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WHAT WORKS WITH CHILDREN AND ADOLESCENTS?

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INTRODUCTION

Major meta-analyses of trials of individual child psychotherapy (Weisz, 1998), cognitive-behaviour therapy for children (Durlak, Fuhrman & Lampman, 1991) and family therapy (Shadish et al, 1993) have all yielded effect sizes of about 0.7 indicating that the average treated case, fares better than approximately 76% of untreated cases after therapy. The results of these meta-analyses are important because they justify the use of psychological interventions for treating children's psychological problems. Broad band meta-analyses have yielded an unequivocally positive answer to the big question– *Does child psychotherapy work?* In contrast, tightly focused narrative reviews and small meta-analyses which examine the effectiveness of specific interventions with specific problems have addressed the narrower question - *What works for whom with children and adolescents?* (Carr, 1999, 2000a,b). The present paper addresses this question with particular reference to a number of the more common conduct and emotional problems which occur during childhood and adolescence.

CONDUCT PROBLEMS

The effectiveness of psychological interventions for four distinct but related categories of conduct problems will be considered in this section. These are

- Oppositional behavioural difficulties
- Attentional and overactivity problems
- Pervasive conduct problems in adolescence
- Adolescent drug abuse

Oppositional behavioural difficulties

Preadolescent children who present with oppositional behavioural problems, temper tantrums, defiance, and non-compliance confined largely to the family constitute a third to

a half of all referrals to child and family mental health clinics and prevalence rates for clinically significant levels of oppositional behavioural problems in the community vary from 2% to 16% (APA, 1994; WHO, 1992; Kazdin, 1995). Oppositional behavioural problems are of particular concern because in the longer term they may lead to pervasive adolescent conduct problems and later life difficulties. Oppositional behavioural difficulties tend to develop gradually within the context of coercive patterns of parent-child interaction and a lack of mutual parental support (Patterson, 1982).

Serketich and Dumas (1996) in a meta-analysis of over 100 studies of behavioural parent training concluded that for childhood oppositional behavioural problems it was a highly effective treatment. Behavioural parent training focuses on helping parents develop the skills to monitor specific positive and negative behaviours and to modify these by altering their antecedents and consequences (e.g., Forehand & Long, 1996; Forehand & McMahon, 1981). For example, parents are coached in prompting their children to engage in positive behaviours and preventing children from entering situations that elicit negative behaviours. They are also trained to use reward systems such as star charts or tokens to increase positive behaviours and time-out to reduce negative behaviours. Behavioural parent training is probably so effective because it offers parents a highly focused way to supportively co-operate with each other in disrupting the coercive parent-child interaction patterns that maintain children's oppositional behaviour problems. It also helps parents develop a belief system in which the child's difficult behaviour is attributed to external situational characteristics rather than to intrinsic characteristics of the child.

The impact of a variety of formats on the effectiveness of behavioural parent training have been investigated and the results of these studies allow the following conclusions to be drawn. Behavioural parent training is most effective for families with children who present with oppositional behavioural problems when offered intensively over at least 20 sessions; exclusively to one family rather than in a group format; and as

part of a multisystemic and multimedia intervention package which includes concurrent individual child-focused problem-solving skills training with video-modeling for both parents and children (Kazdin et al, 1992; Webster-Stratton & Hammond, 1997). Such intensive, exclusive, multisystemic, multimedia programmes are more effective than less intensive, group based, behavioural parent training alone, child-focused problem-solving skills training alone, or video modeling alone with minimal therapist contact. An argument may be made for offering more intensive treatment to cases with more severe difficulties. Where a primary caretaker (typically a mother) is receiving little social support from her partner, then including a component to enhance the social support provided by the partner into a routine behavioural parent training programme may enhance the programme's effectiveness (Dadds et al, 1987).

Attentional and overactivity problems

Attention deficit hyperactivity disorder is now the most commonly used term for a syndrome characterized by persistent overactivity, impulsivity and difficulties in sustaining attention (Hinshaw, 1994; APA, 1994; WHO, 1992). The syndrome is a particularly serious problem because youngsters with the core difficulties of inattention, overactivity and impulsivity which are usually present from infancy may develop a wide range of secondary academic and relationship problems as they develop through the lifecycle. Available evidence suggests that vulnerability to attentional and overactivity problems, unlike oppositional behavioural problems discussed in the preceding section, is largely constitutional, although the precise role of genetic, prenatal and perinatal factors in the etiology of the condition are still unclear. Using DSM IV criteria for attention deficit hyperactivity disorder, a prevalence rate of about 3% to 5% has been obtained in community studies (APA, 1994).

Hinshaw et al (1998) and Barkley (1999) following extensive literature reviews have concluded that family-based multimodal programmes are currently the most effective for children with attentional and overactivity problems. 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-based multimodal programmes are probably effective because they provide the family with a forum within which to develop strategies for managing a chronic disability. As in the case of oppositional behavioural problems discussed above, both behavioural parent training and structural family therapy helps parents and children break out of coercive cycles of interaction and to develop mutually supportive positive interaction patterns. Both family therapy and parent training help parents develop benign belief systems where they attribute the child's difficult behaviour to either the disability (attention deficit hyperactivity disorder) or external situational factors rather than to the child's negative intentions. School based behavioural programmes have a similar impact on school staffs' belief systems and behaviour. Stimulant therapy and coping skills training help the child to control both their attention to academic tasks and their activity levels. Stimulant therapy, when given in low dosages, helps children to both concentrate better and sit still in classroom situations. High dosage levels have a more marked impact on overactivity but impair concentration and so are not recommended. Coping skills training, helps children to use self-instructions to solve problems in a systematic rather than an impulsive manner.

In cases of attentional and overactivity problems, effective family therapy focuses on helping families to develop patterns of organization conducive to effective child management (Barkley et al, 1992). 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.

Parent training, as described in the previous section on oppositional behavioural problems, focuses on helping parents develop the skills to monitor specific positive and negative behaviour and to modify these by altering those interactions and events that occur before and after them (e.g. Barkley, 1987). School based behavioural programmes in cases of attentional and overactivity problems, involve the extension of home based behavioural programmes into the school setting through home-school, parent-teacher liaison meetings (Braswell & Bloomquist, 1991; DuPaul & Eckert, 1997). Coping skills focuses largely on coaching children in the skills required for sustained attention and systematic problem solving (Baer & Nietzel, 1991; Kendall & Braswell, 1985). These skills include identifying a problem to be solved; breaking it into a number of solvable sub-problems; tackling these one at a time; listing possible solutions; examining the costs and benefits of these; selecting the most viable solution; implementing this; monitoring progress; evaluating the outcome; rewarding oneself for successful problem solving; modifying unsuccessful solutions; and monitoring the outcomes of these revised problem-solving plans.

Pervasive conduct problems in adolescence

Pervasive and persistent antisocial behaviour which extends beyond the family to the community; involves serious violations of rules or law-breaking; and is characterized by defiance of authority, aggression, destructiveness, deceitfulness, cruelty, problematic relationships with parents, teachers and peers and typically leads to multiagency involvement is referred to as conduct disorder (APA, 1994; WHO, 1992). Conservative prevalence rates for conduct disorder range from 2% to 6% (Kazdin, 1995).

From a developmental perspective, persistent adolescent conduct problems begin during the preschool years as oppositional behavioural problems, described in an earlier section. For about a third of children these evolve into pervasive conduct problems in adolescence and antisocial personality disorder in adulthood (Loeber & Stouthamer-Loeber, 1998). Three classes of risk factors increase the probability that preschool oppositional behaviour problems will escalate into later life difficulties, i.e. child characteristics notably impulsivity and learning problems, poor parenting practices, and family organization problems (Lehmann & Dangel, 1998).

Kazdin (1998) in a review of empirically supported interventions for conduct disorders concluded that functional family therapy and multisystemic therapy were among the more promising treatments available for adolescents with pervasive conduct problems. Chamberlain and Rosicky (1995) in a review of family based interventions, concluded that treatment foster care may be the most effective intervention for cases of conduct disorder where outpatient family-based approaches have failed.

Functional family therapy aims to reduce the overall level of disorganization within the family and thereby modify chaotic family routines and communication patterns which maintain antisocial behaviour (Parsons & Alexander, 1973, 1982; Alexander & Parsons, 1973; Gordon et al, 1988). Functional family therapy focuses on facilitating high levels of parental co-operation in problem-solving around the management of teenagers' problem behaviour; clear intergenerational hierarchies between parents and adolescents; warm supportive family relationships; clear communication; and clear family rules, roles and routines. Within functional family therapy it is assumed that if family members can collectively be helped to alter their problematic communication patterns and if the lack of supervision and discipline within the family is altered, then the youngsters conduct problems will improve (Alexander & Parsons, 1982). This assumption is based on the finding that the families of delinquents are characterized by a greater level of defensive

communication and lower levels of supportive communication compared with families of non-delinquent youngsters (Alexander, 1973), and also have poorer supervision practices. With functional family therapy, all family members attend therapy sessions conjointly. Initially family assessment focuses on identifying patterns of interaction and beliefs about problems and solutions that maintain the youngsters conduct problems. Within the early therapy sessions parents and adolescents are facilitated in the development of communication skills, problem-solving skill and negotiation skills. There is extensive use of relabelling and reframing to reduce blaming and to help parents move from viewing the adolescent as intrinsically deviant to someone whose deviant behaviour is maintained by situational factors. In the later stages of therapy there is a focus on the negotiation of contracts in which parents offer adolescents privileges in return for following rules and fulfilling responsibilities.

While, functional family therapy focuses exclusively on altering factors within the family system so as to ameliorate persistent conduct problems, multisystemic therapy in addition addresses factors within the adolescent and within the wider social system. Effective multisystemic therapy, offers individualized packages of interventions which target conduct problem-maintaining factors within the multiple social systems of which the youngster is a member (Henggeler, 1999). These multiple systems include the self, the family, the school, the peer group and the community. Multisystemic interventions integrate family therapy with self-regulation skills training for adolescents; school based educational and recreational interventions; and interagency liaison meetings to co-ordinate multiagency input. In multisystemic therapy it is assumed that if conduct problem maintaining factors within the adolescent, the family, the school, the peer group and the wider community are identified, then interventions may be developed to alter these factors and so reduce problematic behaviour (Henggeler & Borduin, 1990). Following multisystemic assessment where members of the adolescent's family and wider network

are interviewed, a unique intervention programme is developed which targets those specific subsystems which are largely responsible for the maintenance of the youngster's difficulties. In the early stages of contact the therapist joins with system members and later interventions focus on reframing the system members' ways of understanding the problem or restructuring the way they interact around the problems. Interventions may focus on the adolescent alone; the family; the school; the peer group or the community. Individual interventions typically focus on helping youngsters develop social and academic skills. Improving family communication and parents' supervision and discipline skills are common targets for family intervention. Facilitating communication between parents and teachers and arranging appropriate educational placement are common school-based interventions. Interventions with the peer group may involve reducing contact with deviant peers and increasing contact with non-deviant peers.

In contrast to functional family therapy which focuses exclusively on the family system or multisystemic therapy which addresses, in addition to family factors, both individual factors and the wider social network, treatment foster care deals with the problem of pervasive conduct problems by linking the adolescent and his or her family to a new and positive system: the treatment foster family. In treatment foster care, carefully selected and extensively trained foster parents in collaboration with a therapist offer adolescents a highly structured foster care placement over a number of months in a foster family setting (Kirgin et al, 1982; Chamberlain, 1990; Chamberlain & Reid, 1991). Treatment foster care aims to modify conduct problem maintaining factors within the child, family, school, peer group and other systems by placing the child temporarily within a foster family in which the foster parents have been trained to use behavioural strategies to modify the youngsters deviant behaviour (Chamberlain, 1994). Adolescents in treatment foster care typically receive a concurrent package of multisystemic interventions to modify problem maintaining factors within the adolescent, the birth family, the school, the peer

group and the wider community. These are similar to those described for multisystemic therapy and invariably the birth parents complete a behavioural parent training programme so that they will be able to continue the work of the treatment foster parents when their adolescent visits or returns home for the long term. A goal of treatment foster care is to prevent the long-term separation of the adolescent from his or her biological family so as progress is made the adolescent spends more and more time with the birth family and less time in treatment foster care.

With respect to service development, it may be most efficient to offer services for adolescent conduct problems on a continuum of care (Chamberlain & Rosicky, 1995). Less severe cases may be offered functional family therapy. Moderately severe cases and those that do not respond to circumscribed family interventions may be offered multisystemic therapy. Extremely severe cases and those who are unresponsive to intensive multisystemic therapy may be offered treatment foster care.

Adolescent drug abuse

While experimentation with drugs in adolescence is widespread, problematic drug abuse is less common. A conservative estimate is that between 5 and 10% of teenagers under 19 have drug problems serious enough to require clinical intervention (Liddle & Dakof, 1995). Drug abuse often occurs concurrently with other conduct problems, learning difficulties and emotional problems and drug abuse is also an important risk factor for suicide in adolescence.

Liddle and Dakof (1995) and Waldron (1996) in literature reviews of a series of controlled clinical trials, concluded that family-based therapy (which includes both family therapy and multisystemic therapy) is more effective than other treatments in engaging and retaining adolescents in therapy and also in the reduction of drug use. From their meta-analysis of controlled family-based treatment outcome studies Stanton and Shadish

(1997) concluded that family-based therapy is more effective in reducing drug abuse than individual therapy; peer group therapy; and family psychoeducation. Furthermore, family-based therapy leads to fewer drop-outs from treatment compared with other therapeutic approaches. Their final conclusion was that while family-based therapy is effective as a stand-alone treatment modality, it can also be effectively combined with other individually based approaches and lead to positive synergistic outcomes. Thus, family therapy can empower family members to help adolescents engage in treatment; remain committed to the treatment process; and develop family rules, roles, routines, relationships, and belief systems which support a drug free lifestyle. In addition family therapy can provide a context within which youngsters could benefit from individual, peer group or school based interventions.

Family systems theories of drug abuse implicate family disorganization in the etiology and maintenance of seriously problematic adolescent drug taking behaviour and there is considerable empirical support for this view (Stanton, & Heath, 1995; Szapocznik & Kurtines, 1989; Hawkins, Catalano & Miller, 1992). Family based interventions aim to reduce drug abuse by engaging families in treatment and helping family members reduce family disorganization and change patterns of family functioning in which the drug abuse is embedded.

Effective systemic engagement, involves contacting all significant members of the adolescent's network directly or indirectly, identifying personal goals and feared outcomes that family members may have with respect to the resolution of the adolescents drug problems and the family therapy associated with this, and then framing invitations for resistant family members to engage in therapy so as to indicate that their goals will be addressed and feared outcomes will be avoided (Szapocznik et al, 1988; Santiseban et al, 1996). Once families engage in therapy, effective treatment programmes for adolescent drug abuse involve the following processes which while overlapping, may be

conceptualized as stages of therapy: problem definition and contracting; becoming drug free; facing denial and creating a context for a drug free lifestyle; family reorganisation; disengagement and planning for relapse prevention (Stanton & Heath, 1995). The style of therapy that has been shown to be effective with adolescent drug abusers and their families has evolved from the structural and strategic family therapy traditions (Minuchin, 1974; Haley, 1980). Effective family therapy in cases of adolescent drug abuse helps family members clarify communication, rules, roles, routines hierarchies and boundaries; resolve conflicts; optimize emotional cohesion; develop parenting and problem-solving skills; and manage lifecycle transitions.

Multisystemic ecological treatment approaches to adolescent drug abuse represent a logical extension of family therapy. They are based on the theory that problematic processes, not only within the family but also within the adolescent as an individual and within the wider social system including the school and the peer group may contribute to the etiology and maintenance of drug abuse (Henggeler & Borduin, 1990). This conceptualization of drug abuse is supported by considerable empirical evidence (Hawkins, Catalano and Miller, 1992; Henggeler et al, 1991). At a personal level, adolescent drug abusers have been shown to have social skills deficits, depression, behaviour problems and favorable attitudes and expectations about drug abuse. As has previously been outlined, their families are characterized by disorganization and in some instances by parental drug abuse. Many adolescent drug abusers have experienced rejection by prosocial peers in early childhood and have become members of a deviant peer group in adolescence. Within a school context drug abusers show a higher level of academic failure and a lower commitment to school and academic achievement compared to their drug-free counterparts. Multisystemic ecological intervention programmes for adolescent drug abusers, like those for adolescents with pervasive conduct problems described earlier, have evolved out of the structural and strategic family therapy traditions

(Henggeler & Borduin, 1990). In each case treated with multisystemic therapy, around a central family therapy intervention programme, an additional set of individual, school-based and peer-group based interventions are offered which target specific risk factors identified in that case. Such interventions may include self-management skills training for the adolescent, school-based consultations or peer-group based interventions. Self-management skills training may include coaching in social skills, social problem-solving and communication skills, anger control skills, and mood regulation skills. School based interventions aim to support the youngsters continuation in school, to monitor and reinforce academic achievement and prosocial behaviour in school, and to facilitate home-school liaison in the management of academic and behavioural problems. Peer group interventions include creating opportunities for prosocial peer group membership and assertiveness training to empower youngsters to resist deviant peer group pressure to abuse drugs.

With respect to service development, the results of controlled treatment trials suggest that, a clear distinction must be made between systemic engagement procedures and the process of family therapy, with resources devoted to each.

EMOTIONAL PROBLEMS

The effectiveness of psychological interventions for anxiety disorders, depression and anorexia nervosa will be considered in this section.

Anxiety

While all children have developmentally appropriate fears, some are referred for treatment of anxiety problems when their fears prevent them from completing developmentally appropriate tasks such as going to school or socializing with friends. The overall prevalence for clinically significant fears and anxiety problems in children and adolescents

is approximately 2% to 9% (Anderson, 1994; APA, 1994; WHO, 1992). With respect to age trends, simple phobias and separation anxiety are more common among preadolescents and generalized anxiety disorder, panic disorder, social phobia, and obsessive compulsive disorder are more common among adolescents (Klein, 1994).

In a review of evidence from experimental single case designs and controlled outcome studies King and Ollendick (1997) concluded that exposure based procedures including systematic desensitization and flooding; modelling; contingency management ; and coping skills training are all effective treatments for childhood phobias. All of these elements have been incorporated along with psychoeducation into a comprehensive programme by Silveman and Kurtines (1999). Following psychoeducation, parents are coached in how to prompt and reinforce their children's courageous behaviour while not reinforcing anxious behaviour. Concurrently children are trained in relaxation and cognitive coping skills. Then children are prompted by parents to expose themselves to feared situations and reinforced by parents for courageous behaviour and for using cognitive coping skills and relaxation to manage their anxiety. Gradually, control over entry into anxiety provoking situations and reinforcement for managing anxiety in these situations is transferred from the parents to the child who learns self-prompting and self-reinforcement skills. The programme concludes with relapse prevention training. Results of two controlled trials with anxious and phobic children support the efficacy of this treatment package. (Silveman and Kurtines, 1999).

Elliott (1999) in a thorough literature review concluded that there is some evidence for the efficacy of behavioural and cognitive-behavioural approaches to school refusal, with effective programmes entailing a high degree of family involvement. For example, Blagg and Yule (1984) found that behavioural family therapy was more effective than a hospital-based multimodal inpatient programme and a home tuition and psychotherapy programme for the treatment of school phobia. Behavioural family therapy included

detailed clarification of the child's problem; discussion of the principal concerns of the child, parents and teacher; development of contingency plans to ensure maintenance of gains once the child returned to school; a rapid return to school plan; and follow-up appointments with parents and teachers until the child had been attending school without problems for at least 6 weeks. A year after treatment, 93% of children that received family based behaviour therapy were judged to have been successful in returning to school compared with 38% of children in the multimodal inpatient programme and 10% of those from the home tuition and psychotherapy programme.

Barrett et al's (1996) found that a family based programme for children with severe generalized anxiety problems was more effective than an individual coping skills training programme. In the family based programme both parents and children attended separate group sessions and some concurrent family therapy sessions and were coached in anxiety management, problem solving and communications skills and the use of reward systems. In the anxiety management sessions parents and children learned to monitor and challenge unrealistic catastrophic beliefs and to use relaxation exercises and self-instructions to cope with anxiety provoking situations. In the problem solving and communication skills sessions, coaching in speaking and listening skills occurred and families learned to manage conflict and solve family problems systematically. In the reward systems sessions, parents learned to reward their children's courageous behaviour and ignore their anxiety-related behaviours and children were involved in setting up reward menus. A year after treatment 90% of those that participated in the family based programme were recovered compared with 70% of those in the individual programme.

Rapoport and Inoff-Germain (2000) from an extensive literature review concluded that cognitive-behavioural programmes which include exposure and response prevention, relaxation training and coping skills training, especially when coupled with pharmacological intervention with serotonin reuptake inhibitors such as clomipramine hold particular

promise for the treatment of obsessive compulsive disorder in children. For examples, March, Mulle and Herbel (1994) found that 80% of children with obsessive compulsive disorder (OCD) in a single group outcome study showed clinically significant improvement after treatment and this was maintained at follow-up following a family-based intervention programme and pharmacological treatment with clomipramine. The programme, *How I ran OCD of my Land* (March & Mulle, 1998), was based on Michael White's narrative therapy externalization procedure, exposure and response prevention, relaxation skills training and coping skills training. In the narrative therapy externalization component of the programme the child and parents were helped to view obsessive compulsive disorder as a medical illness separate from the youngster's core identity. Children were encouraged to externalize the disorder by giving it a nasty nickname and to make a commitment to driving this nasty creature out of their lives. They then were helped to map out a graded hierarchy of situations that elicited obsessions and led to compulsions of varying degrees and those situations in which the child successfully controlled these symptoms were noted. These situations were subsequently monitored on a weekly basis, since increases in the number of these reflected therapeutic progress. In the behavioural family therapy component of the programme children were coached in coping with anxiety by using self-instruction and relaxation skills. Parents were coached to support and reward their children through the process of facing anxiety provoking situations while avoiding engaging in compulsive anxiety reducing rituals.

Perrin, Smith, and Yule (2000) in their review of the treatment of post-traumatic stress disorders in children and adolescents concluded that there is evidence from a small number of controlled trials for the effectiveness of cognitive behavioral programs for this disorder. Such programmes begin with psychoeducation and goal setting following which youngsters are trained in coping and relaxation skills that are subsequently used in exposure sessions. In these sessions therapists facilitate emotional processing of

traumatic memories by helping youngsters recall vivid traumatic memories. Treatment programmes conclude with sessions on relapse prevention.

From this cursory review it is clear that effective psychological intervention programmes for anxiety disorders in children and adolescents are family based and include creating a context within family therapy that allows the child to eventually enter into anxiety provoking situations and to manage these through the use of personal coping skills, parental support and encouragement.

Depression

Major depression is a recurrent condition involving low mood; selective attention to negative features of the environment; a pessimistic cognitive style; self-defeating behaviour patterns; a disturbance of sleep and appetite; and a disruption of interpersonal relationships (APA, 1994; WHO, 1992; Harrington, 1993; Kovacs, 1997; Reynolds & Johnson, 1994). In community samples prevalence rates of depression in preadolescence range from 0.5% to 2.5% and in adolescents from 2% to 8% while 25% of referrals to child and adolescent clinics have major depression.

There is strong evidence that both genetic and family environment factors contribute to the etiology of depression (Reynolds & Johnson, 1994). Parental criticism, poor parent-child communication and family discord have all been found to be associated with depression in children and adolescents. 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.

Cognitive behaviour therapy, conjoint family therapy and concurrent group based parent and child training sessions have all been found to be effective in the treatment of major depression in (Harrington et al, 1998; Kazdin & Marciano, 1998). Effective cognitive

behaviour therapy programmes include psychoeducation, self-monitoring, cognitive restructuring, coping and relaxation skills training, pleasant activity scheduling and problem-solving skills training. Effective family therapy and family based interventions aim to decrease the family stress to which the youngster is exposed and enhance the availability of social support to the youngster within the family context. Core features of all effective family interventions include the facilitation of clear parent-child communication; the promotion of systematic family based problem-solving; and the disruption of negative critical parent-child interactions.

Anorexia

The prevalence of anorexia nervosa – a syndrome where the central feature is self-starvation – among teenage girls is about 1% (APA, 1994; WHO, 1992). Wilson and Fairburn (1998) in a recent extensive literature review concluded that family therapy and combined individual therapy and parent counseling with and without initial hospital based feeding programmes are effective in treating anorexia nervosa (e.g. Crisp et al, 1991; Hall & Crisp, 1987; Robin & Segal, 1999; Le Grange et al, 1992; Russell et al, 1987; Eisler et al, 1997). They also concluded that inpatient refeeding programmes must be supplemented with outpatient follow-up programmes if weight gains made while in hospital are to be maintained following discharge. Key elements of effective treatment programmes include engagement of the adolescent and parents in treatment; psychoeducation about the nature of anorexia and risks associated with starvation; weight restoration and monitoring; shifting the focus from the nutritional intake to normal psychosocial developmental tasks of adolescence; facilitating the adolescent's individuation and increasing autonomy within the family; and relapse prevention. Structural family therapy (Minuchin et al, 1978) and Milan systemic family therapy (Selvini Palazzoli, 1978) are the main treatment models that have influenced the types of therapies evaluated in these

treatment trails. With respect to service development, available evidence suggests that for youngsters with eating disorders effective treatment involves up to 18 outpatient sessions over periods as long as 15 months. Initial hospitalization for weight restoration is essential where medical complications associated with weight loss or bingeing and purging place the youngster at risk.

CLOSING COMMENTS

A number of comments may be made about the material reviewed in this paper. First, well articulated psychological interventions have been shown to be effective for a wide range of child-focused problems. Second, these interventions are brief and may be offered by a range of professionals on an outpatient basis. Third, for many of the interventions, useful treatment manuals have been developed which may be flexibly used by clinicians in treating individual cases. Fourth, the bulk of psychological interventions for which there is evidence of effectiveness have been developed within the cognitive-behavioural and family therapy psychotherapeutic traditions.

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