



Family Therapy for Adolescents: A Research-informed Perspective

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Specific research-informed models of family therapy have been developed for a range of adolescent problems. These include Brief Strategic Family Therapy (BSFT), Functional Family Therapy (FFT), Multisystemic Therapy (MST), Multidimensional Family Therapy (MDFT), and Multidimensional Treatment Foster care (MTFC) for conduct disorder and drug misuse; family-focused cognitive behaviour therapy for anxiety disorders and depression; Attachment-based Family Therapy (ABFT) for depression; family-focused therapy as an adjunct to pharmacological therapy for bipolar disorder; ABFT, youth-nominated support team, and Dialectical Behaviour Therapy (DBT) combined with Multifamily Therapy for self-harm; the Maudsley model of family therapy for eating disorders; and psychoeducational family theory for psychosis. All of these approaches aim to reduce individual and familial risk factors which exacerbate adolescent problems, and enhance protective factors which promote resilience and recovery from psychological difficulties.

Keywords: family therapy, Functional Family Therapy (FFT), Multisystemic Therapy (MST), Multidimensional Treatment Foster Care (MDTFC), Multidimensional Family Therapy (MDFT), Brief Strategic Family Therapy (BSFT), Attachment-based Family Therapy (ABFT), cognitive behaviour therapy (CBT), Dialectical Behaviour Therapy (DBT), conduct disorder, drug misuse, anxiety, obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD), depression, bipolar disorder, suicide, self-harm, anorexia, bulimia

Key Points

- 1 Significant advances have been made in developing research-informed approaches to family therapy for a number of adolescent problems including conduct disorder, drug misuse, anxiety disorder, mood disorders, eating disorders, and psychosis.
- 2 Several research-informed family therapy models of practice for adolescent problems are reviewed in this paper.
- 3 These should be incorporated into pre-qualification training programs for family therapists, and into continuing professional development short courses for experienced practitioners providing mental health services for adolescents.
- 4 Future research should address under-researched adolescent problems and populations such as adolescents from ethnic minorities or with gay and lesbian orientations.
- 5 There is a need for studies to evaluate the effectiveness and cost-effectiveness of family-based treatments shown to be efficacious in specialist treatment centres in routine community settings.

Introduction

Traditionally, approaches to family therapy for adolescent problems were based on clinical observations and case studies rather than on systematic empirical study (Sexton & Lebow, 2015). However, in recent years, with the increasing emphasis on evidence-based practice, significant advances have been made in developing research-

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informed approaches to family therapy for a number of adolescent problems (Carr, 2012, 2014). These include conduct disorder, drug misuse, anxiety disorder, mood disorders, eating disorders, and psychosis.

Conduct Disorder and Drug Misuse

In a meta-analysis of 24 treatment studies of conduct disorder and drug misuse, Baldwin et al. (2012) found that Brief Strategic Family Therapy (BSFT; Szapocznik, Hervis, & Schwartz, 2002; Szapocznik et al., 2015), Functional Family Therapy (FFT; Alexander, Waldron, Robbins, & Neeb, 2013; Sexton, 2011, 2015), Multisystemic Therapy (MST; Henggeler et al., 2009; Schoenwald, Henggeler, & Rowland, 2015) and Multidimensional Family Therapy (MDFT; Liddle, 2002, 2015) were much more effective than waiting-list control conditions and modestly more effective than treatment as usual or alternative treatments. In a meta-analysis of eight family-based treatment studies of adolescent conduct disorder, Woolfenden, Williams, and Peat (2002) found that family-based treatments including FFT, MST, and multidimensional treatment foster care (MTFC; Chamberlain, 2003; Smith & Chamberlain, 2010) were more effective than routine individual or group treatment.

All of the family therapy models of practice evaluated in these meta-analyses focus on solving the main presenting problem (conduct disorder or drug use) and modifying associated risk factors, especially problematic parenting practices, high family stress, low social support, and deviant peer group membership. They all involve conjoint family meetings, and some involve meetings with individual members of the family and the adolescent's social or professional network. In some cases where adolescents had drug problems, these approaches to family therapy were offered as part of multimodal programs involving medical assessment and detoxification. These programs significantly reduced conduct problems and drug use, time spent in institutions, the risk of re-arrest, and recidivism following treatment. They fall on a continuum of care which extends from BSFT and FFT, through more intensive MST and MDFT, to very intensive MTFC. Implementation studies have shown that these models of family therapy practice may be transported from university to community sites, and implemented with fidelity (Henggeler & Sheidow, 2012).

Brief Strategic Family Therapy (BSFT)

BSFT was developed at the Centre for Family Studies at the University of Miami by Josè Szapocznik and his team (Szapocznik et al., 2002, 2015). BSFT aims to resolve adolescent drug misuse by improving family interactions that are directly related to drug use. This is achieved within the context of conjoint family therapy sessions by coaching family members to modify such interactions when they occur, and to engage in more functional interactions. The main techniques used in BSFT are engaging with families, identifying maladaptive interactions and family strengths, and restructuring maladaptive family interactions. BSFT was developed for use with minority families, particularly Hispanic families, and therapists facilitate healthy family interactions based on appropriate cultural norms. Where there are difficulties engaging with whole families, therapists work with motivated family members to engage less motivated family members in treatment. Where parents cannot be engaged in treatment, a one-person adaptation of BSFT has been developed.

BSFT involves 12–30 sessions over 3–6 months, with treatment duration and intensity being determined by problem severity. In a thorough review of research on BSFT, Santiseban, Suarez-Morales, Robbins, and Szapocznik (2006) concluded that it was effective at engaging adolescents and their families in treatment, reducing drug misuse and recidivism, and improving family relationships. There is also empirical support from controlled trials for the efficacy of its strategic engagement techniques for inducting resistant family members into treatment, and for one-person family therapy, where parents resist treatment engagement.

Functional Family Therapy (FFT)

FFT was developed initially by James Alexander at the University of Utah and more recently by Tom Sexton at the University of Indiana (Alexander et al., 2013; Sexton, 2011, 2015). FFT involves distinct stages of engagement, where the emphasis is on forming a therapeutic alliance with family members and reducing negativity using reframing; behaviour change, where the focus is on facilitating competent family problem-solving; and generalisation, where families learn to use new skills in a range of situations and to deal with setbacks. Whole family sessions are conducted on a weekly basis. Treatment spans 8–30 sessions over 3–6 months, with treatment intensity matched to client need. A comprehensive system for transporting FFT from university to community settings and from the US to Europe; training and supervising therapists; and for maintaining treatment fidelity in these settings has also been developed.

In a meta-analysis of 14 studies, Hartnett, Carr, Hamilton, and O'Reilly (2016) concluded that FFT was effective in significantly reducing conduct problems and recidivism rates compared with control conditions or alternative treatments. In a systematic review of 27 clinical trials, Alexander et al. (2013) concluded that compared with routine services, FFT was effective in reducing therapy dropout, conduct problems, drug misuse, placement in foster care, and recidivism in adolescents from a variety of ethnic groups over follow-up periods of up to 5 years. It leads to a reduction in conduct problems in siblings of offenders. It also was less expensive per case than juvenile detention or residential treatment and led to crime and victim cost savings.

Multisystemic Therapy

MST was developed at the Medical University of South Carolina by Scott Henggeler and his team (Henggeler et al., 2009; Schoenwald et al., 2015). MST combines intensive family therapy with individual skills training for the adolescent, and intervention in the school and wider interagency network. MST entails helping adolescents, families, and involved professionals understand how adolescent conduct problems are maintained by recursive sequences of interaction within the youngster's family and social network; using individual and family strengths to develop and implement action plans and new skills to disrupt these problem-maintaining patterns; supporting families to follow through on action plans; helping families use new insights and skills to handle new problem situations; and monitoring progress in a systematic way. MST involves regular, frequent home-based family and individual therapy sessions with additional sessions in school or community settings over 3–6 months. Therapists carry low caseloads of no more than five cases and provide 24-hour, 7-day availability for crisis management.

A comprehensive system for transporting MST to community settings, training and supervising therapists, and for maintaining treatment fidelity in these settings has also been developed. In a review of 21 studies evaluating the effectiveness of MST, Henggeler (2011) found that compared with treatment as usual, MST led to significant improvements in individual and family adjustment which contributed to significant reductions in behaviour problems, drug use, school absence, recidivism, and out-of home placement up to 4 years after treatment. These outcomes entailed significant cost savings in placement, juvenile justice, and crime victim costs.

Multidimensional Family Therapy (MDFT)

MDFT was developed by Howard Liddle and his team at the Center for Treatment Research on Adolescent Drug Abuse at the University of Miami (Liddle, 2002, 2015). MDFT involves assessment and intervention in four domains including: (1) adolescents, (2) parents, (3) interactions within the family, and (4) family interactions with other agencies such as schools and courts. The three distinct phases of MDFT include engaging families in treatment; working with themes central to recovery; and consolidating treatment gains and disengagement. MDFT involves 16–25 sessions over 4–6 months. Treatment sessions may include adolescents, parents, whole families, and involved professionals and may be held in the clinic, home, school, court, or other relevant agencies. The evidence base for MDFT shows that it is more cost-effective than alternative treatments and effective in reducing alcohol and drug misuse, behavioural and emotional problems, negative peer associations, school failure, and family difficulties associated with drug misuse (Liddle, 2015; Rowe, 2012).

Multidimensional Treatment Foster Care (MTFC)

MTFC was developed at the Oregon Social Learning Center by Patricia Chamberlain and her team (Chamberlain, 2003; Smith & Chamberlain, 2010). It combines procedures similar to MST with specialist foster placement, in which foster parents use behavioural principles to help adolescents modify their conduct problems. Treatment foster care parents are carefully selected, and before an adolescent is placed with them, they undergo intensive training. This focuses on the use of behavioural parenting skills for managing antisocial behaviour and developing positive relationships with antisocial adolescents. They also receive ongoing support and consultancy throughout placements which last 6–9 months. Concurrently, the biological family and young person engage in weekly family therapy with a focus on parents developing behavioural parenting practices, and families developing communication and problem-solving skills. Adolescents also engage in individual therapy, and wider systems consultations are carried out with the young people's school teachers, probation officers, and other involved professionals, to insure all relevant members of the young people's social systems are co-operating in ways that promote improvement. About 85% of adolescents return to their parents' home after MTFC.

In a review of three studies of treatment foster care for delinquent male and female adolescents, Smith and Chamberlain (2010) found that compared with care in a group home for delinquents, MTFC significantly reduced running away from placement, re-arrest rate, and self-reported violent behaviour. The benefits of MTFC were due to the improvement in parents' skills for managing adolescents in a consistent, fair, non-violent way, and reductions in adolescents' involvement with deviant peers. These positive outcomes of MTFC entailed significant cost savings in juvenile justice

and crime victim costs. However, in a UK study, MTFC was found to be no more effective than routine care (Green et al., 2014).

Anxiety Disorders

In a meta-analysis of 16 studies, Thulin et al. (2014) found that family-based interventions for children and adolescents with anxiety disorders were as effective as individually based interventions, such as individual or group cognitive behaviour therapy (CBT). Young people in these trials had diagnoses of specific and social phobias, separation anxiety disorder, over-anxious disorder, generalised anxiety disorder, panic disorder with and without agoraphobia, obsessive compulsive disorder (OCD), and post-traumatic stress disorder (PTSD). Effective programs included family psychoeducation about anxiety management, parental involvement in helping adolescents engage in gradual *in vivo* or imaginary exposure to feared situations, and relapse prevention where parents and adolescents learned how to anticipate and deal constructively with setbacks. Adolescents learned anxiety management skills such as relaxation, cognitive coping, and using social support so that they could endure the distress experienced during exposure exercises. Parents learned to identify and challenge their own and their adolescents' anxious thoughts, reward their adolescents' use of anxiety management skills, ignore their adolescents' avoidant or anxious behaviour, manage their own anxiety, model courageous behaviour, and develop communication and problem-solving skills to enhance the quality of parent-adolescent interaction.

Obsessive compulsive disorder (OCD)

Reviews of controlled trials of individual and family-based treatments of OCD in adolescents show that family-based cognitive behavioural exposure and response prevention programs are as effective as similar individual programs for OCD and more effective than pharmacological treatment in adolescence leading to remission rates of 42–100% a year and a half after treatment completion (Barrett et al., 2008; Franklin et al., 2015; Freeman et al., 2014). Paula Barrett's (2007) FOCUS program is a good example of an effective family-based exposure and response prevention protocol for treating OCD in adolescents. FOCUS stands for Freedom from Obsessions and Compulsions Using Skills and was developed and validated at the University of Queensland. In this 16-session program, adolescents are exposed to cues (such as dirt) that elicit anxiety-provoking obsessions (such as ideas about contamination), while not engaging in compulsive rituals (such as hand washing), until habituation occurs. They also learn anxiety management skills to help them cope with the exposure process. Family intervention involves psychoeducation, externalising the problem, monitoring symptoms, and helping parents and siblings support and reward the adolescent with OCD for completing exposure and response prevention homework exercises. Family therapy also helps parents and siblings avoid inadvertent reinforcement of children's compulsive rituals.

Post-traumatic stress disorder (PTSD)

In a systematic review of 10 studies of family-based, trauma-focused cognitive behaviour therapy (TF-CBT) for PTSD in child and adolescent survivors of trauma, Ramirez de Arellano et al. (2014) found it reduced symptoms of PTSD, and in some cases had beneficial effects on depression and behaviour problems. TF-CBT was

developed by Judith Cohen and Anthony Mannarino at the Center for Traumatic Stress in Children and Adolescents, Allegheny General Hospital, Pittsburgh, and Esther Deblinger at the Child Abuse Research Education and Service Institute at the University of Medicine and Dentistry of New Jersey (Cohen, Mannarino, & Deblinger, 2006). In this family-based treatment, cognitive behavioural principles and exposure techniques are used to address symptoms of post-traumatic stress and related concerns such as depression, behaviour problems, and caregiver difficulties. Key elements of the intervention include psychoeducation about common reactions to trauma, coping skills training, gradual exposure to avoided traumatic memories or memory cues, cognitive processing of trauma-related thoughts and beliefs, and parent involvement.

TF-CBT is appropriate for adolescents who have experienced physical or sexual abuse, interpersonal violence, or natural disasters. The approach involves concurrent sessions for traumatised children and their non-abusing parents, in group or individual formats, with periodic conjoint parent–child sessions. Where the trauma has entailed intrafamilial sexual or physical abuse, it is essential that offenders live separately from the victim until they have completed a treatment program and been assessed as low risk for re-offending. The child-focused component involves exposure to trauma-related memories and cues to facilitate habituation to them; and relaxation and coping skills training. If the trauma involved sexual abuse, then children also require assertiveness and safety skills training, and for victimisation, sexual development, and identity issues to be addressed. Concurrent work with non-abusing parents and conjoint sessions with abused children and non-abusing parents focus on helping parents develop supportive and protective relationships with their children, and support networks for themselves.

Depression

Stark, Banneyer, Wang, and Arora (2012) reviewed 25 trials of family-based treatment programs for child and adolescent depression. In treatments evaluated in these studies a variety of formats was used including conjoint family sessions (e.g., Diamond, Diamond, & Levy's (2013) Attachment-based Family Therapy (ABFT); child-focused CBT (Stark, Streusand, Krumholz, & Patel, 2010) or interpersonal therapy (Jacobson & Mufson, 2010) sessions combined with some family or parent sessions; and concurrent group-based parent and child training sessions (such as Lewinsohn's Coping with Depression course (Clark & DeBar, 2010)). Stark et al. (2012) concluded that family-based treatments for child and adolescent depression were as effective as well-established therapies such as individual CBT or interpersonal therapy; led to remission in two-thirds to three quarters of cases at 6 months follow-up; and were more effective than individual therapy in maintaining post-treatment improvement.

Effective family-based interventions aim to decrease the family stress to which youngsters are exposed and enhance the availability of social support within the family context. Core features of effective family interventions include psychoeducation about depression; relational reframing of depression-maintaining family interaction patterns; facilitation of clear parent–child communication; promotion of systematic family-based problem-solving; disruption of negative critical parent–child interactions; promotion of secure parent–child attachment; and helping children

develop skills for managing negative mood states and changing pessimistic belief systems. Diamond et al.'s (2013) ABFT focuses on repairing adolescent–parent attachments by facilitating conversations about past family traumas or ongoing interactional conflicts that have damaged trust. ABFT involves (1) relational reframing of depression, (2) alliance building with the adolescent and then (3) with the parent, (4) repairing adolescent–parent attachment, and (5) competency building. In Lewinsohn's Coping with Depression (Clark & DeBar, 2010) family-based CBT program, the adolescent component includes mood monitoring, affect regulation, pleasant activities scheduling, cognitive restructuring, and social skills training, while the parent component includes psychoeducation, improving communication, and enhancing family coping.

Bipolar Disorder

The primary treatment for bipolar disorder is pharmacological, and involves the initial treatment of acute manic, hypomanic, depressive, or mixed episodes, and the subsequent prevention of further episodes with mood stabilising medication such as lithium. In a review of controlled trials, Washburn, West, and Heil (2011) concluded that family therapy may be helpful in adolescent bipolar disorder as an adjunct to pharmacological treatment by increasing knowledge about the condition, improving family relationships, and improving symptoms of depression and mania. Family therapy for bipolar disorder aims to reduce adolescents' psychosocial impairment and delay relapse by increasing medication adherence, reducing family stress, and enhancing family support. It is premised on the finding that high levels of intrafamilial expressed emotion (involving criticism, hostility, and overinvolvement) are associated with relapse in bipolar disorder and other conditions.

David Miklowitz (2008) at the University of Colorado has developed an evidence-based 21-session family-focused treatment program for bipolar adolescents. The program includes psychoeducation about the condition and its management, and family communication and problem-solving skills training.

Attempted Suicide

Family-based interventions for self-harming adolescents target personal characteristics (such as the presence of psychological disorders) and features of the social context (such as family difficulties) that have been identified as risk factors for attempted suicide in young people. In a review of a series of studies, Carr (2014) concluded that specialised family-based interventions improve the adjustment of adolescents who have attempted suicide. These approaches share a number of common features. They begin by engaging young people and their families in an initial risk assessment process, and proceed to the development of a clear plan for risk reduction which includes individual therapy for adolescents combined with systemic therapy for members of their family and social support networks. ABFT, MST, Dialectical Behaviour Therapy (DBT) combined with MFT, and nominated support network therapy are well developed protocols with some or all of these characteristics.

Attachment-based Family Therapy (ABFT)

ABFT was originally developed for adolescent depression as was noted above, but has been adapted for use with self-harming teenagers (Diamond et al., 2010). This approach aims to repair ruptures in adolescent–parent attachment relationships. Re-attachment is facilitated by first helping family members access their longing for greater closeness and commit to rebuilding trust. In individual sessions, adolescents are helped to articulate their experiences of attachment failures, and agree to discuss these experiences with their parents. In concurrent sessions parents explore how their own intergenerational legacies affect their parenting style. This helps them develop greater empathy for their adolescent's experiences. When adolescents and parents are ready, conjoint family therapy sessions are convened in which adolescents share their concerns, receive empathic support from their parents, and usually become more willing to consider their own contributions to family conflict. This respectful and emotional dialogue serves as a corrective attachment experience that rebuilds trust between adolescents and parents. As conflict decreases, therapy focuses on helping adolescents pursue developmentally appropriate activities to promote competency and autonomy. In this context, parents serve as the secure base from which adolescents receive support, advice, and encouragement in exploring these new opportunities.

Multisystemic Therapy for self-harming adolescents

MST was originally developed for adolescent conduct disorder as was noted above, but has been adapted for use with adolescents who have severe mental health problems including attempted suicide (Henggeler, Schoenwald, Rowland, & Cunningham, 2002). MST for self-harming adolescents involves assessment of suicide risk, followed by intensive family therapy to enhance family support. This is combined with individual skills training for adolescents to help them develop mood regulation and social problem-solving skills, and intervention in the wider school and interagency network to reduce stress and enhance support for the adolescent. MST involves regular, frequent, home-based family and individual therapy sessions with additional sessions in the school or community settings over 3–6 months.

Huey et al. (2004) evaluated the effectiveness of MST for suicidal adolescents in a randomised controlled study of 156 African American adolescents at risk for suicide referred for emergency psychiatric hospitalization. Compared with emergency hospitalization and treatment by a multidisciplinary psychiatric team, Huey et al. found that MST was significantly more effective in decreasing rates of attempted suicide at one-year follow-up.

Dialectical Behaviour Therapy and Multifamily Therapy

DBT was originally developed by Marsha Linehan at the University of Washington for adults with borderline personality disorder. It has been adapted for use with adolescents who have attempted suicide (Miller, Rathus, & Linehan, 2007). This adaptation involves individual DBT therapy for adolescents combined with multifamily psychoeducational therapy. The multifamily psychoeducational therapy helps family members understand self-harming behaviour and develop skills for protecting and supporting suicidal youngsters. The individual therapy component includes modules on mindfulness, distress tolerance, emotion-regulation, and interpersonal effectiveness skills to address problems in the areas of identity, impulsivity, emotional lability, and relationship problems respectively.

Youth Nominated Support Team

Youth Nominated Support Team is a manualised systemic intervention for adolescents who have attempted suicide, in which adolescents nominate a parent or guardian and three other people from their family, peer group, school, or community to be members of their support team (King et al., 2006). For each case, support team members receive psychoeducation explaining how the adolescent's psychological difficulties led to the suicide attempt, the treatment plan, and the role that support team members can play in helping the adolescent towards recovery and managing situations where there is a risk of further self-harm. Support team members are encouraged to maintain weekly contact with the adolescent and are contacted regularly by the treatment team to facilitate this process.

Eating Disorders

A distinction has been made between anorexia nervosa and bulimia nervosa with the former being characterised primarily by weight loss and the latter by a cyclical pattern of bingeing and purging. A series of systematic reviews and meta-analyses support the effectiveness of family therapy for treating these two adolescent eating disorders (Couturier, Kimber, & Szatmari, 2013; Eisler, Le Grange, & Lock, 2015; Lock, 2011; Smith & Cook-Cottone, 2011). After family therapy between a half and two-thirds of adolescents diagnosed with anorexia achieve a healthy weight. In the long term, the negligible relapse rate following family therapy is superior to the moderate outcomes for individually oriented therapies and inpatient treatment. Outpatient family-based treatment is also more cost-effective than inpatient treatment. Evidence-based family therapy for anorexia can be effectively disseminated and implemented in community-based clinical settings.

The Maudsley model of family therapy for anorexia, which was initially developed by Ivan Eisler and Christopher Dare at the Maudsley Hospital in London, is particularly well validated and has been manualised and refined by James Lock at Stanford University, and colleagues (Lock & Le Grange, 2013). In the Maudsley model, family therapy for adolescent anorexia involves helping parents work together to refeed their youngster. This is followed by helping the family support the youngster in developing an autonomous, healthy eating pattern, and an age-appropriate lifestyle. Treatment typically involves between 10 and 20 one-hour sessions over a 6–12-month period. A multifamily group-treatment format has also been developed in which groups of families attend over 11 full days, with the first 4 days being consecutive and the remainder being held at intervals over a number of months (Eisler et al., 2015). Family therapy for adolescent bulimia, following the Maudsley Model, involves helping parents work together to supervise the young person during mealtimes and afterwards, to break the binge-purge cycle. As with anorexia, this is followed by helping families support their youngsters in developing autonomous, healthy eating patterns, and age-appropriate lifestyles (LeGrange & Lock, 2007).

First Episode Psychosis

First episode psychosis is characterised by positive symptoms (such as delusions and hallucinations), negative symptoms (such as lack of goal-directed behaviour and

flattened affect), and disorganised thinking, behaviour, and emotions. Antipsychotic medication is the primary treatment for symptoms of first episode psychosis. Meta-analyses and reviews of controlled trials show when pharmacological intervention is combined with family therapy (Kuipers, Leff, & Lam, 2002), relapse rates are reduced in first episode psychosis, and that multifamily psychoeducational therapy (McFarlane, 2002) is particularly effective (Bird et al., 2010; McFarlane, Lynch, & Melton, 2012; Onwumere, Bebbington, & Kuipers, 2011). Psychoeducational family therapy for schizophrenia involves psychoeducation based on the stress-vulnerability or bio-psycho-social models of psychosis (McFarlane et al., 2012) with a view to helping families understand and manage the condition, antipsychotic medication, related stresses, and early warning signs of relapse. Psychoeducational family therapy also aims to reduce negative family processes associated with relapse, specifically high levels of expressed emotion, stigma, and stresses. Emphasis is placed on blame reduction, and the positive role family members can play in supporting the young person's recovery. Psychoeducational family therapy also helps families develop communication and problem-solving skills. Effective interventions typically span 9–12 months, and are usually offered in a phased format with initial sessions occurring more frequently than later sessions and crisis intervention as required.

Conclusions

There is now a large body of scientific evidence to support the effectiveness of research-informed models of family therapy for conduct, substance use, anxiety, mood, eating, and psychotic disorders. The models of practice reviewed in this paper should be incorporated into pre-qualification training programs for family therapists, and into continuing professional development short courses for experienced practitioners who provide mental health services for adolescents.

Future research should address under-researched adolescent problems and populations (such as adolescents from ethnic minorities or with gay and lesbian orientations). There is a need for larger, multisite trials that include enough cases to provide sufficient statistical power to investigate the effects of mediating and moderating variables on therapy outcome. Such studies are essential for evaluating the impact of family and therapist characteristics on outcome, the role of specific and common therapeutic factors in promoting recovery, and testing hypotheses about mechanisms that underpin therapeutic change. These studies may also have important implications for developing family-based therapy protocols to meet the unique treatment needs of adolescents who do not respond to routine family-based treatment protocols. At a pragmatic level there is a need for studies that evaluate the effectiveness of family-based treatment protocols in routine community settings that have been shown to be efficacious in specialist treatment centres, and in which the cost-effectiveness of family-based treatments in community settings is assessed.

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