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PARENT INVOLVEMENT IN ANXIETY DISORDER THERAPY IN CHILDREN AND ADOLESCENTS

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children and adolescents
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Summary

The aim of this article is to present family therapy as an effective and adequate method of treating anxiety disorders in children and adolescents. Considering the significant prevalence of these disorders in the population of patients seeking help from mental health professionals, the development of effective therapeutic methods to work with anxiety in children and adolescents seems to be highly recommended. The first part of the article presents the characteristics of anxiety disorders in children and adolescents. Next, traditional models of conceptualization of children's anxiety are described. The dominant methods of therapy are shown as well, taking into account the fact that they are insufficiently focused on family factors, which – based on current theoretical concepts and empirical data – should be considered very important in relation to emotional difficulties in children and adolescents. The next part of the article presents research indicating the rationale and even the necessity to involve parents in the treatment of anxiety in their children, as well as therapeutic programs taking into account family interventions. In the summary, there are conclusions, reflections, and proposed directions for further research in the area of family therapy focused on the treatment of anxiety disorders in children and adolescents.

Introduction

Patients with anxiety disorders account for a significant percentage of people who report to mental health professionals that work with children and adolescents. Mental disorders in which anxiety plays a central role include the following: separation anxiety, selective mutism, phobias, social anxiety, generalized anxiety disorder, obsessive-compulsive disorder, and post-traumatic stress disorder. They all have one common element, which is a strong fear of certain internal experiences or external situations and a tendency to avoid them [1]. Contemporary research shows that anxiety disorders are one of the most common difficulties manifested by children and adolescents, and their prevalence ranges from 6.5% to even 22% in the general population [2–4]. Moreover, the frequency of anxiety disorders significantly increases with age, which foremost demonstrates that these disorders do not disappear spontaneously, and secondly,

presupposes a need for early therapeutic interventions [4, 5]. Anxiety disorders can become severe, complex and chronic already in adolescence, and their coexistence with other disorders, mainly of depressive nature, is also evident [4].

The results of longitudinal studies emphasize the continuity of anxiety disorders throughout adolescence until adulthood [6–8]. If left untreated, intense anxiety does not spontaneously cease. As children get older, they require increasingly more corrective intervention and, moreover, permanent, generalized anxiety is more difficult to treat. The accompanying difficulties in psychosocial functioning, such as problems in school, deficits in social competencies, lack of peer relations, low self-esteem, or distorted self-image increase with age and become increasingly difficult to resolve [4]. In the long term, untreated anxiety disorders lead to significant difficulties in functioning in family, school, work and social life, increasing the risk of developing other mental and somatic health problems, including affective and psychosomatic disorders, addictions, and social functioning problems, family conflicts, or experiencing a lower quality of life [2, 4, 9]. This leads to higher costs of somatic and psychiatric treatment in adult patients.

Among the theories explaining the phenomenon of developing anxiety disorders in children, the cognitive model is the one that is the most frequently described [2, 4, 10]. It assumes that the central trait around which symptoms grow is the tendency to experience a sense of threat and uncertainty. This model distinguishes three basic components of experienced anxiety: avoidance behaviours, physiological signals, and the formation of distorted cognitive assessment. Excessive fear, which surpasses the possibility to adapt, leads to the development of distorted cognitive schemas, and, consequently, to excessive concentration on oneself and one's own experience, to an excessive focus on judgement (of oneself and others) and to the perception of various situations as threatening [10].

There is an older, yet still valid, theory, namely the attachment theory of John Bowlby [11], which has been confirmed through the empirical research of Mary Ainsworth [12]. This theory explains the formation of anxiety in children on the basis of the relationship with the parent who does not provide a sufficient sense of security. According to this model, anxiety disorders would be the result of developing an insecure attachment relationship pattern (an anxious-avoidant or anxious-ambivalent bond according to the terminology proposed by Ainsworth), which shapes and maintains the child's anxiety at later stages of development. In fact, the child notices that his/her caregivers are generally unreliable, unavailable, untrustworthy, they do not respond adequately to the child's needs, and that, in difficult situations, the child cannot count on their support and protection. As a result, the child does not learn adequate adaptive methods of regulating emotions and engaging in social relationships and, instead, develops the belief that his/her needs cannot be satisfied through interaction with other people, and that relationships themselves are a

source of distress and anxiety. The concept of the importance of attachment patterns in the development of anxiety disorders in children has been confirmed in many contemporary studies [see 13-15].

Attention has also been drawn to the biological, temperamental determinants of anxiety in particular negative emotionality and behavioural inhibition (BI). An individual tendency to experience intense negative emotions, frustration, and irritability, as well as high reactivity, would be responsible for the development of anxiety disorders in children [16]. The latter feature is associated with the hypersensitivity of the child's nervous system to new and potentially threatening situations, causing excessive activation of the autonomic system, increased cortisol levels, excessive vigilance and reactions of fear in response to new stimuli [17].

Behavioural inhibition is another widely described predictor. It has been found that this feature occurs in about 10-15% of infants and young children who, when exposed to new stimuli, react with anxiety, crying, agitation, withdrawal, clinging to the caregiver, as well as with refraining from taking up activities. Research has confirmed a higher risk of anxiety disorders in the presence of the above-described temperamental traits [16, 18]. On the other hand, more recent studies place more attention on the role of protective factors which can significantly reduce temperamental predispositions. An example of this might be the ability to focus and switch attention away from negative emotional stimuli (the so-called attentional control AC). High levels of attention control have been shown to significantly reduce behavioural inhibition. Children who are able to effectively redirect their attention from anxiety-producing situations to other situations are less likely to persist in behavioural inhibition [19, 20].

In systemic therapy, the emergence of anxiety disorders in children and adolescents is closely related to the family context. Attention has been drawn to the fact that the child may be delegated to certain roles and behaviours, which – if they are too difficult or are experienced by the child in a conflicting manner – may lead to emotional symptoms and problems. In the classical understanding, the anxiety experienced by a child is considered to be a symptom of dysfunction in the family system and cannot be examined without looking into their relationship [21]. In the structural approach, family interactions are described in the category of boundaries, in the communicative approach, the focus is on specific styles of communication between family members, and in the strategic approach, the focus is placed on constant patterns of behaviour [22]. However, if we look at the symptoms from the perspective of the transgenerational approach, we must also take into account family history and examine whether a problem such as anxiety is not part of the multigenerational transmission process. The genogram is a useful therapeutic tool, as it reveals important information about the family system (including intergenerational messages, traumas, family secrets, relations between family members, coalitions, roles in the family).

The functions of the symptom described are characteristic of the first phase of the development of family therapy. More recent approaches, which are influenced by social constructivism, do not emphasize

family dysfunction but rather concentrate on how the patient and his/her family define problems and what meaning they give them through their narratives [21, 22]. As an important process, the analysis of the mechanisms supporting symptoms is also considered, *i.e.* those sequences of interactions that occur in response to the emergence of problematic behaviours [21]. Supportive mechanisms are related to the preferred patterns of family functioning and to the beliefs about the family. They are often unconscious to its members, and their disclosure shows the symptoms in a different light and may signify the beginning of a process of change. In new tendencies in family therapy, great importance is also attached to socio-cultural influences, *e.g.* in the treatment of eating disorders [23]. Contemporary approaches also bring forward some innovative methods of therapy, such as multi-family therapy, which is a combination of family therapy and group therapy [24, 25].

Family factors in the treatment of anxiety disorders in children and adolescents

Among the therapeutic approaches in the treatment of anxiety disorders in children and adolescents, the cognitive-behavioural approach has been the most popular so far. This is in part due to the fact that behavioural and cognitive-behavioural procedures have so far obtained the most empirical confirmation [10, 26–28]. However, even within this theory, in recent decades there has been a growing interest in studying family factors in the development of anxiety disorders in children and adolescents [28]. Researchers and therapists have begun to notice that treating children alone does not produce sufficient results. Lebowitz *et al.* [2, 29] mention that no satisfactory improvement was observed in up to half of the studied children undergoing traditional cognitive-behavioural therapy. What could be the reason for this? Cognitive-behavioural therapy requires, *inter alia*, very good cooperation of the child with the therapist, systematic participation in the therapy, the meticulous performance of tasks as well as compliance with recommendations. However, a therapeutic alliance with the child or adolescent may still not be enough if it fails to establish a good therapeutic relationship with the parents. In fact, they should support the child in the implementation of therapeutic tasks (such as, for example, gradual exposure to anxiety stimuli or the elaboration of cognitive distortions), motivate them to face situations that arouse anxiety, and above all, not to strengthen anxious attitudes and behaviours, of which parents are very often unaware [2, 28, 30]. Examples of such behaviour include parents sleeping with the child who shows separation anxiety, speaking "for the child" who faces social phobia, repeatedly calming the child who suffers from generalized anxiety or obsessive-compulsive disorder. Such actions undertaken by parents strengthen the child's tendency to avoid situations that arouse anxiety, increase his/her dependence on the parent instead of strengthening his/her ability to cope independently, as well as reduce the child's motivation to recover. Moreover, in the treatment of anxiety in children, it is also very important to know what patterns of anxiety behaviour are

presented by the parents themselves, whether they pass them on to their children and, if so, how they do it. Stressful events experienced by the family and methods of coping with them are also important, as well as the parents' own fears and beliefs of which they are not fully aware [2, 10, 30].

Why is it still important to invite parents into the therapeutic process of their children? In their research, Lundkvist-Houndoumadi and Thastum [31] focused on children who did not benefit from traditional cognitive-behavioural therapy. It turned out that the problem may be, among others, different beliefs of adults and children about their motivation for therapy. The parents of the children studied believed that they were motivated to work on overcoming their difficulties, while the children did not have sufficient self-motivation and in their therapy, they felt a double pressure both from the parents and the therapist. The authors also noted that parents often introduced a new and different perspective which would allow therapists to better understand underage patients and their problems.

The parents could observe their children in everyday situations, in various contexts, and check whether and how they apply (or not) the techniques introduced during the therapy. The children also provided them with feedback about the therapy, which they did not always want to share with the therapist. The parents could also provide therapists with information about their children's character, beliefs, style of experiencing, or behaviours that were not always revealed during therapy or that were difficult to observe. They were able to notice the ambivalent attitude of their children towards the problem, which allowed for the interpretation of a lack of therapeutic progress not in terms of resistance but rather as a fear of change. The parents also provided valuable feedback on how the therapeutic program could be modified to better suit the patients' needs (*e.g.* introducing individual meetings, more specific division into groups in terms of symptomatology, extending the duration of the program, introducing *in vivo* techniques, integrating the program with some additional consultancy for parents). It is also important to examine the parents' attitudes towards therapy, their beliefs about the problem and the ways that it should be solved, which may have an impact on how the child thinks about the difficulties experienced as well as about the therapy. A broadened and detailed understanding of the problem allows the therapy to be adapted to what the family and the particular patient really need.

In sum, inviting parents to therapy is important and necessary due to the following: 1) it allows to build a therapeutic alliance with them, 2) it enables learning the parents' beliefs about the child's problem and their attitude towards therapy, 3) it provides us access to information which, as therapists, we would not be able to get otherwise, 4) it enables us to work on how the parents (often unconsciously) strengthen their children's attitudes and anxiety behaviours, as well as on the beliefs and patterns of anxiety behaviours of the parents themselves, 5) it allows to include in the therapy methods of communication, mutual interaction or coping with difficult experiences by the family. Family therapy (compared to individual therapy) can be particularly effective when the individual therapy of the child does not bring about the

intended results. It is helpful to explore the possible causes of failure together: when parents are actively involved in reinforcing positive changes in their child's behaviour, when they suffer from anxiety disorders themselves, and also when the family's function requires therapeutic work [1].

This is the reason why, later in the present article, we will focus on research regarding the forms of therapy for children and adolescents who experience anxiety, in the process of which parents are involved in various ways, taking into account the effectiveness of the proposed programs as well as their practical applications.

Research on parental participation in the therapy of their children's anxiety disorders

Since the 1990s, attention has been paid to the need to involve parents in the process of treating anxiety disorders in children and adolescents. The first attempts combined standard cognitive-behavioural therapy programs (*e.g.* "Zaradny kot" based on the FEAR program) with psychoeducation for parents [28]. Psychoeducational programs, such as the FAM (Family Anxiety Management) program, indicated the need to create an alliance in the fight against the disorder and to strengthen the family in their competencies. They covered a very wide range of issues, such as communication skills, problem-solving, responding to conflict situations, learning to provide positive reinforcement and ignore undesirable behaviour. They also subsumed a large number of references to the parents' emotions, behaviour and style of experiencing (*e.g.* coping with one's own anxiety response) [10]. In some parents, this could cause resistance, which reduced the effectiveness of therapeutic interventions. This is why it became necessary to answer the question about how to work with families on behavioural changes, so as to build a better therapeutic alliance with them and to increase the effectiveness of interactions [32, 33].

One of the first attempts to answer this question was functional-behavioural therapy, which combined learning, cognitive and systemic theories [33]. This approach is not limited to behaviour change itself but assumes that patients need to understand its function. It is additionally important to establish a good therapeutic relationship with patients, in which the parents are not "blamed" for the behaviour that arises in their child, but their behaviour is recognized in terms of "adapting" to the situation. It is supposed that behaviour always has a function and is the concrete result of an interpersonal relationship. As in classical systemic thinking, within functional-behavioural therapy, the therapist focuses on redefining the problem (negative thoughts, emotions, behaviour) and giving it a positive meaning. In a concerted effort, the family and the therapist think about why the behaviour has occurred and how it is strengthened by family members. This approach shows a "marriage" of the systemic approach to working with families and typical methods of behavioural-cognitive therapy [32].

Over the decades which followed, there was a growing interest in the treatment of anxiety disorders in children and adolescents [34], as well as in finding ways to effectively involve parents in their children's therapy. One of the main research trends was to assess the effectiveness of the therapeutic programs applied. Most of them, however, do not focus on family therapy as such but rather on the active participation of parents in the individual therapy of the child or on offering them a group therapy of psychoeducational nature. However, there are therapeutic programs in which traditional work within the cognitive-behavioural theory assumes an extended form and includes a systemic way of thinking and systemic influences. Programs such as FRIENDS, Building Confidence and SPACE belong to this classification.

The FRIENDS program by Barrett [1, 35] is one of the best empirically proven programs conducted in the Family CBT theory for children with anxiety disorders. It combines group therapy and psychoeducational classes for parents with some elements of family therapy. Parallel groups for children and parents include basic elements of CBT in managing anxiety symptoms. However, the described program has additional assumptions that go beyond standard CBT procedures. First, it involves family skills training which shapes mutual support of parents and builds a supportive social network outside the family. Parents and children are encouraged to practice these skills in their daily activities. Moreover, the program supports the process of learning from peers on how to cope with difficult situations and how to apply mutual experiences. The parents' job is to help their children to make and maintain friendships. The group process includes elements such as: normalization of anxiety, group discussions concerning difficult situations and terrifying experiences, and role-playing in the context of common anxiety-generating situations. The authors of the program emphasize the importance of the group process, noting that participants learn just as much from other group members (peers, other parents) as from therapists. The program leaders additionally focus on communication and problem-solving training for children and parents in order to improve their mutual relations. The parents also learn how to reward their children for using their anxiety coping competencies, how to ignore their avoidance and anxiety behaviours, and how to deal with their own anxiety. The evaluation of the program showed its high effectiveness – one year after the end of the FRIENDS program, 68% of children had no anxiety disorders, compared to 6% of children in the control group [35].

"Building Confidence" is another therapeutic program within the Family CBT (FCBT) [9]. "Parents are treated not as support for their children but more as co-clients. The program focuses on parental intrusiveness as a factor supporting and sustaining the child's anxiety. The authors assume that, especially during the therapy of early school-age children, it is important to work with the parents on coping with their own anxiety, as well as supporting their educational competencies. Therapeutic sessions are divided into three parts, one of which is spent with the child individually (25-30 minutes), another, of the same duration, which is devoted to working only with parents, and subsequently a third one, which lasts 15 minutes,

consisting of joint family work. As part of the Building Confidence program, parents learn how to let their children make choices (instead of making decisions for them), how to allow their children to deal with difficulties on their own and to learn by trial and error (instead of taking challenges for their children), how to name and accept their emotions (instead of criticizing them), how to support children's new coping skills, and finally, how to allow children to be independent and have privacy (*e.g.* their children getting dressed by themselves). The effectiveness of the program was measured after one year, and the results of therapeutic work in family and the individual conditions in school-age children were compared. The results showed that the children who had participated in the Building Confidence program scored lower on the anxiety scale (assessed by the parent and the diagnostician). The program proved to be particularly effective in the group of young adolescents. The key moderator was the reduction of the intensity of parental intrusive behaviour.

The SPACE (Supportive Parenting for Anxious Childhood Emotions) program focuses exclusively on working with parents and uses systemic thinking [2, 29]. This program does not take into account teaching parents specific skills, such as positive reinforcement or problem solving, nor does it attempt to use parents as therapists to modify their child's behaviour. Instead, it concentrates on changing the parents' reaction to the child's anxiety states, on dealing with the gradual withdrawal of behaviour that maintains symptoms (called "accommodative" family behaviours).

The first stage of the treatment is called the introductory phase, during which parents are introduced to the systemic conceptualization of childhood anxiety and the principles of its treatment. The second step consists of making the parents and therapist first scrupulously analyse the family's daily schedule and habits, then identify their accommodative behaviour, and, finally, point out problems for further work. In the next stage of therapy, the therapist and the parents plan specific changes in parental behaviour and inform the child about the single changes they intend to introduce. During therapy, work is also done on creating a "common front" in parents which means strengthening the parental subsystem, developing a coherent understanding of the problem and the way of reacting to the child's difficulties. In addition, the therapist and the parents try to extend the child's support system to other significant people (family members, teachers, coaches). On the basis of evaluation studies, the authors of the program concluded that the SPACE program is an effective method of treating anxiety disorders in children. It allows for the reduction of anxiety symptoms in a child, the stress experienced by parents and a significant reduction in the number of supportive ("accommodative") behaviours in parents [2].

Also other therapeutic programs, in theory based mainly on cognitive-behavioural therapy, contain many basic elements of systemic work. For example, in the treatment of school phobia, the role of joint work of children, parents and teachers on creating a plan for returning to school and learning the necessary competencies is underlined, with particular emphasis on good cooperation between the parental and the

school subsystems. The key role of separation anxiety in the emergence of school phobia, the need to work on family dysfunctions and patterns that strengthen the problem in the family, as well as the active inclusion of other systems (school, extended family, environment) in the therapy are also pointed out, giving priority to family and systemic interventions over cognitive-behavioural individual therapy [35, 36]. Family therapy, even if conducted within the cognitive-behavioural approach, gives much higher rates of improvement than individual therapy (in two-thirds of families), largely through work on anxiety, behaviour and the parents' reactions [1, 15]. Richardson [37] suggests that combining these two therapeutic modalities (individual work with the child and simultaneously with the whole family) may be the most effective.

The joint participation of children and parents in therapy is also used in the treatment of obsessive-compulsive disorders. The FOCUS program (Freedom from Obsessions and Compulsions Using Cognitive-Behavioural Strategies) uses not only exposure techniques but also externalization techniques, and all family members, including siblings, are invited to the sessions [1, 38]. A similar procedure takes place in the case of PTSD treatment – during family sessions, there is a focus on reformulating the problem and on supporting parents in building a strengthening and caring relationship with their children [1].

The role of preventive measures in the treatment of anxiety disorders in children should also be mentioned. The important role of prevention in this area has been confirmed in large studies conducted by Ginsburg *et al*. [39]. The research program covered 136 families in which at least one parent suffered from anxiety disorders. In each family, there was at least one child between the ages of 6 and 13 who showed no anxiety symptoms so far. The participants were divided into three groups: one experimental and two control groups. The experimental group participated in a one-year prevention program that included ten two-hour parenting sessions devoted to positive discipline, managing the child's difficult behaviours and promoting the child's self-confidence. One control group received a booklet with information on anxiety disorders in children, while the other group did not perform any interventions. One year later, it turned out that in the latter control group, the prevalence of anxiety disorders in children was 31%. In the first control group, which received psychoeducational content in the form of an information booklet, 21% of children showed symptoms of anxiety disorders (including separation anxiety, panic, phobias and post-traumatic stress disorder), and in the experimental group only 5% did. The effects of the preventive program continued even after a year. Not only do these results clearly confirm the impact of the attitudes, fears and behaviours of their parents on the development of anxiety disorders in children, but they also indicate the legitimacy of introducing preventive measures in this risk group.

Family therapy of anxiety disorders in children - conclusions and considerations

The cited research results and therapeutic programs clearly show that family interventions significantly support the treatment of anxiety disorders in children and adolescents. Moreover, aiming therapeutic interactions only at parents may often be more effective than isolated individual therapy of the child. The described therapeutic programs take into account both typical cognitive-behavioural, psychoeducational, and environmental interactions, as well as techniques intended to support mutual understanding of their emotional states by children and parents, narrative work with the family, and structural or strategic interventions. On the contrary, in the description of most programs, the authors emphasize cognitive-behavioural interactions, ignoring important elements of systemic work and not referring directly to systemic frameworks despite their obvious use in therapeutic work.

It seems that in the case of therapeutic work with the family of a child suffering from anxiety disorders, it may be very useful to embed it in a theoretical systemic frame. It is important to understand at what stage of development the family is, what are the relationships between its members and the patterns of its functioning. It may be useful to know that the parents' educational systems result from their family histories and are unconsciously reproduced in the procreative family, as well as that it is advisable to learn about personal narrations on coping with difficult situations, human nature and methods of engaging in relationships with people. Finally, it is also beneficial to look at the family as a system, taking into account the interplay between its members and the presence of complex cause-and-effect relationships; examining whether the child's behaviour has no additional, hidden meaning (*e.g.* it does not constitute an attempt to maintain family homeostasis by delegating the child to the role of a patient), what the function of the presented symptom; discovering coalitions in the family, noticing the problem of the lack of clear and flexible boundaries between family members and its subsystems. It is also important to look at the family in the context of broader socio-cultural influences [40, 41].

Moreover, reliable and contemporary meta-analyses of studies, including those conducted in the field of evidence-based practice, show that in the case of children and adolescents, systemic therapy is at least as effective as individual therapeutic interventions, and, at the same time, it benefits more from them [1]. However, most randomized clinical trials concern cognitive-behavioural therapy, while it does not appear to be the only effective treatment for anxiety disorders in children and adolescents. Yet, it allows for repetitive intervention, which is crucial in experimental research [42].

No research reports have been found on programs concerning treating anxiety disorders in children and adolescents in a strictly systemic approach, however. This may be due to the lack of adequate quantitative tools available to assess changes in the therapy process; qualitative research has so far dominated in this area [see 24, 42]. It should be emphasized, however, that the qualitative approach is often

the only way to obtain sensitive, non-standard information from respondents but also to better understand their point of view and explore the therapy process and its effectiveness. Therefore, it seems that experimental research is insufficient to study the effectiveness of therapeutic processes, which requires a combination of quantitative and qualitative interactions (mixed-method research), as well as creating tools for assessing the level of anxiety in children, assessing the therapy process and changes in the functioning of the family [see 24, 27, 42–44].

On the other hand, the key elements of the work of any of the schools cannot be overlooked, and systemic therapists can, and perhaps should, use the achievements of the cognitive-behavioural approach to their benefit. This includes understanding the phenomenon of anxiety in children, its cognitive and behavioural aspects and techniques of exposure to anxiety stimuli, working with beliefs, practical learning of communication and ways of reacting to the child's behaviour. When making clinical decisions regarding the plan of therapeutic interventions for children and adolescents, one should take into account the factors identified in the aforementioned studies. It is important to adjust the therapy model to the presented disorders (*e.g.* combining cognitive-behavioural techniques with working with parents and the whole family), to the characteristics of the patient and his/her family (*e.g.* the child's age, his/her readiness to work on the problem, the level of anxiety in parents, openness to group interventions), as well as to take into account possible forms of therapy and the broader socio-cultural context (including the therapist's theoretical preparation and competencies, availability of possible forms of help, including paid therapy, family openness and motivation to undertake family therapy).

However, there are several obstacles to popularising the application of family therapy in the treatment of disorders in children and adolescents. First of all, we observe little access to this therapy in public health care institutions. Family visits are so far unprofitable (in terms of points awarded by the Polish National Health Fund), and the typical requirement of working with two therapists is difficult to implement in many places. The regulation of the president of the Polish National Health Fund of 16 January 2020 [45] provides for the settlement of family therapy sessions depending on the number of participants, as in the case of group therapy sessions. With the current valuation based on the number of people, family therapy does not cover the costs of the service, especially if the sessions were to be conducted by two therapists or last longer than individual therapy sessions (1.5 or 2 hours). We encounter another difficulty when conducting individual visits for parents, which cannot be accounted for as a therapeutic visit in the process of individual therapy for the child. At the same time, research (also those cited in this article) shows that sometimes, therapeutic work takes place during meetings with the parents themselves. This is especially true for young and early school-aged children, who seem to benefit less if treated solely through individual therapy. As a result, even therapists trained in the systemic approach do not have the opportunity to practice family therapy in public health care facilities. It also seems that participants who attend other therapy

courses, and who want to work with children, rarely expand their skills to practice in the area of family therapy.

Conclusions

1. The family context is an important factor in the development of anxiety disorders in children and adolescents.
2. Including parents in the children's anxiety therapy increases the effectiveness of therapeutic interventions.
3. It seems that contemporary therapeutic approaches in the treatment of anxiety disorders in children and adolescents could benefit from combining the achievements of cognitive-behavioural and systemic theories.
4. Contemporary theories concerning family therapy offer various contexts of therapeutic work (working with the whole family, with subsystems, multi-family therapy), which, as research shows, support effective treatment of anxiety disorders.
5. There is a lack of research, especially in Poland, that would assess the effectiveness of systemic therapy for anxiety disorders in children and adolescents. Further development of research methods in this area is needed.
6. Changes in access to family therapy in the public mental health sector are also needed.

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