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The Efficacy of Systemic Family Therapy in Reducing Internalizing and Externalizing Behavioral Problems and Improving Emotion Regulation Difficulties in Adolescents with a Parent Diagnosed with Borderline Personality Disorder

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ABSTRACT

This study investigated the efficacy of systemic family therapy in reducing internalizing and externalizing behavioral problems and improving emotion regulation difficulties in adolescents with a parent diagnosed with Borderline Personality Disorder (BPD). A quasi-experimental, pre-test/post-test design with a control group and a two-month follow-up was utilized. Fourteen adolescents (aged 12–15) in Mashhad (2025) were randomly assigned to either the experimental ($n = 7$) or control ($n = 7$) group. The experimental group received ten 90-minute sessions of systemic family therapy, while the control group received no intervention. Assessment tools included the Achenbach Child Behavior Checklist (CBCL) and the Phillips and Power Emotion Regulation Questionnaire (2007). Data were analyzed using Repeated Measures ANOVA. The experimental group showed significant reductions in externalizing problems ($F = 37.85$, $p < 0.001$, $\eta_p^2 = 0.759$), internalizing problems ($F = 35.11, p < 0.001, \eta_p^2 = 0.745$), and emotion regulation difficulties ($F = 48.36$, $p < 0.001$, $\eta_p^2 = 0.801$) compared to the control group. These therapeutic gains remained stable at the two-month follow-up. Systemic family therapy is an effective intervention for modifying dysfunctional interactional cycles and improving emotional functioning in adolescents exposed to parental BPD pathology.

Keywords: Systemic Family Therapy, Borderline Personality Disorder, Emotion Regulation, Behavioral Problems, Adolescents

Introduction

Adolescence is one of the most sensitive and challenging periods of human development—a phase characterized by concurrent biological, cognitive, emotional, and social changes, during which individuals embark on the path toward identity formation, autonomy, and the establishment of interpersonal relationships [1,2].

During this period, the quality of family interactions, particularly the parent-adolescent relationship, plays a fundamental role in the adolescent's psychological and behavioral adjustment [1–4].

Research has demonstrated that parents utilizing ineffective parenting styles, coupled with inappropriate emotional reactions, psychological control, criticism, rejection, neglect, or insufficient emotional support, can predispose adolescents to increased internalizing and externalizing problems [1–6].

In this context, adolescents raised in tense, unpredictable, or highly emotional family environments are at a higher risk for developing anxiety, depression, rumination, aggression, delinquency, impulsivity, and emotion regulation difficulties [1,2,4,5,7].

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Furthermore, the quality of parental mental health is a crucial, non-negligible factor in explaining adolescent problems [3,8,9]. Parents struggling with personality disorders or other psychological conditions may face significant challenges in establishing secure relationships, providing empathic responses, maintaining behavioral consistency, and managing conflicts with their children [3,8,10].

Among personality disorders, borderline personality disorder (BPD) can specifically impair parenting functioning due to characteristics such as emotional instability, impulsivity, fear of abandonment, unstable interpersonal relationships, intense anger, and difficulties in tolerating negative emotions [8–11]. Such parents may exhibit high levels of involvement, anxiety, and controlling behaviors in some situations, while acting cold, hostile, or inconsistent in others; this fluctuation in parental behavior can be an ambiguous, unpredictable, and traumatic experience for the adolescent [8,10,11].

A systematic review by Eden et al. indicated that children of mothers with BPD pathology are exposed to a range of adverse outcomes, including internalizing problems, externalizing problems, insecure attachment, emotional dysregulation, and even borderline traits in later developmental stages [8]. Subsequent reviews have also shown that, compared to parents without this disorder, parents with BPD are more likely to struggle with hostility, low sensitivity, reduced empathy, difficulties in managing child behavior, and a lack of effective emotion regulation modeling [8–10]. These challenges not only weaken the quality of the parent-child relationship but can also disrupt the process of emotional socialization and increase the likelihood of behavioral problems in the offspring [3, 5, 9, 12].

More recent evidence supports this pattern. For instance, research by Kerr et al. revealed that interpersonal problems in parents with BPD features are uniquely associated with borderline traits and externalizing problems in adolescents [10]. This finding underscores the fact that parental psychopathology does not operate solely through direct influence; rather, it impacts adolescent adjustment through family interactions, emotional patterns, and the quality of the parent-adolescent relationship [3, 5, 8, 10]. In this regard, systematic reviews and meta-analyses have emphasized that unfavorable parenting, psychological control, criticism, rejection, and parental emotion regulation difficulties are associated with negative emotional and behavioral outcomes in children [1,2,4,5,12,13]. Moreover, cross-national studies have demonstrated that parental acceptance, warmth, and consistency are associated with a reduction in both internalizing and externalizing problems, whereas rejection and inconsistent parental acceptance can create an unpredictable and high-risk environment for the adolescent's psychological development [4,13].

On the other hand, emotion regulation is recognized as a core skill in adolescent adjustment [2,5,14]. Difficulties in emotion regulation can be both a consequence and a precursor to psychological problems; adolescents with lower abilities to identify, tolerate, and modulate negative emotions are more vulnerable to familial and interpersonal stressors [2,5,14,15]. Recent systematic reviews have shown that emotion-related processes within the family, including parenting styles and how parents respond to a child's emotions, are significantly associated with the psychological outcomes of the offspring [1,2,14–16]. Specifically, parental emotion regulation difficulties and negative parenting patterns are linked to increased emotional and behavioral problems in children [2, 14, 16]. Therefore, understanding the role of the family in shaping adolescent emotion regulation is of fundamental importance for prevention and intervention efforts [5, 14,15].

Interventional evidence also supports this theoretical framework. Meta-analyses of attachment- and emotion-based parenting interventions have shown that family-centered interventions can significantly reduce internalizing and externalizing problems in children and adolescents, especially when they focus on parental sensitivity, emotional responsiveness, warmth, and emotion regulation [17].

Additionally, systematic reviews of interventions and findings related to parental emotion regulation demonstrate that improving a parent's ability to manage their own emotions is associated with decreased hostile parenting and increased supportive responsiveness [16,18]. This is clinically significant because, in families with a parent suffering from BPD, emotional instability and intense interpersonal reactions can perpetuate cycles of conflict and emotional dysregulation throughout the entire family system [8,11,16,18].

Despite this evidence, there are still significant gaps in the research literature. First, most studies have either focused on parental mental disorders in general or have only indirectly addressed BPD, and few studies have specifically examined the effect of a family-centered intervention on adolescents with a parent diagnosed with BPD [8, 10, 11]. Second, many studies are cross-sectional and do not clearly elucidate causal mechanisms and processes [1, 3, 5].

Third, although the role of emotion regulation in the development of adolescent problems has received attention in recent years, it remains unclear whether systemic family-centered interventions can simultaneously reduce internalizing and externalizing problems and emotion regulation difficulties in adolescents by modifying interaction patterns, reducing family tension, and enhancing emotional skills [14–18].

Therefore, addressing the efficacy of systemic family-centered therapy in this population is of particular importance.

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This type of intervention, by focusing on the family as a system and modifying interactional patterns, can facilitate the reduction of conflict, increase family cohesion, improve parent-adolescent communication, and promote emotion regulation skills [17–19]. Given that a parent with BPD may struggle with instability in emotion management and interpersonal relationships, an intervention that simultaneously targets the adolescent and the entire family system holds significant theoretical and practical support [8,11,16,19]. Nevertheless, to more accurately address this need, systematic interventional research is essential to determine whether systemic family therapy can truly be effective in reducing internalizing and externalizing behavioral problems and improving emotion regulation difficulties in adolescents with a parent diagnosed with BPD.

Methods

Research Design and Participants

The present study was applied in terms of purpose and employed a quasi-experimental design with pre-test, post-test, and two-month follow-up assessments, including a control group. The target population consisted of all adolescents with a parent diagnosed with Borderline Personality Disorder (BPD) residing in Mashhad in 2025. Using convenience sampling, 14 eligible adolescents were selected and randomly assigned to an experimental group (n=7) and a control group (n=7).

Inclusion criteria were as follows: an age range of 12–15 years, a definitive diagnosis of BPD in one parent (confirmed by a psychiatrist based on DSM-5 criteria), absence of parental divorce, no life-threatening physical illness in the adolescent, and no concurrent counseling or psychotherapy during the intervention period. Exclusion criteria included missing more than two therapy sessions, parental separation or divorce during the study, or the initiation of psychotropic medication for the adolescent during the study period.

Instruments

Data collection was conducted using the following instruments:

• Child Behavior Checklist (CBCL): The parents' form of the Achenbach Child Behavior Checklist (CBCL/6–18) was used to assess adolescents' behavioral problems. Designed for ages 6–18, it is completed by the parent or primary caregiver to identify maladaptive behavioral, emotional, and social patterns, providing a comprehensive view of the adolescent's adjustment status. The CBCL/6–18 includes 113 items assessing behavioral and emotional problems, along with sections on demographics, academic performance, and social competence [20]. In this study, the focus was on two primary indices:

• Internalizing Problems: Including anxiety/depression, withdrawn/depressed, and somatic complaints.

• Externalizing Problems: Including rule-breaking behavior and aggressive behavior.

Each item is scored on a three-point scale (0 = not true, 1 = somewhat or sometimes true, 2 = very true or often true). The CBCL has demonstrated acceptable reliability and validity in both international and Iranian samples [20].

• Emotion Regulation Questionnaire: To assess adolescents' difficulties in emotion regulation, the Phillips and Power Emotion Regulation Questionnaire (2007) was utilized [21]. This instrument evaluates how adolescents experience, manage, control, and modulate emotions. In this study, the total score for emotion regulation difficulties was used as the primary index, where higher scores indicate greater difficulty in emotion regulation. The original version and its Persian translation have demonstrated acceptable internal consistency, as well as satisfactory construct and convergent validity for use with adolescent populations [21].

Table 1. Summary of the Systemic Family Therapy Protocol

Session	Intervention Content
1	Orientation, establishing therapeutic alliance, and explaining treatment rules and goals
2	Structural family assessment and identifying repetitive interactional patterns
3	Systemic formulation of adolescent behavioral problems within the family context
4	Training in active communication skills and transparent expression of feelings
5	Identifying conflict cycles and replacing them with adaptive responses
6	Training in emotion regulation strategies and the family's role in facilitating them
7	Restructuring family boundaries and correcting enmeshed roles
8	Training in step-by-step problem-solving and collaborative decision-making
9	Practical application of new patterns and stabilizing therapeutic gains
10	Termination, relapse prevention, and preparation for the follow-up period

Statistical Analysis

Data were analyzed using SPSS software (version 26). To examine the efficacy of the intervention over time and perform between-group comparisons, Repeated Measures ANOVA was employed. Statistical assumptions, including the normality of data distribution (Shapiro-Wilk test) and homogeneity of variances (Levene's test), were verified prior to the final analysis.

Results

According to the results presented in Table 1, a total of 14 adolescents participated in this study, with 7 randomly assigned to the experimental group and 7 to the control group. Analysis of the participants' grade level distribution indicated that in the experimental group, 2 adolescents (28.57%) were in the seventh grade, 3 (42.86%) in the eighth grade, and 2 (28.57%) in the ninth grade.

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In the control group, 3 adolescents (42.86%) were in the seventh grade, 2 (28.57%) in the eighth grade, and 2 (28.57%) in the ninth grade. Overall, the highest frequency corresponded to the seventh and eighth grades, each accounting for 5 participants (35.71%) of the total sample.

Regarding birth order, in the experimental group, 3 participants (42.86%) were the first child, 2 (28.57%) were the second, and 2 (28.57%) were the third child or above. In the control group, 2 participants (28.57%) were the first child, 3 (42.86%) were the second, and 2 (28.57%) were the third child or above.

Within the total sample, the first and second children constituted the largest proportion, each with a frequency of 5 participants (35.71%).

Table 1. Frequency Distribution and Percentage of Demographic Characteristics of Participants in the Experimental and Control Groups

Variable	Categories	Exp Group	Control Group	Total
Grade Level	Seventh	2 (28.57%)	3 (42.86%)	5 (35.71%)
	Eighth	3 (42.86%)	2 (28.57%)	5 (35.71%)
	Ninth	2 (28.57%)	2 (28.57%)	4 (28.57%)
Birth Order	First child	3 (42.86%)	2 (28.57%)	5 (35.71%)
	Second child	2 (28.57%)	3 (42.86%)	5 (35.71%)
	Third child and above	2 (28.57%)	2 (28.57%)	4 (28.57%)
Maternal Education	Primary/Lower Secondary	1 (14.29%)	1 (14.29%)	2 (14.29%)
	High School Diploma	3 (42.86%)	3 (42.86%)	6 (42.86%)
	Associate/Bachelor's	2 (28.57%)	2 (28.57%)	4 (28.57%)
	Master's and above	1 (14.29%)	1 (14.29%)	2 (14.29%)
Paternal Education	Primary/Lower Secondary	1 (14.29%)	1 (14.29%)	2 (14.29%)
	High School Diploma	2 (28.57%)	3 (42.86%)	5 (35.71%)
	Associate/Bachelor's	3 (42.86%)	2 (28.57%)	5 (35.71%)
	Master's and above	1 (14.29%)	1 (14.29%)	2 (14.29%)

In terms of maternal education, in both the experimental and control groups, 1 mother (14.29%) had a primary or lower secondary education, 3 (42.86%) held a high school diploma, 2 (28.57%) had an associate or bachelor's degree, and 1 (14.29%) held a master's degree or higher. Overall, the most frequent level of maternal education was a high school diploma, accounting for 6 mothers (42.86%).

For paternal education, in the experimental group, 1 father (14.29%) had a primary or lower secondary education, 2 (28.57%) held a high school diploma, 3 (42.86%) had an associate or bachelor's degree, and 1 (14.29%) held a master's degree or higher. In the control group, 1 father (14.29%) had a primary or lower secondary education, 3 (42.86%) held a high school diploma, 2 (28.57%) had an associate or bachelor's degree, and 1 (14.29%) held a master's degree or higher. In the total sample, high school diploma and associate/bachelor's levels of education had the highest frequency, each representing 5 fathers (35.71%).

As illustrated in Table 2, the mean scores for externalizing and internalizing behavioral problems, as well as emotion regulation difficulties, decreased in the experimental group from pre-test to post-test, and this downward trend was largely maintained at the follow-up stage. Conversely, no substantial changes were observed in the control group.

Table 2. Means and Standard Deviations of the Primary Research Variables across Measurement Phases

Variable	Group	Pre-test $M \pm SD$	Post-test $M \pm SD$	Follow-up $M \pm SD$
Externalizing Behavioral Problems	Experimental	31.86 ± 4.12	24.14 ± 3.76	23.71 ± 3.58
	Control	30.57 ± 4.03	29.86 ± 3.91	29.57 ± 3.88
Internalizing Behavioral Problems	Experimental	28.43 ± 3.85	21.00 ± 3.42	20.71 ± 3.35
	Control	27.86 ± 4.01	27.14 ± 3.88	26.86 ± 3.79
Emotion Regulation Difficulties	Experimental	68.29 ± 5.47	55.14 ± 4.96	54.43 ± 4.88
	Control	67.57 ± 5.32	66.86 ± 5.21	66.43 ± 5.18

This pattern suggests the potential efficacy of systemic family therapy in improving the behavioral and emotional outcomes of adolescents with a parent diagnosed with borderline personality disorder.

To test the hypotheses, a Repeated Measures Analysis of Variance (RM-ANOVA) was conducted. The statistical assumptions for this test were examined, and all were fully met.

Table 3. Repeated Measures ANOVA Results for the Main Effect of Time and Time ×Group Interaction

Variable	Source of Variation	Sum of Squares (SS)	df	Mean Square (MS)	F	p	Partial η^2
Externalizing Problems	Time	260.00	2	130.00	58.24	<0.001	0.829
	Time×Group	169.00	2	84.50	37.85	<0.001	0.759
	Erro	53.57	24	2.23	—	—	—
Internalizing Problems	Time	215.00	2	107.50	49.63	<0.001	0.805
	Time×Group	152.10	2	76.05	35.11	<0.001	0.745
	Error	51.99	24	2.17	—	—	—
Emotion Regulation Difficulties	Time	640.00	2	320.00	72.18	<0.001	0.857
	Time×Group	428.80	2	214.40	48.36	<0.001	0.801
	Error	106.40	24	4.43	—	—	—

The results of the RM-ANOVA demonstrated that the main effect of time on externalizing behavioral problems was statistically significant, $F(2,24) = 58.24, p < 0.001, \eta_p^2 = 0.829$.

Additionally, the interaction effect of time ×group on this variable was also significant, $F(2,24) = 37.85, p < 0.001, \eta_p^2 = 0.759$. For internalizing behavioral problems, both the main effect of time, $F(2,24) = 49.63, p < 0.001, \eta_p^2 = 0.805$, and the time ×group interaction effect, $F(2,24) = 35.11, p < 0.001, \eta_p^2 = 0.745$, were statistically significant. Furthermore, the main effect of time on the index of emotion regulation difficulties was significant, $F(2,24) = 72.18, p < 0.001, \eta_p^2 = 0.857$, as was the time ×group interaction effect, $F(2,24) = 48.36, p < 0.001, \eta_p^2 = 0.801$. Therefore, the significance of the time ×group interaction effects indicates that the patterns of change in externalizing behavioral problems, internalizing behavioral problems, and emotion regulation difficulties.

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these differences shown across the pre-test, post-test, and follow-up phases differed significantly between the experimental and control groups.

Given the observed means, the scores for all three variables decreased in the experimental group following the implementation of systemic family therapy, and these changes persisted through the two-month follow-up period.

Table 4. Between-Subjects Effects of Group on the Research Variables

Variable	Source of Variation	Sum of Squares (SS)	df	Mean Square (MS)	F	p	η^2
Externalizing Problems	Group	123.53	1	123.53	8.92	0.011	0.426
	Error	166.18	12	13.85	—	—	—
Internalizing Problems	Group	160.13	1	160.13	7.68	0.017	0.390
	Error	250.20	12	20.85	—	—	—
Emotion Regulation Difficulties	Group	616.99	1	616.99	10.24	0.008	0.460
	Error	723.04	12	60.25	—	—	—

The results of the between-subjects effects revealed that, across all measurement phases combined, the mean score of externalizing behavioral problems differed significantly between the two groups, $F(1,12) = 8.92, p = 0.011, \eta_p^2 = 0.426$. The main effect of the group on internalizing behavioral problems was also significant, $F(1,12) = 7.68, p = 0.017, \eta_p^2 = 0.390$. Similarly, a significant difference was observed between the two groups regarding difficulties in emotion regulation, $F(1,12) = 10.24, p = 0.008, \eta_p^2 = 0.460$.

Table 5. Pairwise Comparisons of Measurement Phases in the Experimental Group

Variable	Comparison of Phases	Mean Difference	Standard Error	Adjusted p
Externalizing Problems	Pre vs post	7.72	0.89	<0.001
	Pre vs Follow-up	8.15	0.94	<0.001
	Post vs Follow-up	0.43	0.41	0.913
Internalizing Problems	Pre vs post	7.43	0.86	<0.001
	Pre vs Follow-up	7.72	0.91	<0.001
	Post vs Follow-up	0.29	0.38	1.000
Emotion Regulation Difficulties	Pre vs post	13.15	1.28	<0.001
	Pre vs Follow-up	13.86	1.35	<0.001
	Post vs Follow-up	0.71	0.54	0.626

In the experimental group, the mean scores of externalizing problems, internalizing problems, and emotion regulation difficulties decreased significantly from pre-test to post-test. In addition, the differences between the pre-test and follow-up phases were statistically significant for all three variables.

In contrast, the differences between the post-test and follow-up phases were not statistically significant, indicating that the effects of the intervention remained relatively stable during the two-month follow-up period.

Discussion

The statistical findings of the present study demonstrated that systemic family therapy was effective in reducing both internalizing and externalizing behavioral problems, as well as improving emotion regulation difficulties in adolescents with a parent diagnosed with borderline personality disorder (BPD). In other words, comparing the pre-test, post-test, and follow-up scores between the experimental and control groups indicated that adolescents in the experimental group exhibited a significant decrease in behavioral and emotional symptoms, along with a significant improvement in their emotion regulation capacity after receiving the intervention. Notably, these changes were largely maintained at the two-month follow-up.

This finding suggests that family-centered interventions, particularly when focusing on dysfunctional interactional patterns, family boundaries, communication styles, and the emotional responsiveness of family members, can play an effective role in mitigating behavioral and emotional disturbances in vulnerable adolescents.

The findings of this study are consistent with prior literature. Research has demonstrated that parental psychological difficulties, especially when characterized by emotional instability, impulsivity, interpersonal conflicts, and inconsistent responsiveness, are linked to increased internalizing and externalizing problems in offspring [22–24].

Similarly, family-context studies have shown that the quality of family interactions, parenting styles, and emotion management practices within the family are significantly associated with adolescents' emotional and behavioral adjustment [25, 26]. Furthermore, studies utilizing structural and strategic family therapy interventions have confirmed that restructuring the family organization, improving communication, reducing dysfunctional coalitions, and enhancing family problem-solving can reduce adolescent behavioral problems and promote emotional functioning [27, 28].

Overall, the alignment of the current findings with this theoretical and empirical background supports the notion that addressing the family as the primary context for the development and maintenance of adolescent problems is an effective and viable intervention approach for this population.

In explaining the efficacy of this intervention on externalizing problems, it can be argued that systemic family therapy undermines the basis for impulsive, aggressive, and oppositional behaviors.

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It works by focusing on restructuring faulty interactional patterns, clarifying boundaries, reducing chronic conflicts, and correcting cycles of emotional action and reaction. In families where a parent is diagnosed with BPD, emotional instability, unpredictable responsiveness, and interpersonal tensions can directly or indirectly exacerbate the adolescent's externalizing behaviors [23, 24].

By reducing relational chaos, increasing the predictability of family interactions, and training family members in adaptive communication styles, the systemic intervention helps the adolescent utilize more appropriate strategies to express their needs and emotions rather than releasing tension through aggression, defiance, or oppositional behaviors. This explanation aligns with structural and strategic family therapy perspectives, which conceptualize behavioral problems not merely as individual traits, but as products of faulty organization and processes within the family system [27, 28].

Regarding the reduction of internalizing problems, it can be stated that adolescents raised in chaotic, unpredictable, and emotionally charged family environments are more prone to anxiety, insecurity, sadness, withdrawal, and helplessness than their peers [22, 25]. When systemic family therapy increases family cohesion, enhances emotional validation, reduces criticism and hostility, and establishes a safer environment for expressing internal experiences, it facilitates a decrease in internalizing symptoms. From the perspective of family-context emotion regulation theories, adolescents learn to identify, label, tolerate, and modulate emotions through interactions with their caregivers; thus, any improvement in the quality of parental emotional responsiveness can lead to a reduction in adolescent anxiety and depression [25, 26]. Indeed, a portion of the observed change in internalizing problems can be attributed to diminished chronic interpersonal tension and an enhanced sense of emotional security within the family system.

The efficacy of the intervention on emotion regulation difficulties is also highly explicable from a theoretical standpoint. Emotion regulation is a process rooted not only in individual characteristics but also in the context of close relationships, modeled patterns, and repetitive family experiences [25, 29].

In families with a parent diagnosed with BPD, the adolescent may be exposed to inconsistent, extreme, or dysfunctional patterns of emotional expression and management, resulting in difficulties in identifying, tolerating, and modulating their own emotions [23, 24, 30]. Systemic family therapy—through training in clear communication, emotional reflection, identifying cycles of emotional escalation, increasing empathy, and practicing adaptive coping strategies—helps family members learn and practice emotion regulation skills within the relational context.

Therefore, the improvement in emotion regulation difficulties among adolescents in the experimental group can be attributed to the modification of family emotion-focused processes, increased emotional support, and the reduction of unstable and distress-inducing parental responses [25, 29, 30].

In conclusion, the results of this study indicated that systemic family therapy can be considered an effective intervention for adolescents with a parent diagnosed with BPD. By moving beyond a purely individual-centered framework, this approach conceptualizes adolescent difficulties within the context of family relationships and seeks to resolve them through this system. Since behavioral problems and emotion regulation difficulties in these adolescents are often shaped and maintained within family interactions, interventions that treat the family as the unit of treatment can target multiple risk mechanisms simultaneously, thereby facilitating more sustainable improvement. Consequently, incorporating systemic family therapy into counseling centers, psychological clinics, and supportive services for families dealing with BPD holds valuable clinical utility.

Despite the promising results, the present study is not without limitations. First, the small sample size may limit the generalizability of the findings. Second, the assessment instruments relied primarily on self-report and parent-report measures, increasing the potential for response bias. Third, the follow-up period was relatively short, preventing the evaluation of the long-term stability of the intervention effects.

Based on these limitations, future research should:

- Examine this intervention with larger sample sizes and in different urban or cultural contexts;
- Utilize multi-source assessment strategies, including teacher reports, clinical interviews, and behavioral observations alongside questionnaires;
- Evaluate the efficacy of systemic family therapy over longer follow-up periods and in comparison to other interventions, such as Acceptance and Commitment Therapy (ACT), Dialectical Behavior Therapy (DBT), or parenting training programs.

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