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THE EFFECTIVNESS OF FAMILY THERAPY AND SYSTEMIC INTERVENTIONS FOR CHILD -FOCUSED PROBLEMS

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Running head: Effectiveness of family therapy for children

ABSTRACT

This review updates a similar paper published in JFT in 2001. It presents evidence from meta-analyses, systematic literature reviews and controlled trials for the effectiveness of systemic interventions for families of children and adolescents with various difficulties. In this context, systemic interventions include both family therapy and other family-based approaches such as parent training. The evidence supports the effectiveness of systemic interventions either alone or as part of multimodal programmes for sleep, feeding and attachment problems in infancy; child abuse and neglect; conduct problems (including childhood behavioural difficulties, ADHD, delinquency and drug abuse); emotional problems (including anxiety, depression, grief, bipolar disorder and suicidality); eating disorders (including anorexia, bulimia and obesity); and somatic problems (including enuresis, encopresis, recurrent abdominal pain, and poorly controlled asthma and diabetes).

INTRODUCTION

This paper summarizes the evidence base for systemic practice with child-focused problems, and updates a similar paper published in JFT eight years ago (Carr, 2000). It is also a companion paper to a review of research on the effectiveness of systemic interventions for adult-focused problems (Carr, 2008a). Over the past 8 years within the field of family therapy two trends are particularly salient (Carr, 2004, 2005, 2006, 2008b; Rivett, 2001, 2002, 2003). Among family therapist practitioners, narrative and social constructionist approaches informed by a post-modern ideology have become increasingly popular in informing a vibrant and creative approach to conducting therapy. In contrast, among family therapy researchers, the development and rigorous scientific evaluation of integrative manualized models of practice, drawing on structural, strategic, and cognitive behavioural therapeutic traditions, and informed by a positivist ideology has contributed the growth of an evidence base for systemic intervention. The current review is timely and important because there is a global move toward evidence-based practice and increasing pressures across health systems internationally to prioritise the provision of evidence-based interventions. With the inevitable issue of competition for limited resources, it is essential for systemic practitioners to be well informed about the evidence base for their approach, and to incorporate evidence based practices into their clinical style, so they can compete for those resources. Results of meta-analyses confirm that for many child and adult mental health problems and relationship difficulties, systemic interventions such as couples and family therapy are effective. Shadish and Baldwin (2003) reviewed 20 meta-analyses of systemic interventions for a wide range of child and adult-focused problems. The average effect-size across all meta-analyses was .65 after therapy, and .52 at 6-12 months follow-up. These results show that, overall, the average treated family, fared better after therapy and at follow-up than in excess of 71% of families in control groups. In the current climate of evidence-based practice, it is important for systemic practitioners to

draw this conclusion about the overall effectiveness of couples and family therapy to the attention of service managers, funders and policy makers. However, such broad conclusions are of limited value for informing routine clinical practice. Practitioners require specific evidence-based statements about the types of family-based interventions that are most effective for particular types of problems. The present paper address this question with particular reference to problems of infancy, child abuse and neglect, conduct problems, emotional problems, eating disorders, and somatic problems. This particular set of problems has been chosen because extensive computer and manual literature searches showed that, for each of these areas, meta-analyses, controlled trials or experimental single case studies of family-based interventions have been reported.

In this paper a broad definition of systemic practices has been taken, which covers family therapy and other family-based interventions such as parent training or multisystemic therapy, which engage family members or members of the families' wider networks in the process of resolving problems for young people from birth up to the age of 18 years. The focus is on treatment rather than prevention, so pre-natal preventative interventions such as the Nurse-Family Partnership programme for low-income young pregnant women have been excluded (Olds, 2002). Extensive computer and manual literature searches were conducted for systemic interventions with a wide range of problems of childhood and adolescence. Major data bases, family therapy journals, and child and adolescent mental health journals were searched, as well as major textbooks on evidence based practice. Where available, meta-analyses and systematic review papers were selected for review, 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 for review. Only in the absence of such trials, were uncontrolled studies selected. This strategy was adopted to permit the strongest case to be made for systemic evidence-

based practices with a wide range of child-focused problems, within the space constraints of a single paper.

PROBLEMS OF INFANCY

Family-based interventions are effective for a proportion of cases with sleeping, feeding and attachment problems. These occur in about a quarter to a third of infants and are of concern because they may compromise family adjustment and later child development (DelCarmen-Wiggins and Carter, 2004; NICHD Early Child Care Research Network, 2006).

Sleep problems

Family-based behavioural programmes are an effective treatment for settling and night waking problems, which are the most prevalent sleep difficulties in infancy (Stores, 2001). In these programmes, parents are coached in reducing or eliminating children's day time naps, developing positive bedtime routines, reducing parent-child contact at bedtime or during episodes of night waking, and introducing scheduled waking where children are awoken 15-60 minutes before the child's spontaneous waking time and then resettled. A systematic review of 41 studies of family-based behavioural programmes for sleep problems in young children by Mindell (1999) and of 9 randomized controlled trails of family-based and pharmacological interventions by Ramchandani et al. (2000), indicate that both family-based and pharmacological interventions are effective in the short term, but only systemic interventions have positive long-term effects on children's sleep problems.

Feeding problems

Severe feeding problems in infancy, which may be associated with failure to thrive, include food refusal, self-feeding difficulties, swallowing problems, and frequent vomiting. Family-based behavioural programmes are particularly effective in addressing these problems (Kedesdy and Budd, 1998). Such programmes involve parents prompting, shaping and reinforcing appropriate feeding behaviour and ignoring inappropriate feeding responses. In a systematic review of 29 controlled single case and group studies, Kerwin (1999) concluded that such programmes were effective in ameliorating severe feeding problems and improving weight gain in infants and children with developmental disabilities.

Attachment problems

Infant attachment insecurity is a risk factor for a range of adjustment problems in later life (Berlin and Ziv, 2005). In a meta-analysis of 70 studies evaluating interventions to reduce attachment insecurity, Bakermans-Kranenburg et al. (2003) concluded that brief, highly-focused family-based interventions that specifically aimed to enhance maternal sensitivity were particularly effective in improving maternal sensitivity and reducing infant attachment insecurity. The most effective interventions focused on helping mothers develop sensitivity to their infants' cues; involved fathers as well as mothers; and spanned no more than 15 sessions. In these programmes mothers learned to carry infants close to their chest, in their arms or in special baby-carriers, for extended time periods. They also learned to recognize, interpret and respond to infants' signals to pre-empt and minimize distress. Programmes used a variety of methods including workbooks, video modelling, video feedback and direct coaching to achieve these aims. Broader programmes that aimed to address many psychosocial family issues over longer time periods were less effective than brief, behavioural, sensitivity-focused programmes.

The results of this review suggest that in developing services for families of infants with sleeping, feeding and attachment problems, only relatively brief out-patient

programmes are required, involving **up to 15 sessions** over 3-4 months for each episode of treatment.

CHILD ABUSE AND NEGLECT

Systemic interventions are effective in a proportion of cases of child abuse and neglect. These problems have devastating effects on the psychological development of children (Myers et al., 2002)**.** In western industrialized countries, the prevalence of physical child abuse is 10-25% (Wekerle and Wolfe, 2003). Community surveys show that the prevalence of sexual abuse involving contact between the perpetrator and child is 1-16% in males and 6-20% in females (Creighton, 2004).

Physical abuse and neglect

Systematic narrative reviews concur that for physical child abuse and neglect, effective therapy is family-based, structured, extends over periods of at least 6 months, and addresses specific problems in relevant subsystems including children's posttraumatic adjustment problems; parenting skills deficits; and the overall supportiveness of the family and social network (Chaffin and Friedrich, 2004; Edgeworth and Carr, 2000; MacDonald, 2001; MacLeod and Nelson, 2000; Skowron and Reinemann, 2005; Tolan et al., 2005). Cognitive behavioural family therapy (Kolko, 1996; Kolko and Swenson, 2002), parent-child interaction therapy (Chaffin et al., 2004; Hembree-Kigin and McNeil, 1995; Timmer et al, 2005), and multisystemic therapy (Brunk et al., 1987; Henggeler et al., 1990) 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 controlled trial Kolko (1996) found that at one year follow-up conjoint cognitive behavioural family therapy and concurrent parent and child cognitive behaviour therapy were both more effective than

routine services in reducing the risk of further abuse in families of school-aged children in which physical abuse had occurred. The 16 session programme involved helping parents and children develop skills for regulating angry emotions, communicating and managing conflict, and developing alternatives to physical punishment as a disciplinary strategy (Kolko and Swenson, 2002).

Parent-child interaction therapy for physical abuse. In a controlled trial of parent-child interaction therapy, Chaffin et al (2004) found that at 2 years follow-up, only 19% of parents who participated in parent-child interaction therapy had a re-report for physical abuse compared with 49% of parents assigned to standard treatment. Parent-child interaction therapy involved 6 sessions which aimed to enhance parent motivation to engage in parent training; 7 sessions devoted to live coaching of parents and children in positive child-directed interactions; and 7 sessions devoted to live coaching of parents and children in behavioural management of discipline issues using time-out and related procedures.

Multisystemic therapy for physical abuse and neglect. Brunk et al. (1987) compared the effectiveness of multisystemic therapy and group-based behavioural parent training in families where physical abuse or neglect had occurred. Families who received multisystemic therapy showed greater improvements in family problems and parent-child interaction after treatment. Multisystemic therapy involved joining with family members and members of their wider social and professional network, reframing interaction patterns, and prescribing tasks to alter problematic interaction patterns within specific subsystems (Henggeler and Borduin, 1990). Therapists designed intervention plans on a per-case basis in light of family assessment; used individual, couple, family and network meetings in these plans; and received regular supervision to facilitate this process; and carried small case loads of 4-6 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 and Heflinger, 1996). In a meta- analysis of six studies of trauma-focused cognitive behaviour therapy, Macdonald et al. (2006) found an effect size of .43, which indicates that the average treated case fared better than 67% of control group cases who received standard care. These findings are consistent with the results of previous narrative reviews (Chaffin and Friedrich, 2004; Cohen, Mannarino, Murray et al., 2006; Putnam, 2003; Ramchandani and Jones, 2003; Reeker et al., 1997; Stevenson, 1999). 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 the offender live separately from the victim until they have completed a treatment programme and been assessed as being at low risk for re-offending (Doren, 2006). The child-focused component involves exposure to abuse-related memories to facilitate habituation to them; relaxation and coping skills training; learning assertiveness and safety skills; and addressing victimization, sexual development and identity issues. Concurrent work with non-abusing parents and conjoint sessions with abused children and non-abusing parents focus on helping parents develop supportive and protective relationships with their children, and develop support networks for themselves.

The results of this review suggest that in developing services for families in which abuse and / or neglect has occurred, programmes that begin with a comprehensive network assessment and include along with regular family therapy sessions, the option of parent-focused and child-focused interventions should be prioritized. Programmes should

span at least 6 months, with the intensity of input matched to families' needs. Therapists should carry small case loads **of less than 10 cases.**

CONDUCT PROBLEMS

Family-based systemic interventions are effective for a proportion of cases of childhood behaviour problems (or oppositional defiant disorder), attention deficit hyperactivity disorder, pervasive adolescent conduct problems, and drug abuse. All of these difficulties are of concern because they may lead to co-morbid academic, emotional and relationship problems, and in the long-term to adult adjustment difficulties (Burke et al. 2002; Loeber et al., 2000). They are also relatively common. In a review of community surveys, Costello et al. (2004) found that the median prevalence rate for oppositional defiant disorder was 3.7%; for ADHD was 2.7%; for conduct disorder was 3.7%; and for substance abuse was 4.5%. Prevalence rates for these four types of problems ranged from 1-24% across studies.

Childhood behaviour problems

Childhood behaviour problems are maintained by both personal attributes (such as self-regulation problems) on the one hand, and contextual factors (such as problematic parenting practices) on the other, and treatment programmes have been developed to target each of these sets of factors (Burke et al., 2002; Loeber et al., 2000).

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% of children, with gains maintained at one year follow-up, particularly if periodic follow-up sessions are offered (Barlow et al., 2002; Behan and Carr, 2000; Brestan and Eyberg, 1998; Burke et al., 2002; Coren et al., 2002; Farrington and Welsh, 2003; Kazdin, 2007; Nixon, 2002;

Nock, 2003; Serketich and Dumas, 1996). Behavioural parent training also has a positive impact on parental adjustment problems. For example, in meta-analyses of parent training studies Serketich and Dumas (1996) found an effect size of .44 and McCart et al. (2000) found an effect size of .33 for parental adjustment. Thus, the average participant in parent training fared better than 63-65% of control group cases. Behavioural parent training is far more effective than individual therapy. For example, in a meta-analysis of 30 studies of behavioural parenting training, and 41 studies of individual therapy, McCart et al. (2006) found effect sizes of .45 for parent training and .23 for individual therapy.

A critical element of behavioural parent training, which derives from Patterson's (1976) seminal work, is helping parents develop skills for increasing the frequency of children's prosocial behaviour (through attending, reinforcement, and engaging in child-directed interactions) and reducing the frequency of antisocial behaviour (through ignoring, time-out, contingency contracts, and engaging in parent directed interactions).

Immediate feedback, video-feedback and video-modelling have been used in effective behavioural parent training programmes. With video feedback, parents learn child management skills by watching videotaped episodes of themselves using parenting skills with their own children. With immediate-feedback, parents are directly coached in child-management skills through a 'bug in the ear' while the therapist observes their interaction with their children from behind a one-way mirror. Eyberg's Parent-Child Interaction Therapy for parents of preschoolers is a good example of this approach (Brinkmeyer and Eyberg, 2003). With video-modelling based, parents learn child management skills through viewing video clips of actors illustrating successful and unsuccessful parenting skills. Webster-Stratton's Incredible Years programme is a example of this type of approach (Webster-Stratton and Reid, 2003).

The effectiveness of behavioural parent training programmes may be enhanced by concurrently engaging children in therapy which aims to remediate deficits in self-

regulation skills, such as managing emotions and social problem-solving (Kazdin , 2003; Webster-Stratton and Reid, 2003).

In a meta-analysis of 31 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 (Brinkmeyer and Eyberg, 2003) and Triple-P (Sanders et al., 2004) programmes, which included additional sessions on parental support and stress management, were far more effective than standard versions of these programmes.

The results of this review suggest that in developing services for families where childhood behaviour problems are a central concern, behavioural parent training should be offered, with the option of additional child-focused and parent-focused interventions being offered where assessment indicates particular vulnerabilities in these subsystems. Programmes should span at least 6 months, with the intensity of input matched to families' needs. Each aspect of the programme should involve about 10-20 sessions depending on need.

Attention and overactivity problems

Attention deficit hyperactivity disorder (ADHD) is currently the most commonly used term for a syndrome, usually present from infancy, characterized by persistent overactivity, impulsivity and difficulties sustaining attention (Barkley, 2005). Available evidence suggests that vulnerability to attentional and overactivity problems, unlike oppositional

behavioural problems discussed in the preceding section, is largely constitutional (Barkley, 2005).

Systematic reviews concur that systemic interventions for ADHD, comprising sessions with families, school-staff and young people are best offered as elements of multimodal programmes involving stimulant medication (Anastopoulos et al., 2005; Friemoth, 2005; Hinshaw et al., 2007; Jadad et al., 1999; Klassen et al., 1999; Nolan and Carr, 2000; Schachar et al., 2002). For example, Hinshaw et al. (2007) in a review of 14 randomized controlled trials, concluded that about 70% of children benefit from multimodal programmes. Results of two recent large controlled trials, have raised complex questions about the extent of the contribution of non-pharmacological interventions to the impact of multimodal programmes (Abikoff et al., 2004; Jensen et al., 2007). It seems that in the short-term, the benefits of multimodal programmes are largely due to the impact of stimulant medication, but in the long-term, systemic interventions with families, schools and children play an increasingly important role.

Multimodal programmes typically include stimulant treatment of children with drugs such as methylphenidate combined with family therapy or parent training; school based behavioural programmes; and coping skills training for children. Family therapy for ADHD focuses on helping families develop patterns of organization conducive to effective child management (Anastopoulos et al., 2005). Such patterns of organization include a high level of parental co-operation in problem-solving and child management; a clear intergenerational hierarchy between parents and children; warm supportive family relationships; clear communication; and clear moderately flexible, rules, roles and routines. School-based behavioural programmes involve the extension of home-based behavioural programmes into the school setting through home-school, parent-teacher liaison meetings (Du Paul and Stoner, 1994). Coping skills training focuses largely on

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

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

Pervasive conduct problems in adolescence

About a third of children with childhood behaviour problems develop conduct disorder, which is a pervasive and persistent pattern of antisocial behaviour which extends beyond the family into the community (APA, 2000; WHO, 1992). Adolescent self-regulation and skills deficits; problematic parenting practices; and extrafamilial factors such as deviant peergroup membership, high stress and low social support maintain conduct disorder, and are targeted by effective treatment programmes (Burke et al., 2002; Loeber et al., 2000).

In a meta-analysis of 8 family-based treatment studies of adolescent conduct disorder, Woolfenden et al. (2002) found that family-based treatments including functional family therapy, multisystemic therapy and treatment foster care were more effective that routine treatment. Family-based treatments significantly reduced time spent in institutions; the risk or re-arrest; and recidivism 1-3 years following treatment. These effective family-based psychosocial interventions for adolescent conduct disorder fall on a continuum of care which extends from functional family therapy; through more intensive multisystemic

therapy; to very intensive treatment foster care (Brosnan and Carr, 2000; Kazdin, 2007; Nock, 2003).

Functional family therapy. Functional family therapy is a manualized model of systemic family therapy for adolescent conduct disorder (Sexton and Alexander, 2003). 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 8-30 sessions over 3-6 months. A comprehensive system for transporting functional family therapy to community settings, training and supervising therapists, and for maintaining treatment fidelity in these settings has also been developed. In a systematic review of 13 clinical trials of functional family therapy, Alexander et al. (2000) concluded that this approach to therapy is effective in reducing recidivism by 26-73% in adolescent offenders with conduct disorders from a variety of ethnic groups over follow-up periods of up to 5 years, compared with those receiving routine services. It also leads to a reduction in conduct problems in siblings of offenders. In a review of a series of large scale effectiveness studies, Sexton and Alexander (2003), found that functional family therapy was $5,000-12,000 less expensive per case than juvenile detention or residential treatment and led to crime and victim cost savings of over $13,000 per case. The same review concluded that in a large scale effectiveness study, the drop-out rate for functional family therapy was about 10% compared to the usual drop out rates of 50-70% in routine community treatment of adolescent offenders.

Multisystemic therapy. Multisystemic therapy is an manualized approach to the treatment of adolescent conduct disorder which combines intensive family therapy with individual skills training for the adolescent, and intervention in the wider school and

interagency network (Henggeler and Lee, 2003). 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 3-6 months. Therapists carry low case loads of no more than 5 cases and provide 24 hour, 7 day availability for crisis management. A comprehensive system for transporting multisystemic therapy to community settings, training and supervising therapists, and for maintaining treatment fidelity in these settings has also been developed. In a meta-analysis of 11 studies evaluating the effectiveness of multisystemic therapy, Borduin et al. (2004), found a post-treatment effect size of .55, which indicates that the average treated case fared better than 72% of control group cases receiving standard services. Positive effects were maintained up to 4 years after treatment. Multisystemic therapy had a greater impact on improving family relations than on improving individual adjustment or peer relations. In a systematic review of 8 studies Henggeler and Lee (2003), concluded that compared with treatment-as-usual, multisystemic therapy led to significant improvements in individual and family adjustment which contributed to significant reductions in out-of home placement, recidivism, behaviour problems, substance abuse and school absence. Multisystemic therapy led to a 25-70% decrease in re-arrests and a 47-64% decrease in rates of out-of-home placement over 1-4 years. These outcomes entailed cost savings of over $60,000 per case in placement, juvenile justice and crime victim costs.

Multidimensional treatment foster care. Multidimensional treatment foster care combines procedures similar to multisystemic therapy with specialist foster placement, in which foster parents use behavioural principles to help adolescents modify their conduct problems (Chamberlain and Smith, 2003, 2005). 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 6-9 months. Concurrently, the biological family and young person engage in weekly family therapy with a focus on parents developing behavioural parenting practices, and families developing communication and problem-solving skills. Adolescents also engage in individual therapy, and wider systems consultations are carried out with youngsters' school teachers, probation officers and other involved professionals, to insure all relevant members of youngsters' social systems are co-operating in ways that promote youngsters' improvement. About 85% of adolescents return to their parents home after treatment foster care. In a review of 2 studies of treatment foster care for delinquent male and female adolescents, Chamberlain and Smith (2003) found that compared with care in a group home for delinquents, multidimensional treatment foster care significantly reduced running away from placement, re-arrest rate and self-reported violent behaviour. 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.

From this review it may be concluded that in developing services for families of adolescents with conduct disorder, it is most efficient to offer services on a continuum of

care. Less severe cases may be offered functional family therapy, up to 30 sessions over a 6 month period. Moderately severe cases and those that do not respond to circumscribed family interventions may be offered multisystemic therapy up to 20 hours per month over a periods of op to 6 months. Extremely severe cases and those who are unresponsive to intensive multisystemic therapy may be offered treatment foster care for a period of up to year and this may then be followed with ongoing multisystemic intervention. It would be essential that such a service involve high levels of supervision and low case loads for front line clinicians because of the high stress load that these cases entail and the consequent risk of therapist burnout.

Drug abuse in adolescence

In a systematic narrative review of 53 studies of the treatment of adolescent drug abusers, Williams and Chang (2000) concluded that comparative studies consistently showed family therapy to be more effective than other types of treatments including individual therapy, therapeutic communities, outward bound programmes, and 12 step Minnesota model programmes. In three systematic reviews covering 13 controlled trials of family therapy for adolescent drug abuse, Liddle and his team (Liddle, 2004; Ozechowski and Liddle, 2000; Rowe and Liddle, 2003) concluded that, for a significant proportion of youngsters, family therapy was more effective than routine individual or group psychotherapies in engaging and retaining youngsters in therapy, reducing drug use, and improving psychological, educational and family adjustment. These gains were maintained a year or more after treatment. Family therapy was also more cost-effective than residential treatment. In a meta-analysis of 7 studies of the effectiveness of family therapy compared to alternative therapies for adolescent drug abuse, Stanton and Shadish (1997) found an effect size of .39 for reduced drug use at follow-up, which indicates that the average case receiving family therapy fared better than 66% of cases that received other

forms of treatment.

Effective family therapy for adolescent drug abuse involves regular family sessions over a 3-6 month period, as well as direct work with youngsters and other involved professionals, with therapy intensity matched to the severity of the youngster's difficulties (Cormack and Carr, 2000; Liddle, 2004; Liddle et al., 2005; Muck et al., 2001; Ozechowski and Liddle, 2000; Rowe and Liddle, 2003; Santiseban et al., 2006; Szapocznik and Williams, 2000; Williams and Chang, 2000). Family therapy for adolescent drug abuse involves distinct phases of engaging youngsters and their families in treatment; helping families organize for youngsters to become drug-free; helping families create a context for the youngster to maintain a drug free lifestyle; helping youngsters acquire skills to remain drug free; family re-organization; co-operation with other community services and professionals; relapse prevention training for youngsters and their families; and disengagement. In some instances youngsters may require such therapy to be offered as part of a multimodal programme involving medical assessment, detoxification, and methadone maintenance, if youngsters are addicted to heroin and are unready to become completely drug-free. Liddle's (2005) multidimensional family therapy, and Szapocznik et al.'s (2002) brief strategic family therapy are manualized treatment models with particularly strong evidence bases.

This review suggests that services for adolescent drug abuse should involve an intensive family engagement process and thorough assessment, followed by regular family sessions over a 3-6 month period, coupled with direct work with youngsters and other involved professionals. The intensity of therapy should be matched to the severity of the youngster's difficulties. Where appropriate, medical assessment, detoxification, or methadone maintenance should also be provided.

EMOTIONAL PROBLEMS

Family-based systemic interventions are effective for a proportion of cases with anxiety disorders, depression, grief following parental bereavement, bipolar disorder, and attempted suicide. 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 review of community surveys, Costello et al. (2004) found that the median prevalence rate for anxiety disorders was 8.1%, with a range from 2-24%; the median prevalence rate for major depression was 4.7%, with a range form 1-13%; and the prevalence of bipolar disorder in young people was under 1%. Between 1.5 and 4% of children under 18 lose a parent by death, and a proportion of these show complicated grief reactions (Black, 2002). Estimates of the prevalence of suicide attempts in adolescence range from 1-4% in males and 2-10% in females (Bridge et al., 2006).

Anxiety

Anxiety disorders in children and adolescents include separation anxiety, phobias, generalized anxiety disorder, obsessive compulsive disorder and post-traumatic stress disorder (APA, 2000; WHO, 1992). All are characterized by excessive fear of particular internal experiences or external situations, and avoidance of these. Systematic reviews of the effectiveness of family-based treatment for anxiety disorders, show that it is at least as effective as individual cognitive behaviour therapy; more effective than individual therapy in cases where parents also have anxiety disorders; and more effective than individual interventions in improving the quality of family functioning (Barmish and Kendall, 2005; Diamond and Josephson, 2005). Barrett's *FRIENDS* programme is the best validated family-based intervention for childhood anxiety disorders (Barrett and Shortt, 2003). In the child-focused element of this programme youngsters learn anxiety management skills such as relaxation, cognitive coping and using social support. In the family-based

component, parents learn to reward their children's use of anxiety management skills, ignore their avoidant or anxious behaviour, manage their own anxiety, and develop communication and problem-solving skills to enhance the quality of parent-child interaction.

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 et al., 1999; Heyne and King, 2004; King and Bernstein, 2001; King et al., 2000). 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 member's attempts to accommodate to, or prevent these rituals. Two trials support the effectiveness of family-based exposure and response prevention as an effective treatment for OCD in young people (Barrett et al., 2005; Storch et al., 2007). In a comparative trial involving 40 young people with OCD, Barrett et al. (2005) found that family-based therapy offered to individual cases or groups of cases were equally effective. At 12 to 18 months following treatment 70-84% of cases were in remission. The intervention programme used

in this study is called FOCUS which stands for Freedom from Obsessions and Compulsions Using Cognitive-Behavioural Strategies and involves 14 weekly sessions with two later follow-up sessions (Barrett and Farrell, in press). Exposure and response prevention is the individual element of the programme. With this, children are exposed to cues (such as dirt) that elicit anxiety provoking obsessions (such as ideas about contamination), 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. Family intervention involves psychoeducation, 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. In a second trial involving 40 young people with OCD, Storch et al. (2007) found that an intensive daily programme of 14 sessions over 3 weeks and a less intensive programme of 14 weekly sessions of family-based exposure and response prevention treatment were equally effective, leading to remission in 72-77% of cases. The protocol was similar, though not identical to that used in Barrett et al's (2005) study.

This review suggests that in developing services for children with anxiety disorders, family therapy of up to 15 sessions should be offered, which allows children to enter into anxiety provoking situations in a planned way and to manage these through the use of coping skills and parental support.

Depression

Major depression is an episodic disorder characterized by low or irritable mood, loss of interest in normal activities, and most of the following symptoms: psychomotor agitation or retardation, fatigue, low self-esteem, pessimism, inappropriate excessive guilt, suicidal ideation, impaired concentration, and sleep and appetite disturbance (APA, 2000; WHO,

1992). Typical episodes last for 4 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 youngsters find themselves involved in stressful social systems in which there is limited access to socially supportive relationships (Shortt and Spence, 2006). Family-based therapy, aims to reduce stress and increase support for young people within their families. But other factors also provide a rational for family therapy. Not all young people respond to antidepressant medication (Goodyer et al., 2007). 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).

Conjoint family therapy and concurrent group-based parent and child training sessions are as effective as individual cognitive behavioural and psychodynamic therapies in the treatment of major depression, and lead to remission in two thirds to three quarters of cases at 6 months follow-up (Curry et al., 2003; Diamond, 2005; Diamond et al., 2002; Lewinsohn et al, 1990, 1996; Sanford et al., 2006; Trowell et al., 2007; Weersing and Brent, 2003). 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 the facilitation of clear parent-child communication; the promotion of systematic family based problem-solving; the disruption of negative critical parent-child interactions; and the promotion of secure parent-child attachment. With respect to clinical practice and service development, family therapy for episodes of adolescent depression is relatively brief requiring about 12 sessions, but 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.

Grief

A number of single group outcome studies and controlled trials show that psychotherapy leads to improved adjustment in children following loss of a parent (Black and Urbanowicz, 1987; Cohen et al., 2002; Cohen and Mannarino, 2004; Cohen, Mannarino and Deblinger, 2006; Kissane and Bloch, 2002; Rotherham-Borus et al, 2004; Sandler et al., 1992, 2003). Effective therapy for grief reactions following parental bereavement may include a combination of family and individual interventions (Cohen, Mannarino and Deblinger, 2006; Kissane and Block, 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 12 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 (APA, 2000; WHO, 1992). The primary treatment for bipolar disorder is pharmacological,

and involves the initial treatment of acute manic, hypomanic, depressive or mixed episodes, and the subsequent prevention of further episodes with mood stabilizing medication such as lithium (James and Javaloyes, 2001; Lofthouse and Fristad, 2004; Pavuluri et al., 2005). Bipolar disorder typically first occurs in late adolescence or early adulthood and its course, even when treated with mood stabilizing medication, is significantly affected by stressful life events and family circumstances on the one hand, and family support on the other. The high frequency of relapses among young people with bipolar disorder provides the rationale for the development of relapse prevention interventions.

Psyhoeducational family therapy aims to prevent relapses by reducing family stress and enhancing family support for youngsters with bipolar disorder who are concurrently taking mood stabilizing medication such as lithium (Miklowitz and Goldstein, 1997). Family therapy for bipolar disorder typically spans about 12 sessions and includes psychoeducation about the condition and its management, and family communication and problem-solving skills training. Results of three studies suggest that psychoeducational family therapy may be helpful in adolescent bipolar disorder in increasing knowledge about the condition, improving family relationships, and improving symptoms of depression and mania (Fristad et al., 2002, 2003; Miklowitz et al., 2004; Pavuluri et al., 2004). With respect to clinical practice and service development, family therapy for bipolar disorder in adolescence is relatively brief requiring about 12 sessions, and should be offered as part of a multimodal programme which includes mood stabilizing medication such as lithium.

Attempted suicide

A complex constellation of risk factors has been identified for attempted suicide 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)

(Bridge et al., 2006). Both sets of factors are targeted in family-based treatment for attempted suicide in adolescence. Six studies have found that a range of specialized family therapy interventions improve the adjustment of adolescents who have attempted suicide (Harrington et al., 1998; Huey et al., 2004; Katz et al., 2004; King et al., 2006; Rathus and Miller 2002; Rotheram-Borus et al., 2000). Effective approaches 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. Multisystemic therapy, dialectical behaviour therapy combined with multifamily therapy, and nominated support network therapy are well developed protocols with these characteristics.

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 3-6 months. Huey et al. (2004) evaluated the effectiveness of multisystemic therapy for suicidal adolescents in a randomized controlled study of 156 African American adolescents at risk for suicide referred for emergency psychiatric hospitalization. Compared with emergency hospitalization and treatment by a multidisciplinary psychiatric team, Huey et al. found that multisystemic therapy was significantly more effective in decreasing rates of attempted suicide at one year follow-up.

Dialectical behaviour therapy and multifamily therapy. Dialectical behaviour therapy, which was originally developed for adults with borderline personality disorder, has been adapted for use with adolescents who have attempted suicide (Miller et al., 2007). This adaptation involves individual therapy for adolescents combined with multifamily psyhoeducational therapy. The multifamily psychoeducational therapy helps family members understand self-harming behaviour and develop skills for protecting and supporting suicidal youngsters. The individual therapy component includes modules on mindfulness, distress tolerance, emotion-regulation, and interpersonal effectiveness skills to address problems in the areas of identity, impulsivity, emotional liability and relationship problems respectively. Evidence from two controlled outcome studies support the effectiveness of dialectical behaviour therapy with adolescents who have attempted suicide. In a study of suicidal adolescents with borderline personality features, Rathus and Miller (2002) compared the outcome for 29 cases who received dialectical behaviour therapy plus psychoeducational multifamily therapy, and 82 cases who received psychodynamic therapy plus family therapy. In each programme, participants attended therapy twice weekly. Both programmes led to reductions in suicidal ideation. Significantly more cases completed the dialectical behaviour therapy programme, and significantly fewer were hospitalized during treatment. In a further study of 62 suicidal adolescent inpatients, Katz et al. (2004) found that both dialectical behaviour therapy and routine inpatient care led to significant reductions in parasuicidal behaviour, depressive symptoms, and suicidal ideation, but dialectical behaviour therapy led to significantly greater reductions in behaviour problems.

Youth Nominated Support Team. Youth Nominated Support Team is a manualized systemic intervention for adolescents who have attempted suicide, in which adolescents nominate a parent or guardian and three other people from their family, peer group, school or community to be members of their support team (King et al. 2000). For

each case, support team members receive psyhoeducation explaining how the adolescent's psychological difficulties led to the suicide attempt, the treatment plan, and the role that support team members can play in helping the adolescent towards recovery and managing situations where there is a risk of further self-harm. Support team members are encouraged to maintain weekly contact with the adolescent and are contacted regularly by the treatment team to facilitate this process. King et al. (2006) evaluated the Youth Nominated Support Team programme in a randomized controlled trial of 197 girls and 82 boys who had attempted suicide and been hospitalized. They found that, compared with routine treatment with psychotherapy and antidepressant medication, the Youth-Nominated Support Team programme led to decreased suicidal ideation and mood-related functional impairment in girls at 6 months follow-up, but had no significant impact on boys.

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

EATING DISORDERS

Family therapy is effective for a proportion of children and adolescents with anorexia, bulimia and obesity. 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 eating disorders in young people. A distinction has been made between anorexia nervosa and bulimia nervosa with the former being characterized primarily by weight loss and the latter

by a cyclical pattern of bingeing and purging (APA, 2000; WHO, 1992). Childhood obesity occurs where there is a body mass index above the 95th percentile with reference to age and sex specific growth charts (Lissau et al., 2004). Anorexia, bulimia and obesity conditions are of concern because they lead to long-term physical and / or mental health problems.

Anorexia nervosa

In a systematic narrative review of 6 uncontrolled and 5 randomized treatment trials of family therapy for adolescent anorexia, Eisler (2005) concluded that after treatment between a half and two-thirds of cases achieve a healthy weight. At 6 months to 6 years follow-up, 60-90% have fully recovered and no more than 10-15% are seriously ill. Eisler also noted that the negligible relapse rate following family therapy is superior to the moderate outcomes for individually oriented therapies. It is also far superior to the high relapse rate following inpatient treatment, which is 25-30% following first admission, and 55-75% for second and further admissions. These conclusions are consistent with those of previous narrative reviews (Le Grange and Lock, 2005; Mitchell and Carr, 2000; Wilson and Fairburn, 2007). Family therapy for adolescent anorexia involves helping parents work together to refeed their youngster. This is followed by helping the family support the youngster in developing an autonomous, healthy eating pattern, and an age appropriate lifestyle (Lock et al., 2001).

Bulimia nervosa

Two trials of family therapy for bulimia in adolescence show that it is more effective than supportive therapy (Le Grange et al., 2007), and as effective as cognitive behaviour therapy (Schmidt et al., 2007), which is considered to be the treatment of choice for bulimia in adults, due its strong empirical support (Wilson and Fairburn, 2007). In both

trials, at 6 months follow-up, over 70% of cases treated with family therapy showed partial or complete recovery. Family therapy for adolescent bulimia involves helping parents work together to supervise the young person during mealtimes and afterwards, to break the binge-purge cycle. As with anorexia, this is followed by helping families support their youngsters in developing autonomous, healthy eating patterns, and age appropriate lifestyles (Le Grange and Locke, 2007).

Obesity

In a systematic narrative review of 42 randomized controlled trials of treatments for obesity in children, Jelalian and Saelens (1999) concluded that family-based behavioural weight reduction programmes were more effective than dietary education and other routine interventions. They led to a 5-20% reduction in weight after treatment and at 10 year follow-up 30% of cases were no longer obese. These results are consistent with those of other narrative reviews (Epstein, 2003; Young et al., 2007; Zametkin et al., 2004). Childhood obesity is due predominantly to lifestyle factors including poor diet and lack of exercise, and so family-based behavioural treatment programmes focus on lifestyle change. Specific dietary and exercise routines are agreed, and parents reinforce young people for adhering to these routines (Jelalian et al., 2007).

In planning systemic services for young people with eating disorders, it should be expected that treatment of anorexia or bulimia will span 6-12 months, with the first 10 session occurring weekly and later sessions occurring fortnightly, and then monthly. For obesity, therapy may span 10-20 sessions followed by periodic infrequent review sessions over a number of years to help youngsters maintain weight loss.

SOMATIC PROBLEMS

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

Enuresis

In a systematic review and meta-analysis of 53 randomized controlled trials, Glazener et al., (2003) found that family-based urine alarm programmes were an effective treatment for childhood nocturnal enuresis (bed-wetting). These programmes involve coaching the child and family to use an enuresis alarm, which alerts the child as soon as micturition begins. Family-based urine alarm programmes, if used over 12 –16 weeks, are effective in about 60-90%% of cases (Houts, 2003). With a urine alarm, 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 awake 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.

Encopresis

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

approach to family therapy for encopresis. Silver et al. (1998) found success rates of 63% and 37% for narrative and behavioural family therapy respectively. With narrative family therapy, the soiling problem was externalized and referred to as *Sneaky Poo*. Therapy focused on parents and children collaborating to outwit this externalized personification of encopresis (White, 2007).

Recurrent abdominal pain (RAP).

Results of 4 trials have shown that behavioural family therapy is effective in alleviating recurrent abdominal pain, often associated with repeated school absence, and for which no biomedical cause is evident (Finney et al., 1989; Robins et al. 2005; Sanders et al., 1989, 1994). Such programmes involve family psychoeducation about RAP and its management, relaxation and coping skills training to help children manage stomach pain which is often anxiety -based, and contingency management implemented by parents to motivate children to engage in normal daily routines, including school attendance. This conclusion is consistent with those of other systematic narrative reviews (Janicke and Finney, 1999; Murphy and Carr, 2000; Spirito and Kazak, 2006; Weydert et al., 2003).

Poorly controlled asthma

Asthma, a chronic respiratory disease with a prevalence rate of about 10% among children, can lead to significant restrictions in daily activity, repeated hospitalization, and if very poorly controlled asthma is potentially fatal (Lehrer et al., 2002). 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 20 studies, Brinkley et al. (2002) concluded that family-based interventions for asthma spanning up to 8 sessions, were more effective than individual therapy, and included psyhoeducation 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.

Poorly controlled diabetes

Type 1 diabetes is an endocrine disorder characterized by complete pancreatic failure (Plotnick, 1999). The long-term outcome for poorly controlled diabetes may include blindness and leg amputation. For youngsters with diabetes, blood glucose levels as close as possible to the normal range is achieved through a regime involving a combination of insulin injections, balanced diet, exercise and self-monitoring of blood glucose. In a systematic review of 11 studies Farrell et al. (2002) found that family-based programmes of 10-20 sessions were effective in helping young people control their diabetes, and that different types of programmes were appropriate for young people at different stages of the lifecycle. For youngsters 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.

This review suggests that family therapy may be incorporated into multimodal, multidisciplinary paediatric programmes for a number of somatic conditions including enuresis, encopresis, recurrent abdominal pain, and both poorly controlled asthma and

diabetes. Systemic intervention for these conditions should be offered following thorough paediatric medical assessment, and typically interventions are brief ranging from 8-12 sessions.

DISCUSSION

A number of comments may be made about the evidence reviewed in this paper. First, for a wide range of child-focused problems systemic interventions are effective. Second, these interventions are brief, rarely involving more than 20 sessions, and may be offered by a range of professionals on an outpatient basis. Third, treatment manuals have been developed for many systemic interventions and these may be flexibly used by clinicians in treating individual cases. Fourth, most evidence-based systemic interventions have been developed within the cognitive-behavioural, structural and strategic traditions. The implications of these findings will be discussed in the final section of a companion paper (Carr, 2008).

The results of this review are broadly consistent with the important role accorded to systemic interventions and family involvement within NICE guidelines for a range of disorders in children and adolescents including depression (NICE 2004a), eating disorders (NICE, 2004b), attempted suicide (NICE, 2004c), bipolar disorder (NICE, 2006), OCD (NICE, 2005a), PTSD (NICE, 2005b), and diabetes (NICE, 2004d).

A broad definition of systemic intervention has been adopted in this paper. There are pros and cons to this approach. On the positive side, it provides the widest scope of evidence on which to draw in support of systemic practice. This is important in a climate where there is increasing pressure to point to a large and significant evidence base to justify funding family therapy services (or indeed any particular type of psychotherapy). However, the broad definition of systemic intervention taken in this paper potentially blurs the unique contribution of those

practices developed within the tradition of family therapy, as distinct from interventions in which parents are included in an adjunctive role to facilitate individually focused therapy

The findings of this review have implications for research, training and practice. With respect to research, while the evidence-base for the effectiveness of family therapy for conduct problems, drug abuse and eating disorders is well developed, future research should prioritize the evaluation of systemic interventions for child abuse and neglect, emotional problems and psychosis in young people. More research is also required on social-constructionist and narrative approaches to systemic practice, which are very widely used. With respect to training, evidence-based practices reviewed in this paper should be incorporated into family therapy training programmes and continuing professional development short courses for experienced systemic practitioners. With respect to routine practice, family therapists should work towards incorporating the types of practices described in treatment resources listed below, when working with families of children and adolescents with the types of problems considered in this paper.

TREATMENT RESOURCES

Sleep problems

Mindell, J. and Owens, J. (2003) *A Clinical Guide to Paediatric Sleep: Diagnosis and Management of Sleep Problems.* Philadelphia: Lippincott Williams and Wilkins.

Stores, G. (2001) *A Clinical Guide to Sleep Disorders in Children and Adolescents.* Oxford: Oxford University Press.

Feeding problems

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

Attachment problems

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

Physical abuse

Hembree-Kigin, T. and McNeil, C. (1995) *Parent-Child Interaction Therapy*. New York: Plenum Press.

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

MacDonald, G. (2001) *Effective Interventions for Child Abuse and Neglect. An Evidence-Based Approach to Planning and Evaluating Interventions.* Chichester: Wiley.

Child sexual abuse

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

Trepper, T. and Barrett, M. (1989*) Systemic Treatment of Incest. A Therapeutic Handbook.* New York: Brunner-Mazel.

Childhood behaviour problems

Dadds, M. and Hawes, D. (2006) *Integrated Family Intervention for Child Conduct Problems.* Brisbane: Australian Academic Press.

Incredible Years Programme Webpage - http://www.incredibleyears.com/

Kazdin, A. (2005) *Parent Management Training*. Oxford; Oxford University Press.

Parent Child Interaction Therapy Webpage http://pcit.phhp.ufl.edu/

Parents Plus Programme webpage http://www.parentsplus.ie/

Tripple P Webpage - http://www.triplep.net/

Attention deficit hyperactivity disorder

Barkley, R. (2005) *Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and*

Treatment (Third Edition) New York. Guilford.

DuPaul, G. and Stoner, G. (1994) *ADHD in Schools: Assessment and Intervention Strategies*. New York: Guilford.

Adolescent conduct disorder

Alexander, J., Barton, C., Gordon, D., Grotpeter, J., Hansson, K., Harrison, R., Mears, S., Mihalic, S., Parsons, B., Pugh, C., Schulman, S., Waldron, H. and Sexton, T., (1998) *Blueprints for Violence Prevention, Book Three: Functional Family Therapy (FFT)* Boulder, CO: Centre for the Study and Prevention of Violence. Available at http://www.colorado.edu/cspv/publications/blueprints.html

Chamberlain, P. (1994) *Family Connections: A Treatment Foster Care Model for Adolescents With Delinquency*. Eugen, OR, Northwest Media Inc. Available at http://www.northwestmedia.com/foster/connect.html

Chamberlain, P. (2003) *Treating Chronic Juvenile Offenders: Advances Made Through the Oregon Multidimensional Treatment Foster Care Model* . Washington, DC: American Psychological Association.

Henggeler, S., Mihalic, S., Rone, L., Thomas, C., and Timmons-Mitchell, J. (1998) *Blueprints for Violence Prevention, Book Six: Multisystemic Therapy (MST)* Boulder, CO: Centre for the Study and Prevention of Violence. Available at http://www.colorado.edu/cspv/publications/blueprints.html

Henggeler, S., Schoenwald, S., Bordin, C., Rowland, M. and Cunningham, P. (1998) *Multisystemic Treatment of Antisocial Behaviour in Children and Adolescents.* New York: Guilford.

Sexton, T. and Alexander, J. (1999) *Functional Family Therapy: Principles of Clinical Intervention, Assessment, and Implementation*. Henderson, NV: RCH Enterprises.

Adolescent drug abuse

Liddle, H. (2005) *Multidimensional Family Therapy for Adolescent Substance abuse.* New York: Norton. A version of this book is available at www.chestnut.org/LI/cyt/products/MDFT_CYT_v5.pdf

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://www.drugabuse.gov/TXManuals/bsft/BSFTIndex.html

Szapocznik, J. and Kurtines, W. (1989) *Breakthroughs In Family Therapy With Drug Abusing Problem Youth.* New York: Springer.

Anxiety

Barrett, P. and Farrell, L. (in press), FOCUS: *Freedom from Obsessions and Compulsions Using Cognitive-Behavioural Strategies.* Australian Academic Press

FRIENDS anxiety management programme. http://www.friendsinfo.net/

Heyne, D. and Rollings, S. (2002) *School Refusal.* Oxford, UK: Blackwell.

Kearney, C. and Albano, A. (2007) *When Children Refuse School. Therapist Guide* (Second Edition) Oxford: Oxford University Press.

Depression

Brent's Therapy manuals. www.wpic.pitt.edu/research/star/ or BrentDA@upmc.edu

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.

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.

Rotheram-Borus, M. (1998) *Intervention Manuals for Project TALC (Teens and Adults Learning to Communicate) Parents Living with AIDS.* Los Angeles, CA: UCLA Semel Institute Centre for Community Health. Available at http://chipts.ucla.edu/interventions/manuals/intervhra1.html

Bipolar disorder

Miklowitz, D. and Goldstein, M. (1997) *Bipolar Disorder: A Family-Focused Treatment Approach.* New York: Guilford Press

Suicide 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.

Jurich, A. (2008) *Family Therapy with Suicidal Adolescents.* New York: Routledge.

King, C., Kramer, A., and Preuss, L. (2000) *Youth-Nominated Support Team Intervention Manual.* Ann Arbor, MI: University of Michigan, Department of Psychiatry.

Miller, A., Rathus, J. and Linehan, M. (2007) *Dialectical Behaviour Therapy With Suicidal Adolescents.* New York: Guilford.

Eating disorders

Le Grange, D. and Locke, J. (2007) *Treating Bulimia in Adolescents. A Family-Based Approach.* New York: Guilford.

Lock, J., Le Grange, D., Agras, W., and Dare, C. (2001) *Treatment Manual for Anorexia Nervosa. A Family Based Approach.* New York: Guilford.

Enuresis

Herbert, M. (1996) *Toilet Training, Bedwetting and Soiling.* Leicester: British Psychological Society.

Encopreis

Buchanan, A. (1992) *Children Who Soil. Assessment and Treatment.* Chichester: Wiley.

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APA (2000) *Diagnostic and Statistical Manual of the Mental Disorders (Fourth Edition-Text Revision, DSM –IV-TR)* Washington, DC: APA.

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and Juffer, F. (2003) Less is more: Meta-analyses of sensitivity and attachment interventions in early childhood. *Psychological Bulletin,* **129**: 195-215.

Barkley, R. (2005) *Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment (Third Edition).* New York. Guilford.

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Barmish, A. and Kendall, P. (2005) Should parents be co-clients in cognitive-behavioural therapy for anxious youth? *Journal of Clinical Child and Adolescent Psychology*, **34**: 569-581.

Barrett, P. and Farrell, L. (in press), FOCUS: *Freedom from Obsessions and Compulsions Using Cognitive-Behavioural Strategies.* Australian Academic Press

Barrett P., Farrell L., Dadds, M. and Boutler , N. (2005) Cognitive-behavioral family treatment of childhood obsessive-compulsive disorder: long-term follow-up and predictors of outcome. *Journal of the American Academy of Child and Adolescent Psychiatry*, **44**: 1005–1014.

Barrett, P. and Shortt, A. (2003) Parental involvement in the treatment of anxious children. In A. Kazdin, and J. Weisz (Eds) *Evidence Based Psychotherapies for Children and Adolescents* (pp. 101-119). New York: Guilford.

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

Black, D. (2002) Bereavement. In M. Rutter and E. Taylor (Eds) *Child and Adolescent Psychiatry: Modern Approaches* (Fourth Edition, pp. 299-308). London: Blackwell.

Black, D. and Urbanowicz, M. (1987) Family intervention with bereaved children. *Journal of Child Psychology and Psychiatry,* **28**: 467-476.

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Dear Alan

Thank you for your for all the work you have put into these reviews. I am pleased to accept them for publication.

As I am coming to the end of my period as Editor, they will be published under the new Editor (Mark Rivett) probably sometime early next year.

Ivan Eisler

Editor, Journal of Family Therapy

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