below into their routine clinical work.

Treatment resources

Sleep problems

Mindell, J. and Owens, J. (2009) *A clinical guide to paediatric sleep: diagnosis and management of sleep problems* (2nd ed.). Philadelphia: Lippincott Williams and Wilkins.

Sheldon, S., Kryger, M., Ferber, R. and Gozal, D. (2014) *Principles and practice of paediatric sleep medicine* (2nd ed.). New York: Elsevier/Saunders.

Feeding problems

Kedesdy, J. and Budd, K. (1998) *Childhood feeding disorders: behavioural assessment and intervention*. Baltimore, MD: Paul. H. Brookes.

Attachment problems

Juffer, F., Bakermans-Kranenburg, M. and van IJzendoorn, M. (2008) *Promoting positive parenting: an attachment-based intervention*. Mahwah, NJ: Erlbaum.

Lieberman, A. and Van Horn, P. (2005) *Don't hit my mommy: a manual for child–parent psychotherapy with young witnesses of family violence*. Washington: Zero to Three Press.

Powell, B., Cooper, G., Hoffman, K. and Marvin, B. (2014) *The circle of security intervention: enhancing attachment in early parent–child relationships*. 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, CA: Sage Publications.

McNeil, C. and Hembree-Kigin, T. (2011) *Parent-child interaction therapy* (2nd ed.). New York: Springer.

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, E., Mannarino, A. P. and Cohen, J. A. (2015) *Child sexual abuse: a primer for treating children, adolescents, and their nonoffending parents* (2nd ed.). New York, NY: Oxford University Press.

Childhood behaviour problems

Dadds, M. and Hawes, D. (2006) *Integrated family intervention for child conduct problems*. Brisbane: Australian Academic Press.

Kazdin, A. (2005) *Parent management training*. Oxford: Oxford University Press.

Generation Parent Management Training Oregon – https://www.generationpmto.org
Incredible Years Programme – http://www.incredibleyears.com/
Kazdin Parent Management Training – http://alankazdin.com
Parent Child Interaction Therapy – http://www.pcit.org
Parents Plus Programme – http://www.parentsplus.ie/
Triple P – http://www.triplep.net/

Attention deficit hyperactivity disorder

Barkley, R. (2013) *Defiant children: a clinician's manual for parent training* (3rd ed.). New York: Guilford Press.
Barkley, R. (2014) *Attention deficit hyperactivity disorder: a handbook for diagnosis and treatment* (4th ed.). New York: Guilford Press.

Adolescent conduct disorder and drug misuse

Alexander, J., Waldron, H., Robbins, M. and Neeb, A. (2013) *Functional family therapy for adolescent behaviour problems*. Washington, DC: American Psychological Association.
Chamberlain, P. (1994) *Family connections: a treatment foster care model for adolescents with delinquency*. Eugen, OR: Northwest Media Inc.
Chamberlain, P. (2003) *Treating chronic juvenile offenders: advances made through the Oregon multidimensional treatment foster care model*. Washington, DC: American Psychological Association.
Henggeler, S., Schoenwald, S., Bordin, C., Rowland, M. and Cunningham, P. (2009) *Multisystemic therapy for antisocial behaviour in children and adolescents* (2nd ed.). New York: Guilford Press.
Liddle, H. A. (2002) *Multidimensional family therapy treatment (MDFT) for adolescent cannabis users: Vol. 5 Cannabis Youth Treatment (CYT) manual series*. Rockville, MD: Centre for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. Available at: http://awmueller.com/psicologia/drogas_thc_familia.pdf.
Sexton, T. (2011) *Functional family therapy in clinical practice*. New York: Routledge.
Szapocznik, J., Hervis, O. and Schwartz, S. (2002) *Brief strategic family therapy for adolescent drug abuse*. Rockville, MD: National Institute for Drug Abuse. Available at http://archives.drugabuse.gov/TXManuals/BSFT/BSFTIndex.html.
Brief Strategic Family Therapy – http://www.bsft.org/
Functional Family Therapy – http://www.functionalfamilytherapy.com, http://www.fftllc.com
Multidimensional Family Therapy – http://www.mdft.org
Multisystemic Therapy – http://www.msstservices.com/
Treatment Foster Care Oregon – http://www.tfcoregon.com

Anxiety

Cohen, J., Mannarino, A. and Deblinger, E. (2006) *Treating trauma and traumatic grief in children and adolescents*. New York: Guilford Press.
Freeman, J. and Garcia, A. M. (2008) *Family-based treatment for young children with OCD: therapist guide*. New York: Oxford University Press.
Kearney, C. and Albano, A. (2007) *When children refuse school. Therapist guide* (2nd ed.). New York: Oxford University Press.
FRIENDS anxiety management programme – https://www.friendsresilience.org/faq/

Depression

Diamond, G., Diamond, G. and Levy, S. (2013) *Attachment-based family therapy for depressed adolescents*. Washington, DC: American Psychological Association.
Lewinsohn's coping with depression programme. http://www.kpchr.org/public/acwd/acwd.html

Grief

Cohen, J., Mannarino, A. and Deblinger, E. (2006) *Treating trauma and traumatic grief in children and adolescents*. New York: Guilford Press.
Kissane, D. and Bloch, S. (2002) *Family focused grief therapy: a model of family-centred care during palliative care and bereavement*. Buckingham, UK: Open University Press.

Bipolar disorder

Miklowitz, D. (2008) *Bipolar disorder: a family-focused treatment approach* (2nd ed.). New York: Guilford Press.

Self-harm in adolescence

Henggeler, S., Schoenwald, S., Rowland, M. and Cunningham, P. (2002) *Multisystemic treatment of children and adolescents with serious emotional disturbance*. New York: Guilford Press.
Miller, A., Rathus, J. and Linehan, M. (2007) *Dialectical behaviour therapy with suicidal adolescents*. New York: Guilford Press.

Eating disorders

Le Grange, D. and Locke, J. (2007) *Treating bulimia in adolescents. a family-based approach*. New York: Guilford Press.
Lock, J. and Le Grange, D. (2013) *Treatment manual for anorexia nervosa. A family based approach* (2nd ed.). New York: Guilford Press.
Eisler, I., Simic, M., Blessitt, E. and Dodge, L. and Team (2016) *Maudsley service manual for child and adolescent eating disorders* (revised). London, UK: Child and Adolescent Eating Disorders Service, South London and Maudsley NHS Foundation Trust. Available at: http://www.national.slam.nhs.uk/services/camhs/camhs-eatingdisorders/resources/

Enuresis

Herbert, M. (1996) *Toilet training, bedwetting and soiling*. Leicester: British Psychological Society.

Encopresis

Buchanan, A. (1992) *Children who soil. assessment and treatment*. Chichester: Wiley.

Psychosis

Kuipers, L., Leff, J. and Lam, D. (2002) *Family work for schizophrenia* (2nd ed.). London: Gaskell.

McFarlane, W. (2002) *Multifamily groups in the treatment of severe psychiatric disorders*. New York: Guilford Press.

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Bergman, A., Axberg, U., and Hanson, E. (2017) When a parent dies – a systematic review of the effects of support programs for parentally bereaved children and their caregivers. *BMC Palliative Care*, **16**(1): E39.

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