



**Systemic family therapy for severe functional disorders in youths.
A qualitative study in a psychiatric setting**

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A qualitative study in a psychiatric setting

Running head: Family therapy for functional disorders in youths

Abstract

This study aimed to explore participant experiences of systemic family therapy (SFT) for youths with functional disorders (FD).

Method: Qualitative interviews with 21 participants (youths and parents) were performed, after their completion of family therapy. Analysis was based on Interpretative Phenomenological Analysis.

Results: Theme 1) *Challenges of creating meaning and understanding of child-symptoms in family therapy*: Symptom understanding and explanation was an important and sometimes challenging theme of SFT for FD in youth. Theme 2) *Clinical encounters in family therapy promote dialogue*: The SFT setting was experienced to be beneficial as it facilitated a dialogue that differed from the everyday family conversation.

Conclusions: SFT can provide a space for empowering dialogue in FD treatment. For therapy to be acceptable and meaningful for youths and parents, symptom explanations have to be exculpatory, tangible and in line with the personal experiences of the family.

Practitioner points

- Little is known about the participant experience of systemic family therapy for severe functional disorders in youths
- Addressing family dynamics during therapy can be experienced as an invasion of the family-domain
- Symptom explanations should be exculpatory, tangible and point towards solutions for the family
- Systemic family therapy can support empowering processes for families of youths with functional disorders

For Peer Review

Introduction

Functional disorders (FD), characterized by disabling and bothersome physical symptoms without clear organic pathology, are common in children and adolescents (Rask et al., 2009, Berntsson et al., 2001, Rask et al., 2019). FD cause significant impairment and reduced quality of life in childhood, including school absence, withdrawal from peer relations and disturbed family functioning (Garralda et al., 2015, Rask et al., 2009, Rangel et al., 2000, Jordan et al., 2007, Moulin et al., 2015, Rask, 2012).

Currently there are no clinical guidelines on which treatment to offer this patient group (Eminson, 2007, Fonagy and Cottrell, 2014). However, psychological treatments have shown promising results (Bonvanie et al., 2017, Abbott et al., 2017, Eccleston et al., 2014). Targeting the whole family in treatment is often emphasised as important (Hulgaard et al., 2017) due to the potential family influences on the precipitation and perpetuation of FD in children and adolescents (Schulte and Petermann, 2011, van Tilburg et al., 2015, van Gils et al., 2014, Hulgaard, 2020).

Family-based approaches in child mental health can comprise a variety of treatments, from systemic psychotherapy, where both children and parents are treated together, to parent training programs where parents act as supporters for child treatment (Carr, 2014, Diamond and Josephson, 2005, Hulgaard et al., 2017). Research focusing on how youths and their parents experience systemic family therapy (SFT) is almost entirely missing in the literature (Sheridan et al., 2010, Faulkner et al., 2002). A qualitative study found that parents who sought SFT for a variety of different problems, e.g. adolescent depression or adolescent substance abuse, emphasised the importance of the SFT therapeutic climate and structure to allow constructive change within the family and improvement of the adolescent's symptoms to happen (Sheridan et al., 2010).

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3 To the best of our knowledge, this is the first study to explore the participant perception of
4 SFT based treatment for youths with FD (Hinton and Kirk, 2016). The study is part of a
5
6 larger research project exploring the experiences of youths with severe FD and their parents
7
8 in the context of transition from a paediatric department to child and adolescent mental
9
10 health services (CAMHS) (figure 1). Two previous papers conducted in the same setting,
11
12 before the commencement of SFT, have focused on the families' illness perceptions
13
14 (Hulgaard et al., 2019b), and on parenting experiences, including their attitudes to referral
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16 from a somatic to a psychiatric setting (Hulgaard et al., 2019a). Results from these studies
17
18 suggested barriers and scepticism towards SFT among family members. In the present
19
20 study we will extend these findings by exploring some of these participants' experiences
21
22 after termination of SFT. The concept of patient empowerment is used as a theoretical
23
24 perspective, in order to broaden our understandings of how SFT may support potential
25
26 change within families (Feste and Anderson, 1995, Gaughan et al., 2014). Empowerment is
27
28 defined as an enhanced sense of self efficacy that occurs as a result of an empowering
29
30 process which aims to engage the participant in defining meaningful health related goals
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32 and in achieving these (Anderson and Funnell, 2010, Tengland, 2007, Schulz and
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34 Nakamoto, 2013).
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45 *Insert figure 1 about here*

46 47 48 49 **Methods**

50 51 *Design*

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53 A qualitative study design was chosen as we wanted to explore participant experiences with
54
55 SFT for FD in youths (Smith and Osborn, 2007, Thorogood, 2009, Malterud, 2001).
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3 The overall study was conducted according to the guidelines of the Danish Ethical
4 Committee and approved by the Danish Data Protection Agency (Record no. 17/28315).

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8 The research team consisted of a medical doctor and trainee in child and adolescent
9 psychiatry (first author, DRH), and two senior medical doctors and specialists in child and
10 adolescent psychiatry (CUR, GD) and one medical anthropologist (MBR). Only GD
11 worked in the clinical setting under study.
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19 *Participants and Procedures*

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21 In total 21 participants from 8 families (8 youths, 8 mothers and 5 fathers) who had all
22 received at least 5 sessions of family therapy, were purposively sampled for variation
23 concerning child gender, socioeconomic status and type and duration of symptoms.
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28 Families were referred to CAMHS by the paediatric department. Five of these families
29 were recruited for participation prior to family therapy as part of the overall study (figure1).
30
31 As six families from the prior studies were excluded from participation in the current study
32 (figure 1), the decision was made to include three additional families, to increase
33 information power (Malterud et al., 2016).
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40 Healthcare professionals from either the paediatric department or CAMHS asked families
41 for participation. Those who were interested received further oral and written project
42 information by the first author and written consent was obtained before study inclusion.
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46 After termination of SFT, in-depth semi-structured interviews were conducted with the
47 youths and the parents, respectively. Separate interviews were chosen as we expected both
48 youths and parents to be more inclined to share possible challenges or negative emotions
49 regarding their shared participation in family therapy.
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55 The entire research team participated in the development and adjustment of the interview
56 guide which was tested in a pilot interview. The first author conducted and subsequently
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2
3 transcribed the interviews verbatim, using a pre-developed transcription guide. Questions
4
5 were open-ended and focused on symptom perception, treatment experience and sense of
6
7 empowerment. Questions to youths were adjusted to fit their age and intellectual
8
9 competencies (Kortessluoma et al., 2003). Interviews were performed 1 – 5 months after
10
11 ended treatment, between June 2015 and January 2018. They lasted between 48 and 108
12
13 minutes for parents (mean 69 minutes) and between 27 and 45 minutes for youths (mean 34
14
15 minutes). The participants chose interview settings: Private home (6 families) or the first
16
17 authors' office (2 families).
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23

24 *Setting*

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26 The study was conducted in the CAMHS at Odense University Hospital in Denmark, which
27
28 has a target population of 430,000 people. The department has a specialised team to offer
29
30 assessment and treatment of youths with severe FD and a well-established collaboration
31
32 with the paediatric department. The team consists of medical doctors, psychologists and
33
34 nurses, all trained in family-based psychotherapy.
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40 *Treatment*

41
42 The provided family therapy is not manualized but draws on core principles of SFT
43
44 (Retzlaff et al., 2013, Cottrell and Boston, 2002). The following description of the standard
45
46 treatment course is based on detailed information provided by the involved therapists.
47
48 Therapy sessions are conducted with the child and parents, and sometimes siblings present.
49
50 The primary goal is to help the youth regain a normal everyday life including restoring peer
51
52 relations, school attendance and leisure activities. Two therapists are assigned to each
53
54 family and are present during both the initial assessment and the subsequent therapy
55
56 sessions. Each session lasts 75 - 90 minutes and is scheduled every 2 – 5 weeks. The total
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3 number of sessions is adjusted to meet the needs of the individual family but will typically
4
5 be 5 – 10 sessions.
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8 Assessment and psychoeducation:
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10 During the first two sessions a thorough history of the youth's functional symptoms is
11
12 taken. In collaboration with, and based on the experiences of the family, possible
13
14 predisposing, precipitating and perpetuating biological, psychological and social stressors
15
16 are identified (table 1). In parallel with the history taking there is focus on psychoeducation.
17
18 Based on the biopsychosocial model for FD (Garralda et al., 2015), symptoms are
19
20 explained as bodily reactions to various stressors.
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22

23
24 Family therapy sessions:
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26 The therapists aim to collaborate with the family in defining themes for therapy sessions by
27
28 emphasising the families' accounts. Themes can be, but are not necessarily, related to
29
30 potential perpetuating factors in the family. Typical themes are presented in table 1.
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35 ***Table 1 to be inserted about here***
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40 *Analysis*
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42 The analysis was based on interpretative phenomenological analysis (IPA) principles. The
43
44 analytic focus was on how youths and their parents experienced SFT (Smith and Osborn,
45
46 2007, Smith et al., 2009). Interviews were conducted, transcribed and analysed
47
48 consecutively. Individual interviews were read in full several times and initial thoughts
49
50 were noted. Subsequently, emergent themes were noted for each participant. Parents' and
51
52 youths' accounts were analysed individually, not as group accounts. A cross-case analysis
53
54 then identified convergences and divergences between accounts, and superordinate themes
55
56 were identified. The software program NVIVO11 assisted analysis.
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3 Researcher audit was used at several steps of the research process to increase validity. The
4
5 co-author (GD) audited interview technique and analysis. Especially, possible
6
7 preconceptions by the psychiatrists in the research team about advantages of family therapy
8
9 were countered by reflective discussion among all four authors. In the final steps of the
10
11 analysis, themes, subthemes and coding tree were audited by all four co-authors. Further,
12
13 initial drafts of the paper were commented on by the entire project group
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19 **Results**

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21 Details about participants are presented in table 2.

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23 While the current study cannot evaluate the effect of SFT, it is noteworthy that 7 of the 8
24
25 families by their own accounts described symptom improvement during the course of SFT,
26
27 however not necessarily attributing the improvement to the SFT treatment.
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31 As described in the following, two main themes with subthemes were identified, pertaining
32
33 to the participant experience of the content of therapy sessions and of the SFT setting,
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35 respectively.
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40 ***Table 2 to be inserted about here***

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45 *Theme 1: Challenges of creating meaning and understanding of child symptoms in family*
46
47 *therapy*

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49 The following section explores the participants' experiences of the content of SFT sessions
50
51 with focus on the process of co-creating meaning and mutually agreeable symptom
52
53 understanding between therapist, youth and parent.
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56 *Invading the family space*
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3 Family members sometimes felt their personal and family space invaded during family
4 therapy, especially when the therapists targeted the family context and dynamics as possible
5 perpetuating factors, and when these explanations were at odds with the family's views.
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10 Britta was referred to CAMHS with functional paralysis of the legs, and these symptoms
11 improved rather quickly during therapy. Her symptoms had changed the family dynamics,
12 as the parents were afraid of exacerbating Britta's symptoms by overloading her. Britta
13 recalls how therapists addressed these changes by suggesting that Britta should participate
14 in family chores:
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22 *Britta: "Well we kind of got into an argument at one point, actually, about the*
23 *fact that they interfered – a lot – with what happened in our home. They*
24 *almost decided exactly what we were supposed to do. They said I should help*
25 *cooking dinner, because I should be more independent and stuff. And we did*
26 *understand that, but maybe they thought that I was more of a spoiled kid than*
27 *I really am. And I did not want to cook because I really don't like to cook. But*
28 *we had to do what they said, and I was really angry about that."*
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38 Britta felt that her voice and input were not sufficiently heard. She disagreed with the
39 therapist's interpretation of the reasons and significance of her not cooking dinner at home.
40 Further, she felt the therapists implied that she was a spoiled kid. Britta did not seem to
41 accept or agree with the relevance of addressing these family dynamics in relation to her
42 symptoms. The use of "we" suggests a feeling of unity and agreement with - and support by
43 her parents, and further, it could be interpreted as a demonstration of Britta's resistance
44 towards the therapists' interference with- and invasion of her family- domain.
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53 Mie had been struggling with severe and disabling leg - pain for years, resulting in
54 complete absence from school and temporary use of a wheelchair. Her parents felt very
55 strongly that Mie's symptoms had a physical cause, which had not been sufficiently
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3 explored, thus they did not agree with a multifactorial explanation. They had only agreed to
4 the referral to SFT in a CAMHS setting, as they felt that the healthcare system left them
5 without other options (Hulgaard et al., 2019b). Mie's symptoms did not improve during
6 family therapy, and the whole idea of psychotherapy and of engaging in a dialogue about
7 family dynamics and relations as perpetuating factors, did not make sense to the family
8 members.
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17 *Mie's mother: My experience was that we were looking for a reason that had*
18 *caused this pain almost spontaneously without a physical cause. And I felt,*
19 *well it was almost as if it was all about poking around in our personal life in*
20 *an indecent way.*
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26 With Mie's parents, the efforts to co-create meaning and explore possible perpetuating
27 factors failed, as therapists and parents were unable to establish any common grounds about
28 symptom understanding. Thus, the therapists' efforts to gain insight into family dynamics
29 was by the parents seen as irrelevant in relation to Mie's symptoms. With that context
30 lacking, the discussion of family dynamics in relation to their daughter's symptoms was
31 experienced to be invasive and indecent. Further, the parents' sense of not being listened to
32 by health care professionals, something they had been struggling with for years and
33 specifically in relation to referral to CAMHS, was exacerbated by a focus on - for them
34 irrelevant – family dynamics.
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46 Addressing family dynamics and relations could be experienced as an invasion of the
47 family space and associated to a feeling of being judged as a family. These feelings were
48 exacerbated when family dynamics were suggested as relevant themes for therapy by the
49 therapists but not recognized or agreed upon by the family.
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56 *Empowering explanations*
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3 As a general proposition, the explanation about FD as bodily reactions to various
4
5 biopsychosocial stressors made sense to families and was helpful, when mutually agreeable
6
7 stressors were identified and addressed in family therapy. During interviews, youths and
8
9 their parents frequently employed symptom explanations such as “*stress*”, “*the body is*
10
11 *stressed*”, “*it is when I take in too much*”, “*my brain is overloaded*”, “*the brain is over*
12
13 *stimulated*”, “*the body says stop*”. These concurred with the written and oral
14
15 psychoeducation provided previously in the paediatric department and were repeated by the
16
17 therapists during treatment in CAMHS.
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20
21 Sanne had suffered from both physical illness (fractured foot and thyroid disease) and
22
23 severe functional pain for years (table 2), the latter causing her to miss school and social
24
25 activities. Sanne and her mother described that the family members during the course of
26
27 SFT reached a mutually agreeable and new symptom understanding about the functional
28
29 stomach pain as a bodily reaction to “*stress*”:
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33 *Sanne: The explanation helped a lot. It was that - now I understood why I got*
34
35 *the stomach pain and that nothing was actually wrong in my stomach. But it*
36
37 *was because I was stressed.*
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40 For Sanne it was essential to be able to attribute symptoms to being stressed, as this
41
42 explanation was meaningful and operational, and further provided legitimacy to the
43
44 discussion in SFT of ways to alleviate stressful activities, e.g. addressing within family
45
46 stressfull conflicts or stress at school.
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49 Results from the previous study on the parenting experience (Hulgaard et al., 2019a)(figure
50
51 1), showed how within-family perpetuating factors could evoke parental feelings of guilt or
52
53 even of being blamed for their child’s symptoms. In line with these findings, Kira’s parents
54
55 described feelings of guilt in relation to Kira’s symptoms, especially at the point of referral
56
57 to SFT. Kira had suffered from severe functional back pain and inability to walk. Her
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3 parents sought various public and private treatment approaches and recalled their
4
5 scepticism and ambivalence towards psychological family-based treatment for Kira's
6
7 symptoms. For them, psychoeducation about the biopsychosocial multicausal explanatory
8
9 model for FD was helpful.
10
11

12 *Kira's mother: "I also think that illustrations and material that can illustrate*
13 *explanations, like the biopsychosocial model, they can provide hope, and*
14 *further, they can take some of the guilt away. And I have felt a lot of guilt, and*
15 *some of that could be taken away, which was a good thing."*
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22 Kira's mother used the complexity of the multicausal explanatory model to relieve feelings
23
24 of guilt, possibly as it facilitated the view that family relations and dynamics may be
25
26 relevant to address, without being the sole cause of symptoms.
27

28 Symptom understanding, and explanations were an important and sometimes challenging
29
30 theme of SFT for FD in youths. Mutually agreeable symptom explanations could provide
31
32 legitimacy to themes addressed during therapy and to the use of SFT for FD in youths as
33
34 such. Explanations were more likely to be agreed to by the family when they pointed
35
36 towards ways to manage and alleviate symptoms, such as the explanation about "stress",
37
38 which provided a rationale for exploring possible stressors and since reducing them.
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45 ***Theme 2: Clinical encounters in family therapy promote dialogue***

46
47 This theme pertains to the SFT setting, the therapeutic dialogue and the experience of joint
48
49 participation by family members.
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51 *A room for talking and listening*

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53 Attending family therapy was experienced as providing a space for dialogical opportunity,
54
55 where therapists facilitated conversation and listening among family members about their
56
57 individual understanding of the child's symptoms but also about their family as such. This
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2
3 was emphasised as important by most youths and parents and provided meaning to the
4
5 concept of joint participation of youths and parents during family sessions: “*We got to talk*
6
7 *about everything*”, “*we just talked a lot about our family*”; “*just being in there together*”;
8
9 *just sitting down and listening to everybody*”; “*we shared the experience*”.

10
11
12 Some parents described however how sharing therapy time with the whole family could not
13
14 accommodate all their needs, as they also felt the need for consulting the therapists without
15
16 their child present. These parents described reluctance to address feelings such as
17
18 frustration, powerlessness and insecurity with their child present.
19

20
21
22 Still, in general families recognized the type of dialogue which they engaged in during SFT
23
24 as helpful, not necessarily explicitly in relation to symptoms but for the family as a whole,
25
26 as illustrated in the following quote:
27

28
29 *Kira: Talking helped us a lot. Not at first. At first, I felt that it was really*
30
31 *irritating, but later I enjoyed it.*

32
33 Talking during family therapy was experienced to be helpful for “us”, signifying the whole
34
35 family. Kira describes a process of growing comfortable with this new way of talking, from
36
37 being irritated at first to enjoying it in later sessions.

38
39
40 “*Listening*” was also emphasised as important. Kira’s family described how they used to
41
42 try to fix any problems or difficult emotions that Kira would face through parental comfort
43
44 and advice. This possibly left Kira with a sense that emotions such as sadness and anger
45
46 were wrong or unacceptable and could exacerbate her physical symptoms. For Kira’s
47
48 parents, a key element of SFT was to learn new “listening skills”.
49

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51
52 *Kira’s mother: I think that the information we were given over here right from*
53
54 *the start was about listening instead of talking. This very concrete*
55
56 *information, I think that helped a lot.”*
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Becoming a better “listener”, both in the therapy session and in the everyday family life, was helpful for the within family communication and further helped relieving Kira’s symptoms.

The setting of SFT was experienced to be beneficial as it facilitated a dialogue that differed from the everyday family conversation, a space for potential *sharing, listening, being together and talking*. Further, SFT shifted focus away from the child with symptoms towards the family as a whole.

However, some parents could feel restricted by the presence of their child when addressing difficult emotions.

Discussion

The current qualitative study aimed to explore the participant experiences and possible empowering processes of youths with severe FD and their parents during SFT.

The previous papers from the overall study (figure 1), conducted at the point of referral, found resistance and scepticism among parents and youths towards SFT (Hulgaard et al., 2019b, Hulgaard et al., 2019a) .

As the study was conducted in a secondary public healthcare setting, the SFT could only be accessed through referral by a paediatric department, and while all of the included families had accepted referral, none of them had actively sought SFT treatment and some families’ had critical preconceptions towards the family therapy format (Hulgaard et al., 2019b).

We identified two overall themes:

Theme 1) *Challenges of creating meaning and understanding of child- symptoms in family therapy*, illustrates how symptom understanding, and explanations were an important and sometimes challenging theme of SFT for FD in youth. The content of the sessions was

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3 experienced as tangible, beneficial and empowering by some families, when it was
4
5 mutually agreeable, helpful and meaningful.
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8 Theme 2) *Clinical encounters in family therapy promote dialogue*: The SFT setting was
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10 experienced to be beneficial as it facilitated a dialogue that differed from the everyday
11
12 family conversation, a space for potential *sharing, listening, being together and talking*.
13
14 New ways of family communication and relating could be practiced and adjusted during
15
16 SFT, providing meaning to the concept of joint family sessions for parents and youths.
17
18 The emphasis on dialogue and listening during family therapy was in line with fundamental
19
20 principles of empowerment theory which by definition is a relational concept (Salmon et
21
22 al., 1999, Salmon and Hall, 2003, Kirmayer, 1988, Kirmayer et al., 2004).
23
24

25
26 Symptom explanations and causes were addressed by the therapists in this study before and
27
28 during family therapy and mutually agreeable understandings between the family and the
29
30 therapists were reached in some cases. Stress oriented explanations causing the “body to
31
32 say stop” were generally helpful and exculpatory for youths and parents. Multicausal
33
34 symptom attribution, as well as exculpatory explanations, where parents did not feel solely
35
36 blamed for symptoms, reduced parental feelings of guilt and thus increased parental sense
37
38 of empowerment. Further, explanations preferably had to point towards ways to alleviate
39
40 symptoms. These characteristics of what youths and their parents accepted as meaningful
41
42 explanations were in line with Salmons concept of “empowering explanations” (Salmon,
43
44 2007). Empowering explanations are legitimizing, meaningful and lead to an alliance
45
46 between doctor and patient (Salmon et al., 1999, Salmon, 2007). In family therapy and in
47
48 empowering processes, the input and viewpoint of both student (patient/ family) and
49
50 teacher (doctor/ therapist) is valued and considered necessary, when addressing problems
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52 and challenges. By utilising the input of the family to engage them in both defining and
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3 working towards a particular health outcome, SFT could frame empowering processes
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5 (Kirmayer et al., 2004, Salmon and Hall, 2003).
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8 Results illustrated that the therapists sometimes suggested possible explanatory family
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10 factors, which were at odds with the families' own experiences and explanations. Not all
11
12 families did readily accept these explanations. Validation of youths and parents as
13
14 significant actors possessing relevant knowledge about the family and possible family
15
16 stressors seemingly was important for a mutual symptom understanding and further for the
17
18 treatment alliance, when addressing possible family stressors in SFT. This notion is
19
20 supported by theories about empowering dialogues in health suggesting that such alliances
21
22 could be remedied by acknowledging the family members' knowledge about their personal
23
24 life, ideas, values, competencies (Wallerstein and Bernstein, 1988, Anderson and Funnell,
25
26 2010, Feste and Anderson, 1995, Halvorsen et al., 2020). Nonetheless, the expansion of the
27
28 medical field into the social and family life of patients, has been critically discussed by
29
30 Salmon and Hall, who have argued that the biopsychosocial explanation grants the doctor
31
32 access to judging and changing the psychosocial life of patients (Salmon and Hall, 2003,
33
34 Salmon and Hall, 2004). This point of view can provide a critical perspective on treating
35
36 FD through SFT, and results showed that some families indeed felt judged and their family
37
38 space invaded by the therapists. Family explanations were experienced to be acceptable by
39
40 parents, when they were introduced in an exculpatory way and when they shifted focus
41
42 towards solutions rather than causes. This is in line with the suggestion by Kirmayer, that a
43
44 significant step forward in FD consultations could be to shift focus away from the
45
46 discussion of causes towards a discussion of solutions (Kirmayer et al., 2004).
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53 *Strengths and limitations:*

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55 The rather small number of participants was in line with IPA sampling principles.

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57 However, due to the narrow aim, specified sampling, strong dialogue and thorough analysis
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3 (Malterud et al., 2016), we believe the study and its results may be transferable to other
4 family therapy settings for FD. One limitation though, is that sampling did not succeed to
5 include any families where parents were divorced. As the treatment approach is family
6 therapy, the views of families with different structures would have been important and
7 likely to present different views, possibly revealing more struggle with the concept of joint
8 sessions for both parents and youths.
9

10 A qualitative approach to broaden the understanding of the participant experience of SFT
11 for FD in youth is appropriate as previous research in this area is sparse (Salmon, 2013).
12 Separate interviews with parents and youths, respectively, provided the researchers with
13 multiple perspectives on the SFT participant experience (Salmon and Young, 2018).
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28 **Conclusion**

29 This study provides important new insights to the under-researched area of how SFT is
30 experienced by youths with FD and their parents. SFT with joined sessions for youths and
31 parents could provide a space for empowering dialogue. However, for explanations about
32 FD to be acceptable and empowering in family therapy, they have to be in line with the
33 personal experiences of family members, be exculpatory and tangible.
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45 **4.3 Practice implications**

46 SFT for youths with FD can frame empowering processes in the family. The use of
47 multifactorial explanatory models, where the family is seen as part of the solution, rather
48 than weighting them as part of the cause may increase acceptability and potentially
49 treatment effect.
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3 The family can be part of the solution either through targeting symptom perpetuating
4 factors such as reducing stress at school or through the introduction of more helpful
5 parenting strategies by therapists e.g. improvement of family communication.
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15 honestly shared their stories.
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21 I confirm all patient/personal identifiers have been removed or disguised so the
22 patient/person(s) described are not identifiable and cannot be identified through the details
23 of the story. Female aliases have been used for all participating youths.
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Table 1. Typical themes addressed in family therapy sessions

Structure of sessions	Themes
Assessment and psychoeducation Sessions 1 and 2	Identification of possible: <ul style="list-style-type: none"> - Predisposing factors (Family related, e.g. health problems within the family; physical, psychiatric, functional. Adverse family climate) - Precipitating factors (e.g. viral infections, physical trauma, acute psychosocial stress) - Perpetuating factors (Family related, e.g. overprotective family environment, somatic symptom attribution, family conflicts; child related, e.g. personality traits, coping strategies; iatrogenic, e.g. repeated examinations and disagreement among health care professionals)
Family therapy 5 - 10 sessions	Psychoeducation Family conflicts and conflict-solving Setting boundaries within the family Family symptom understanding Experiences regarding symptom exacerbation and alleviation Individuation and identity development of the youth Parental feelings of guilt and shame concerning their child's symptoms. Family illness behaviours

Table 2: Participant characteristics

Number of families		8 families
Sex of youths	Female	7 families
	Male	1 family
Age of youths		11 – 16 years
Marital status of parents	Married	8 families
	Divorced	0
Family members participating in therapy	Mother and father	8 families
	Siblings participating in all sessions	2 families
	Siblings participating in some sessions	2 families
Parents participating in the interview	Mother and father	4 families
	Only mother	3 families
	Only father	1 family
Symptoms experienced by youths before therapy	Pain	5 youths
	Fatigue	4 youths
	Sensitive to sounds and smell	1 youth
	Seizures	1 youth
	Inability to walk	3 youths
	Paralysis/ weakness of the legs	4 youths
	Dizziness	2 youths
Symptom duration		1 – 5 years
Experienced symptom improvement after family therapy	Yes	7 families
	No	1 family

