Adolescence is an important period of growth in which, ideally, a healthy transition from dependence on family occurs, particularly in Western societies. This may be perceived, however, as meaning that young people are increasingly less likely to need family involvement and support in their lives. As a consequence of this, there is no consistent approach to the involvement of family members in treatment and intervention options for young people in need of support. This article examines recent literature regarding adolescent–parent relationships, and explores the evidence for family-based interventions that address problems occurring in adolescence.

There is little doubt that the relationship between children and parents changes during adolescence. A shift from a dependence on parents to increased involvement with peers and others occurs during this period, with the timing of such changes being dependent on the cultural expectations of the environment (Christie & Viner, 2005). In this sense, adolescent relationships with parents move to inter-dependence, resulting in reciprocally supportive and connected networks not just with family members, but also friends, partners, colleagues and others (Daniel, Wassell, & Gilligan, 1999).

The role of parents in an adolescent’s life, however, remains important and is often underestimated (Schofield & Beek, 2009). A growing body of literature indicates that many family-related protective factors—such as providing a secure base, being caring, providing a feeling of connectedness and being valued, providing support and giving a sense of belonging—are linked to positive outcomes in adolescence and beyond (e.g., Luthar, 2006; Paradis, Giaconia, Reinherz, Beardslee, Ward & Fitzmaurice, 2011; Rayner & Montague, 2000). For example, one longitudinal study in the US showed that adolescents who felt highly valued and were able to confide in family members at age 15 had substantially reduced risks for mental illness at age 30 (Paradis et al., 2011). The benefits of parental monitoring and limit-setting are also emphasised within the literature (Luthar, 2006), with poor parental monitoring clearly linked to negative outcomes.
in adolescence, such as antisocial behaviour, substance use and sexual risk-taking (Hayes, Smart, Toubourou, & Sanson, 2004). The limits set by parental monitoring, however, may provoke tension as the adolescent negotiates the struggle between developing their autonomy while continuing to have close bonds with their parents (Luthar, 2006).

This tension may also be evident in service provision to young people. Changes in the levels of autonomy and control in the parent–adolescent relationship can be mirrored in the shifting balance between parents’ and minors’ rights regarding issues related to health and wellbeing, including the young person’s safety, his/her level of competence to make decisions and the decision-making process itself (Larcher, 2005). Responsibility for decision-making around these issues is further complicated by the fact that adolescents have developing, yet often immature, cognitive capacities (Patton & Viner, 2007). For example, structural and functional changes in the brain in adolescence indicate that the ability to synchronise emotion and cognition improve over the course of adolescence. In early adolescence, parts of the brain that deal with reward processing are more easily aroused, but those that deal with harm avoidance and self-regulation are still comparatively immature (Steinberg, 2009). This has been described as having the ability to start the engine before being skilled at driving (Steinberg, Dahl, Keating, Kupfer, Masten & Pine, 2006).

Family risk and protective factors

There has been an increased understanding of the role of family-based risk and protective factors for adolescent risk behaviours. For example, there is extensive research that highlights the link between the family environment and adolescent depression (Micucci, 2009). Characteristics of such family environments may include physical and sexual abuse, neglect, attachment problems, parental mental illness, and family conflict, stress and breakdown (Larner, 2009). Research also indicates that characteristics of family environments—such as family breakdown, conflict, poor communication, lack of emotional warmth, abuse and neglect—can lead to homelessness (Hyde, 2005; Suk-Ching Liu, 2005; Thompson & Pillai, 2006). Chamberlain and McKenzie (2004) talked about “critical junctures”—defining moments, such as bitter family disputes or violence, on the “career path” of youth homelessness.

In contrast, close relationships with parents can be a protective factor against poor outcomes.

Part of this protective relationship is the “secure base” function that parents continue to play in the adolescent years (Daniel et al., 1999), particularly by mothers (see Markiewicz, Lawford, Doyle, & Haggart, 2006). While the secure base serves a physical and psychological role in early childhood, the emotional and psychological support offered via a warm and communicative child–parent relationship plays an even more important role in adolescence (Allen et al., 2003; Schofield & Beek, 2009). Gilligan (2006) termed this a “scaffolding” role; that is, support is provided when needed and withheld when not. While parents are ideal to play this role, other significant adults can also play a part (Rayner & Montague, 2000), including members of the extended family (Luthar, 2006).

The importance of having supportive relationships between parents and young people continues into early adulthood. Vassallo, Smart, and Price-Robertson (2009) found that parents continued to play the role of adviser and supporter to young adult children, while moving away from the more tangible and practical support offered in childhood. Interestingly, in that study, parents often underestimated the level of support they actually provided to young adult children, which was highly valued by the young people themselves. Parents therefore continue to be a vital presence in young people’s lives. This is contrary to popular beliefs around the diminishing role of parents in late adolescence/early adulthood—a view that many parents themselves held in that study.

Family also remains important for young people who are removed from the family home. Being an adolescent doesn’t necessarily diminish a desire for young people in care to be adopted or to have a permanent family connection (Charles & Nelson, 2000). These young people need the same family connections as other young people. This is supported by research on young people who leave care, which shows that contact with non-abusive family members can assist with a successful transition out of care (Maunders, Liddell, Liddell, & Green, 1999). Dwyer and Miller (2006) likewise suggested that family relationships remain an enormous source of pain for young people who have run away or been removed from family, and the desire for connection remains deeply held. Physical separation over many years, they suggested, rarely equates to emotional separation.
Family involvement in interventions for adolescents

If there are risk factors within the family that influence outcomes for adolescents, it makes sense that family should be seen as part of any intervention addressing adolescent problems. Interestingly, Steinberg (2009) argued that although scientific evidence on adolescent brain development is more advanced and more consistent than early brain development, policy investment tends to lie with early childhood development. Equally, in terms of service delivery, parents and families are seen as being vital to successful early childhood interventions; however, far fewer programs focus on families when late childhood and beyond is reached (Ryan, 2003). For example, Dwyer and Miller (2006) argued that while fewer and fewer services are mandated to work with young people and families together, family work is essential to assisting recovery from trauma.

Traditionally, youth services have often focused on young people’s rights to individuation, autonomy and confidentiality; to the extent that family factors known to be important in healthy development are overlooked (Robinson & Pryor, 2006). Garfat (2003) suggested that youth work has historically cast the family as irrelevant, then, more recently, as being relevant in a negative sense, such as being the cause of the problem or the “enemy”. This may be potentially detrimental where workers are only involved in young people’s lives for a limited time without working on more enduring connections. As such, including or at the very least working with an awareness of family and/or other significant adults, would seem essential (Robinson & Pryor, 2006). In the case of psychiatric treatment, it has been suggested that, as a minimum, good clinical practice would include the involvement of family, especially to contain suicide risk (Bickerton, Hense, Benstock, Ward, & Wallace, 2007).

What works?

If we adopt the view that working jointly with families and adolescents is a logical response to the outcomes of recent research, what do we know about what works? While there are a growing number of studies that are evaluating the use of family-based interventions for problems in adolescence, the evidence is tentative in many areas at this stage. (See Box 1 for a discussion about types of family therapies.)

<table>
<thead>
<tr>
<th>Box 1: Examples of therapies involving family members</th>
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<tr>
<td><strong>Family therapy</strong> is a type of psychotherapy that is based on family systems theory, which considers the family as its own system and not just the sum of its individual members. Therapists work with all family members (where possible) to bring about change in issues that are having an effect on family functioning and the home environment. There are a number of different types of family therapies, some of which are outlined below.</td>
</tr>
<tr>
<td><strong>Brief strategic family therapy</strong></td>
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<td>Brief strategic family therapy is a time-limited and family-based approach to adolescent substance use and similar problems. It is based on the fundamental assumption that the foundation of child development is the family, and highlights the importance of family interactions in the development of adolescent problem behaviour. Interventions are short-term but flexible to meet the diverse needs of families, and consist of three intervention processes: joining, diagnosing and restructuring (Austin et al., 2005).</td>
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<tr>
<td><strong>Functional family therapy</strong></td>
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<td>This is a variant of family therapy that incorporates elements of behavioural and cognitive theories and practice, but also focuses on the functional nature of problems within a family; for example, the problems of an adolescent that regulate distance to or from other family members (Cottrell &amp; Boston, 2002).</td>
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<tr>
<td><strong>Multisystemic therapy</strong></td>
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<td>This is a strengths-based family intervention that considers problems as having multiple determinants (Carey &amp; Oxman, 2007). It comprises detailed assessment of the factors involved in behaviours, followed by a combination of therapeutic interventions drawn from strategic and structural family therapy, parental training, marital therapy, and social skills training. As such, multisystemic therapy encompasses more than family therapy, but family therapy remains a key element. Families and other societal systems are at the core of multisystemic therapy (Cottrell &amp; Boston, 2002).</td>
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<tr>
<td><strong>Structural family therapy</strong></td>
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<td>This form of family therapy focuses on family structure and how it relates to “good” or “bad” functioning. The individual is seen as being interdependent with the surrounding social structure, which affects behaviour and expression (Aponte &amp; VanDeusen, 1981). Therapy aims to change the structure and interactional patterns in families so that problems are not maintained. The therapist works with issues in the “here and now” and coaches family members regarding different ways of behaving. A typical goal might be to address unhelpful coalitions between family members in order to strengthen the parenting team.</td>
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As a starting point, existing evidence that has been considered in reviews by the Cochrane Collaboration are mixed in their endorsement of family therapy/interventions, with most areas examined needing further research. The strongest evidence exists for the effectiveness of family and parenting interventions in reducing time spent by juvenile delinquents in institutions (Woolfenden, Williams & Peat, 2001). Family therapy for anorexia nervosa shows some evidence of effectiveness compared to “treatment as usual” in the short term, although this is based on a small number of trials (Fisher, Hetrick & Rushford, 2010). Family therapy for depression in general shows promise (Henken, Huibers, Churchill, Restifo & Roelofs, 2007), although young people are not specified in this review of depression. It would appear that the effectiveness of family-based interventions for problems in adolescence is an area of research that is comparatively in its infancy, and caution needs to be adopted in embracing any particular approach.

However, there appears to be promise in the wider body of research to date on family-based approaches. In particular, family-based therapies are increasingly considered to be among the most effective current treatments for adolescent substance abuse (Austin, Macgowan & Wagner, 2005; Carr, 2009; Carey & Oxman, 2007; Cottrell & Boston, 2002; Diamond & Josephson, 2005; Hogue & Liddle, 2009). In Australia, evaluations of the BEST-Plus program, a whole-of-family therapy option for families of adolescents drug abusers, indicate that the program is effective in helping families to redevelop positive family environments that encourage recovery from drug abuse. The program has also been shown to have a similar positive impact on other adolescent behaviours, indicating that the behaviours are symptoms, rather than causes, of difficult family relationships (Bamberg, Findley & Toumbourou, 2006).

Evidence supports the use of family-based therapies to address other problems in adolescence. A review of a decade of randomised clinical trials, which compared interventions that included parents in the treatment of child and adolescent psychiatric disorders with other types of therapy (such as individual therapy), concluded that family interventions are effective (Diamond & Josephson, 2005). Carr (2009) argued that family-based therapies are as effective as individual cognitive behavioural therapy and psychodynamic therapy in the specific treatment of major adolescent depression. Larner (2009) similarly called for the integration of family therapy into treatments for adolescent depression, due to “limited, but encouraging” support for a family therapy approach (see also David-Ferdon & Kaslow, 2008). Some of the suggested features of family interventions for depression include:

- improving communication skills;
- promoting systemic family-based problem-solving;
- promoting attachment and disruption of negative and critical interactions between parents and adolescents; and
- building family resilience and hope and helping families manage depression and contain suicidal risk (Carr, 2009; Larner, 2009).

Family-based treatment is also increasingly being used with adolescents who have eating disorders. Randomised controlled trials and case studies indicate that family-based treatment is showing promising results for adolescents with anorexia nervosa, particularly with younger patients who have a shorter duration of illness (Varchol & Cooper, 2009). Support has also been found for family-based treatments for co-morbid behaviours (e.g., delinquency and drug abuse), externalising behaviours (e.g., aggression) and internalising behaviours (e.g., anxiety), although the evidence base is limited (Hogue & Liddle, 2009). Family-based treatments have also been used to address conduct disorders (Carr, 2009; Cottrell & Boston, 2002), school refusal, obsessive-compulsive disorder, grief, bipolar disorder, attempted suicide and somatic problems such as recurrent abdominal pain (Carr, 2009).
Types of therapies

There are various forms of family therapy, some of which are highlighted in Box 1. The evidence on which is the most effective therapy, and under what circumstances it is most effective, is limited.

A systematic review by Austin et al. (2005) found that two interventions (multidimensional family therapy and brief strategic family therapy) have demonstrated efficacy in treating adolescent substance abusers, with other therapies (e.g., functional family therapy, multisystemic therapy) showing promise.

Multisystemic therapy has been extensively researched in other studies and is regarded as one of the few empirically tested treatments for young people (Littell, 2005). Long-term reductions in aggressive criminal behaviour were found in a 4-year follow up of a randomised clinical trial of multisystemic therapy with juvenile offenders (Henggeler, Clingempeel, Brondino & Pickrel, 2002). It has also been described as a promising intervention for the treatment of adolescent substance abuse (Carey & Oxman, 2007), and has been used to address delinquency, with outcomes such as improved family relations, decreased behavioural problems and decreased out-of-home placements (Utting, Monteiro & Ghate, 2006). However, questions have been raised regarding the evidence base for the efficacy of multisystemic therapy (Littell, 2005; 2008; Littell, Campbell, Green & Toews, 2005), and more rigorous and independent evaluations are needed to support the existing evidence.

It has been suggested that work in this area is at the point where “implementation science” is needed (Hogue & Liddle, 2009). In other words, there is a growing urgency to work out how to implement favourable findings, given that family-based therapies are not used widely in working with adolescents. There is also a need to determine how to export validated treatments to “real world” clinical settings (Diamond & Josephson, 2005). This includes considering the best methods of delivering empirically supported family therapy in a range of settings to address a range of problems, and creating clinical/policy guidelines to support this work. Hogue and Liddle (2009) suggested a “core elements” approach, using a small number of overlapping practice elements that clinicians can mix and match to suit client presentation. Similarly, interventions that are delivered using standardised manuals to maintain treatment integrity are supported by the literature (Cottrell & Boston, 2002).

Engaging families of adolescents in treatment

When the focus is on individual treatment for adolescent problems (Brown, 2008; Robinson & Pryor, 2006), it may be difficult to engage parents in a therapeutic process, not least if they fail to recognise or are threatened by suggestions of their possible role in the problem. This is, however, an under-researched area. Brown (2008), in an article on child and adolescent mental health services, highlighted the dilemma for therapists in these situations. She suggested that the request to “fix” the child can lay the blame and onus for change on the child. If therapists otherwise choose to expand the family’s view to include the part they might play in the child’s symptoms, the risk is that the family will drop out of therapy.

There has, unfortunately, been little written on how parents can be helped to see their own role in how their child’s problems have emerged (Brown, 2008). A therapeutic alliance with both adolescents and parents is the key to successful treatment, yet this may be difficult to balance in practice.

A practice example

Resources for Adolescents and Parents (RAPS)

RAPS is a program of Relationships Australia (NSW), and is funded by the Commonwealth Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) under the Family Support Program. RAPS is based in Parramatta and serves the Sydney Metropolitan Area. The program description below provides an example of the way in which a family-based intervention program for adolescent problem behaviours operates.

Established in 1990, RAPS is a preventative service working with both adolescents and their parents on issues that may lead to youth homelessness, including violence, substance abuse, truancy, running away, self-harm and family conflict. In addition to family therapy, a joint parent-teenager group has been developed to assist parents and teenagers to strengthen their relationship and assist parents with skills such as setting boundaries. RAPS also runs seminars for parents that cover understanding adolescence, the importance of adolescent–parent connectedness and the importance of boundary-setting. The seminars also serve as a “soft” entry point for the family therapy services offered by RAPS.

Multisystemic therapy is regarded as one of the few empirically tested treatments for young people.
There are seven principles behind the work of RAPS, which are derived from the relevant literature on adolescent–parent relationships and treatments for problem behaviours in adolescence:

1. Adolescents are in a unique developmental stage between childhood and adulthood that takes over a decade to complete. It is a common misconception that this is a time of separation when, in fact, the role of parents in supporting, empathising, guiding and setting boundaries for adolescents is crucial.

2. Workers can assist parents to maintain the balance between them having a connected relationship with and being in a hierarchical position in relation to their adolescent.

3. Effective work with adolescents includes also involving parents and other family members, as relationships are interconnected and affect each other.

4. As well as family, a broader “systems perspective” locates an adolescent’s problem behaviours within other systems, such as school, peer groups and community.

5. Early intervention in problem behaviours is preferable. This will help to avoid escalation into more serious problems from which recovery becomes more difficult, such as homelessness and its associated poor health and wellbeing outcomes.

6. Experienced workers with training in family therapy are needed, as they must be competent in handling the challenges of engaging with and managing both parents and adolescents in the same space.

7. Workers need access to good consultation and supervision.

Evaluation

RAPS routinely evaluates their work with every family. At the end of counselling, an evaluation form with a reply paid envelope is sent to every family member aged 12 and over. The results are collated and used to revise the program every 6 months.

In 1999, RAPS was evaluated as part of an independent evaluation of all 12 existing services that were funded under the then Department of Family and Community Services Adolescent Mediation and Family Therapy program. RAPS was cited in the evaluation as a model of best practice. In 2008, RAPS was included in an independent evaluation of all Relationships Australia’s (NSW) counselling programs, in which clients reported there was “high counselling service benefit” across all these programs.

Summary and conclusion

Evidence regarding risk and protective factors that exist in the family domain for adolescent problem behaviours is now well established. While one of the primary goals of adolescence is to individuate from family, this has often been construed as there being a dwindling need for parental involvement in adolescents’ lives. Research suggests the contrary, with parents continuing to play an important role for adolescents as they move through a period of intense and prolonged growth (e.g., Vassallo et al., 2009).

Alongside this, there is an emerging body of evidence that suggests that family-based interventions are potentially effective for a range of problems in adolescence, including eating disorders, depression, conduct disorder and substance abuse. Therefore, the time appears right for increasing the number of programs that utilise family-based treatment for adolescent risk behaviours, accompanied by appropriate training for workers and rigorous evaluation.

The evidence outlined in this paper indicates that funding of programs to address problems in adolescence should be contingent on what strategies will be undertaken to include families, or if family is unavailable, other adults who are currently or could play a significant role in the adolescent’s life. This will help to build the “scaffolding” (Gilligan, 2006) that will be available to the adolescent once they leave the comparative safety of any service provision and the guiding hand of transient workers. Evaluation needs to be an essential part of service delivery to assist in growing the evidence base in this area. Lastly, the message that family remain an integral part of an adolescent’s life needs to be reinforced with schools, organisations and families and, equally importantly, with adolescents themselves.

Endnotes

1. “Family-based interventions” can be defined as those based on family systems theory, but may also included principles from other sources, such as cognitive behavioural theory, attachment theory and developmental theory (Austin, Macgowan & Wagner, 2005).

2. Based on the best available information about health care interventions, the Cochrane Collaboration reviews explore the evidence for and against the effectiveness and appropriateness of treatments (medications, surgery, education, etc.) in specific circumstances. For more information, visit: <www.cochrane.org/reviews/clibintro.htm>

3. Treatments considered “as usual” in Fisher et al. (2010) included nutritional rehabilitation, psychological (e.g., cognitive behavioural)
therapies and pharmacological (e.g., antidepressant medication) therapies.

4 Multidimensional family therapy is a treatment system for families that attempts to use a number of therapeutic approaches to help family members to deal with problems. See Dakof (2010) for a more detailed description of the types of therapies involved.

References


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