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# Conquering Invisible Elephants: The Effects of Family Involvement on Adolescent Recovery from Mental Illness

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Conquering Invisible Elephants:  
The Effects of Family Involvement on Adolescent Recovery from Mental Illness

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A Thesis Submitted to Fulfill the Requirements of the Honors Program at Assumption College

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**Abstract**

This paper explored the extent to which current treatments for adolescents with anorexia nervosa (AN), conduct disorder (CD), and depression have involved families in therapy. Various past and present therapies for all three adolescent disorders were reviewed and effective treatment components of family therapy were identified and compared across the treatment approaches. A review of the literature indicated that family therapy was more effective and beneficial for the adolescent patient than individual treatments not involving families. While individualized treatments helped to improve adolescent symptomatology, family therapy provided a more comprehensive approach as it focused not only on symptom reduction but also on changing the very family environments and dynamics that oftentimes played a role in the etiology of these disorders. The McMaster Model of Family Functioning was utilized to highlight the different dimensions of family functioning included in current treatments of AN, CD, and depression. Suggestions regarding dimensions of family functioning that should be included in family treatments to provide the most comprehensive approach for adolescents with mental disorders were provided.

## Conquering Invisible Elephants:

### The Effects of Family Involvement on Adolescent Recovery from Mental Illness

The developmental stage of adolescence is a culturally defined period. Originating in western cultures, it is characterized as the time in an individual's life between the ages of twelve to twenty four years (Patel, Flisher, Hetrick, McGorry, 2007). Some researchers set the age range for adolescence between 10 and 26 years. Many conceive of this transition as being a tenuous time in an individual's life; ten long years full of drama, rule breaking, and groundings. For many, it is a time for first love, missing curfew, and questionable fashion taste. It is without a doubt one of the most tumultuous times in an individual's life. Puberty, identity crises, friends, family, and developing goals in life are just a few of the challenges adolescents across the globe face. Adolescence is a transitional time in a young person's life; not fully an adult just yet, but also most certainly not a child. Many adolescents seem to pass through this life phase without a major crisis. However, due to many environmental and biological risk factors, a significant number of today's adolescents must face something much more daunting than everyone in school knowing their latest crush. At least one out of every four to five adolescents in the general population will suffer from at least one mental illness in any given year (Patel, et al., 2007). This is a grave statistic emphasizing that these adolescents clearly need more health care attention. Suicide is the second leading cause of death among 15 to 29-year-olds (World Health Organization). In 2011, the United States reported having 195 adolescents in juvenile hall per 100,000 people, with 70 – 80% estimated to have at least one mental illness (National Center for Juvenile Justice). In a turn of the century report by the United States Department of Health and Human Services, 79% of adolescents diagnosed with a mental illness did not receive the help

they needed (1999). Given these staggering statistics, it is hard to believe that there are not more services structured into societies and health care systems to help those adolescents successfully recover from mental illness. Moreover, this increase in adolescent mental illness is not limited to one specific diagnosis. While countries like the United Kingdom are reporting higher rates of conduct problems in adolescents, other countries like China and India report suicide as a leading cause of death for their adolescent population (Patel, et al. 2007). It is imperative that globally, everyone – from health care workers to family members – coordinate their efforts to see that each and every adolescent has the opportunity to thrive in their environment.

Two summers ago, I interned at a psychiatric hospital on an adolescent floor and noticed the divide between the amounts of patient versus family care administered over the course my stay. One patient's story in particular was influential in the research and writing of this thesis. This adolescent girl was no more than thirteen and had just endured what seemed to be the worst sixth grade experience ever, full of endless bullying, bad friends, poor self image, and the true belief that she had little to contribute to the world. She was admitted to the hospital by her worried parents because she had told her parents that she heard voices telling her to kill herself. She made a steady recovery in the hospital's care – practicing safe living habits and becoming increasingly more like her previously bubbly self. The day she was discharged, she said “good-bye forever” to all and seemed happier than she had ever been. Sadly, she returned back to the treatment unit as a “bounce back” less than a day later, and staff were dumbfounded. After an emergency therapy session with both psychiatrists and therapists present, she told them that her family had planned a big “welcome back” party and invited all her friends and family. As a result of this, she had a total meltdown. Overwhelmed with all of her guests, she simply could not handle this situation. This adolescent's story illustrates how important it is to not only address

adolescents' symptoms in treatment, but to involve their parents in therapy and address the family dynamics which contributed the development and maintenance of the problems. This girl's relapse might have been fully prevented if her family had been more involved in treatment. As this example shows, families must be involved in the treatment process of their adolescent children in order for them to fully understand the nature of the mental illness and ensure that the home environment and family dynamics support the adolescent's recovery.

Three of the most common mental illnesses found in the adolescent population are anorexia nervosa, conduct disorder, and depression. All three have the power to debilitate not only the adolescent, but whole families in their wake. Each of these illnesses has the ability to become an invisible elephant looming within the family environment – something that is not directly addressed, but weighs down and slowly drains both the patient and the family of their resources and mental health.

Anorexia nervosa (AN) is an eating disorder characterized by four specific diagnosable symptoms in patients: A refusal to maintain body weight at or above the acceptable normal range for age and height, intense fear of gaining weight and becoming fat, denial of current low body fat, and for females, the absence of three consecutive menstrual cycles<sup>i</sup> (Grange, 2010). Anorexia Nervosa is known to affect up to one percent of the world's population of adolescent females. Often adolescents with AN will function at a seemingly normal pace of life, secretly obsessing over weight until someone notices their abnormal eating patterns. With a ten percent mortality rate, AN is a serious disorder that should not be taken lightly as a "phase" in an adolescent's life (Patel, et al., 2007).

In contrast to AN, conduct disorder, CD, is a behavior disorder characterized by the adolescent exhibiting a clear pattern of antisocial behavior usually highlighted by aggressive and

destructive patterns and attitudes (Lee et. al, 2009). Conduct disorder was originally seen as an inherent temperament problem, beginning in infancy and unchanged by experience (Scott, 2012) but today has clearly delineated symptoms and is one of the main behavior disorders classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, APA, 2013). Symptoms of CD are divided into four different areas: aggression toward people or animals, destruction of property without intent of aggression toward people or animals, deceitfulness (lying, stealing), or serious violations of rules (Bernstein, 2014). While the thrill-seeking adventures of adolescence may seem relatively harmless, it is important for both adolescents and parents to recognize the difference between “living a little” and a pattern of destructive, aggressive, or antisocial behavior. If left untreated, CD can escalate and result in the involvement with the cinderblock hotels of the criminal justice system.

A third common disorder in adolescence involves major depressive disorder (MDD). Depression in adolescents used to be by some considered as a normative aspect of this developmental stage (Petersen, Compas, Brooks-Gunn, Stemmler, Ey, Grant, 1993). Conventional thought was that adolescents were bound to get sad at times, but eventually would “grow out of it”. Today, the study of depression in adolescence has come to the forefront of concern in the psychiatry field as research has shown that depression in adolescence can lead to lifelong depression or other mental illnesses in adulthood (Petersen et. al, 1993). There are three different levels of depression that have been studied in adolescents: depressed mood, depressive syndrome, and clinical depression. Each level is considered increasingly more severe with clinical depression, or MDD, as the most intense (Petersen et al., 1993). There are many symptoms of depression in adolescence, the most common being feelings of sadness, irritability, loss of interest in usually stimulating activities, trouble concentrating, tiredness and loss of

energy, insomnia or sleeping too much, and changes in appetite (Morano,1993). Clinical depression can sometimes lead to suicidal thoughts, feelings, or attempts. It is not known why some adolescents get depressed while others do not, nor why some adolescents to attempt to kill themselves (Morano, 1993). Eleven percent of American adolescents alone will have had at least one depressive episode by the time they are eighteen (National Institute of Mental Health, 2014). Worldwide, suicide was the second leading cause of death for adolescents in 2012 (World Health Organization, 2014). Depression in adolescents is certainly not something to be waved off with the encouragement “you will be all grown up soon.”

It is important to know how to best help adolescents facing serious mental illnesses. Regardless of diagnosis, each adolescent diagnosed with a mental illness is part of the next generation of people, the generation that soon will be the voice of all generations. Having as many of them as healthy as possible is not only beneficial to them, but also to society. The question is: How can today’s experts in the field best help them? Studies around the world have explored the etiology and treatment of adolescents’ mental illnesses, trying to develop specific therapies and different medications.

An often overlooked yet simple asset to helping adolescents combat these different mental illnesses are their families. If there were a systematic way for caregivers and families to get involved in the treatment of adolescents’ mental illnesses, perhaps adolescents would recover faster and for longer periods of time. Especially since parents and family likely have played a role in the initial development and maintenance of the adolescent’s mental illness, they should play a role in the adolescent’s recovery from it. Family systems theory proposes that the whole family system, not just one member, needs to be helped in order for changes to last (Becvar & Becvar, 1982). Given the tools to improve family dynamics and functioning, most families,



though not all, would likely want to be involved in helping their children. It is time for families and societies to stop ignoring the existence of invisible elephants in one out of every four living rooms across the globe. Adolescent mental illness is a reality, and we as a global society must do everything in our power to curb it.

This paper first reviews changes in the definition of “family”, and then discusses past and current treatments for adolescents with anorexia nervosa, conduct disorder, and depression to determine the extent to which families are involved in the various treatments. The efficacy of treatments that do and don’t include families of adolescents are compared and evidence will be provided that dysfunctional family dynamics need to be addressed in treatments that include the whole family. Finally, this paper will explore the findings specific to the McMaster Model of Family Functioning for each of the three disorders and delineate those dimensions of family functioning that all treatment should include to provide the most comprehensive family approach for adolescents with mental disorders.

### **The Untapped Goldmine – Families**

For as long as humans have been on Earth, families have been the cornerstone of society. The word “family” originates from the Latin word, “*famulus*”, meaning servant (Webster, 2014). In a sense, families most certainly do serve one another. From a biological standpoint, children serve their parents as vessels for their genes to be passed on to the next generation. Parents serve their children by teaching them how to survive in their environments. Families have been a constant in society, but the definition has constantly changed over time (Goldenberg & Goldenberg, 2013). The definition of family was expansive and included extended family as well as an abundance of children in the twentieth century. In western cultures, this definition has decreased during the twenty-first century to encompass a more limited number of members.

Traditionally in society, families were defined as a father, mother and at least one child. If that were today’s definition, a majority of families would not be considered as such because often families vary greatly in size, number of parents, and gender of parents (Goldenberg & Goldenberg, 2013). Nevertheless, while families have changed over time, the basic structural characteristics of them have not. “Affection, loyalty, and a continuity or durability of membership characterizes all families” write Goldenberg and Goldenberg (2013, p. 4). The authors discuss that those who cohabitate together, regardless of biological connections, for any period of time, develop patterns of living together and arrange their lives to maximize satisfaction (Goldenberg & Goldenberg, 2013). Families are often cited as an individual’s place of refuge, a group to turn to in a crisis when no one else is available to help. For example, when a family member is getting an operation, families are usually asked if they would like to donate blood to assist the family member through the surgery. Families are present and involved at births, deaths, and in the care of their sick members; this involvement is a natural instinct for

most families. Family involvement is a service each member of a family gives to another in the form of time, support, reliability, and trustworthiness. All of these characteristics are what the origin of the word, “*famulus*”, refers to. While it is true that some families do not habitually have this unspoken expectation of involvement, this paper will argue that treatments of adolescents’ problems should involve the whole family. As will become clear in this literature review, family therapy can help target dysfunctional family patterns and in effect help both adolescents and their families improve their functioning.

Despite the widely recognized importance of family involvement in recovery from physical and mental problems, some areas of health care including clinics, schools, and mental health programs do not get families as involved as they should. This can impede the recovery process for the individual as well as for the family. As previously noted adolescents across the globe are, more than ever, in need of major mental health assistance in all areas of prevention, treatment, and recovery (Patel et al., 2007). This paper will compare the outcome studies on treatments involving families with those individual treatments for adolescents and provide evidence that family involvement in therapy is most beneficial. Experts in the field have disagreed for a long time on how effective family involvement is in treating anyone with a mental illness. Fifty years ago, it was much more common to send those with mental illness away from their families for years at a time. Mental illness was seen as incurable and shameful (Walsh, 2003.) Even the storied Kennedy family, who had both the means and the abilities to take care of one of their own, sent Rosemary Kennedy away after a failed lobotomy attempt.

Within the last twenty years, however, experts have come to recognize the important role of family involvement in helping adolescents recover from mental illness. Bettmann and Jaspersen (2009) completed a thorough evaluation of inpatient and residential treatment, calling

attention to the need for more hospitals to incorporate family therapy within their models. It should be emphasized that the call for greater family involvement in adolescent treatments does not imply that families are to be blamed for their adolescents' disorders, but simply that family involvement provides many benefits for adolescents' treatments (Chamberlin, 2005). The majority of the current literature consists of outcome studies comparing the effectiveness of various treatments focused on specific diagnoses, such as conduct disorder, depression, or anorexia nervosa. As such, these outcome studies commonly focused on a narrow aspect of family dysfunction directly involved in maintaining the problematic adolescent behavior, rather than focusing treatments on various aspects of family functioning.

A comprehensive model of family functioning used in both the psychological and medical fields is the McMaster Model of Family Functioning. This model divides family functioning into six dimensions in order to describe the "structure, organization, and transactional patterns of the family unit" (Epstein, Bishop, Levin, 1978 pg. 21). The six dimensions include Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, and Behavior Control and have been used to describe both functional as well as critically dysfunctional families.

The first dimension, Problem Solving, is simply defined as "a family's ability to resolve problems to a level that maintains effective family functioning" (Epstein et al., 1978 pg. 21) and is coded separately for families' ability to solve instrumental or mechanical problems and affective or emotional problems.

How the family exchanges information is defined as Communication within the McMaster model. There are different styles of communicating involving direction and clarity in verbal communication. Those families who are able to communicate clearly and directly are

scored as high on the communication spectrum, while those who communicate in masked or indirect ways are scored as low on the communication dimension and less functional.

The third dimension, Roles, is defined as “repetitive patterns of behavior whereby individual family members fulfill family function” (Epstein et al., 1978 pg. 23) and divided into two categories: necessary and other family functions. Necessary roles are roles every family has to perform, such as who will provide finances or take care of children, whereas the category of “other family roles” involve roles unique within each family.

The fourth dimension, Affective Responsiveness refers to the degree to which family members respond to each other with the appropriate quality and quantity of emotions. Emotions are divided into welfare feelings (positive and happiness orientated) and emergency feelings (distress and fear). Families who are unable to express the right proportion or amount of either group of feelings are seen as dysfunctional.

The dimension of affective involvement refers to the extent to which family members show interest in and value the activities and passions of the other family members (Epstein et al., 1978). Affective involvement in families ranges from absolutely no involvement to over involvement, both highlighting opposite ends of involvement found in dysfunctional families.

Lastly, the dimension of Behavior Control is defined as the way in which families manage members’ behaviors in physically dangerous situations, during the expression of psychological needs, and during socialization within and outside of the family. Functional families are able control their behaviors in dangerous situations, express their needs to each other, and socialize within and outside of the family (Epstein et al., 1978).

None of the current treatments for adolescents focused on all of these different dimensions of family functioning identified by the McMaster model. Instead of utilizing a

comprehensive treatment approach which addresses families' patterns of dysfunctional communication, ineffective problem-solving styles, poor behavioral control, unsuccessful role completion, and inappropriate affective involvement and responsiveness, clinicians have only focused on aspects of family dysfunction unique to specific adolescent disorders. Yet, a broader focus on various dimensions of family dysfunction in treatments of adolescents' disorders might be the key to better long-term improvements of adolescents and their families. Some research suggests that therapists should be the main agents of change in the therapy and delegate specific parts to the parents as co-therapists (Bailey, 1996). Other research supports focusing therapy on family-wide problems to resolve underlying problems in family dynamics rather than physical symptoms of the mental illness within the patient (Mikkelsen, Bereika, McKenzie, 1993). There are also disagreements among family therapists about which type of family therapy is most effective, though their common goal is to help adolescents recover from mental illness more effectively and with greater long-term benefits. The following is a review of various treatments shown to be effective with adolescents who have Anorexia nervosa, conduct disorder, and depression. Dimensions of the McMaster model addressed by current family therapies will be identified and compared across treatments for these three different disorders.

### **Anorexia nervosa: Treatment Options**

About forty years ago, anorexia nervosa (AN) was treated in adolescents with a focus on individual symptom reduction. Individual treatments for adolescents with AN focused on problem behaviors such as refusing to eat and an irrational fear of gaining weight. Family dynamics and readjusting adolescents' social life in and outside their families were not initially a concern in the therapy for AN. In an effort to improve therapy outcomes, researchers and therapists began to search for new ways in which AN in the adolescent population could be treated. Starting in the 1990's, clinicians and researchers began to realize the importance of involvement of families in the treatment of adolescents with AN. Today, family therapy models are at the forefront of AN treatment for adolescents due to their remarkable success for improving functioning of both individual patients and their families.

In several studies published within the last twenty years, researchers found family therapy models to be as or more effective than individual therapy for AN. Robin, Siegel, and Moye (1995) compared behavioral family systems therapy (BFST) versus ego-oriented individual therapy (EOIT). Behavioral Family Systems Therapy is an intergenerational family approach to therapy where with the guidance of the therapist, parents take charge of their child's eating in order for the patient to properly gain weight. This type of family therapy focuses on family communication styles, parental control, and supervision of adolescents. Parents remain in control of eating until normal weight has been established and maintained; then control is shifted back to the adolescent. Concurrently, problem solving strategies and communication skills are discussed and practiced with the therapist (Robin, et al., 1995).

BFST has been compared to individual treatment approaches with little family involvement, included ego-oriented therapy. In ego-oriented individual therapy, (EOIT), the

therapist focuses on the strengthening the adolescent's ego and coping skills, solving his or hers identity problems, and improving their relationships in order to alleviate their eating disordered symptoms. Families met with the therapist only bimonthly and therapy involved mostly psychoeducation. During this aspect of treatment with families, the therapist taught the parents about AN, normal adolescent development, and how to prepare for and cope with a recovering patient (Robin, et al., 1995). When BFST and EOIT were compared, both therapies significantly helped patients recover from AN, but BFST improved patient functioning more than EOIT. BFST was also noted to help families communicate more positively (Robin, et al., 1995). Though Robin and colleagues noted that it was still unclear how much family therapy was needed to help in adolescent treatment, it should be noted that their study was one of the first to compare family versus individual treatments.

Today, the necessity for family involvement in treatment is less disputed than it once was. In 2012, to further establish that family involvement indeed does help patients in recovering from anorexia nervosa, researchers completed a comparative outcome study between patients who received "treatment as normal", individual therapy, and family therapy. Results showed that those who received family therapy stayed healthier for longer after treatment (Godart et al., 2012). Even more recently, researchers Ciao, Accurso, Fittsimmons-Craft, Lock, and Le Grange (2015) compared family functioning levels between adolescent-focused therapy (AFT) to family-based therapy (FBT). Adolescent-focused therapy is most comparable to EOIT as they both focus on the individual adolescent and involve the family minimally. Around half of families with an AN patient in this study self-reported some deficiency in family functioning, specifically in family cohesion, organization, and emotional expression at the onset of treatment. Findings after treatment indicated that many families reported an increase in family functioning at the



conclusion of treatment, regardless of their perception of family functioning as good or bad at the onset of treatment. Adolescent patients were shown to report greater dysfunction in the family than parents at all stages of treatment. The report of greater dysfunction was related to poorer psychological wellbeing and greater clinical severity among patients (Ciao et al., 2015). The study also showed that while both treatment models provided improvement to family function and normal functioning was imperative for full remission, FBT impacted specific aspects of family function, including problem solving, emotional behavior control, and communication, in a more positive way than AFT (Ciao et al., 2015). It was concluded that FBT treated a greater number of dysfunctional behaviors in families more effectively and provided better awareness and understanding of the illness to all family members compared to AFT (Ciao et al., 2015).

On account of the field's evolving understanding of the illness and effectiveness of family involvement, anorexia nervosa treatments now center on behavioral family systems therapy (BFST), strategic family-based (FBT) and multi-family based therapies (Eisler, 2005; Robin & Grange, 2010). As previously discussed, BFST is said to, "combine behavioral, cognitive, and family systems perspective and interventions to help adolescents and their parents overcome AN" (Robin & Grange, 2010, p. 346). Through the three different phases of therapy, both the patient and the family learn how to properly maintain weight and overcome dysfunctional communication common in families with AN (Robin & Grange, 2010).

Similarly, strategic FBT focuses on readjusting family dynamics that have contributed to the problem, including family communication, language, and tone used in addressing family members. FBT also works on developing alternative methods of family problem solving (Walsh, 2005). A common model for FBT used in treatment of adolescents with AN is the Maudsely model where FBT is broken down into three distinct phases. The first phase works to establish

healthy eating habits and limit any positive symptoms such as purging by placing the parents in charge of the adolescent's eating. The second stage shifts the role of eating back onto the adolescent to give them the power and authority to eat properly. The third stage focuses on addressing any developmental and family problems between the adolescent and the family. A comparison study between the Maudsley model and individual therapy was conducted and researchers found that ninety percent of those who were assigned to FBT Maudsley model remained in recovery at a five-year follow-up, while only 36% of those who were in the individual therapy remained.

A more community-based treatment, multi-family therapy, focuses on several families within a group setting. Families at different stages of treatment come together for group meals and therapy sessions while also attending individual family treatment sessions (Eisler, 2005). Multi-family group therapy can illustrate to families early in their treatments how improvement in family dynamics can help both the adolescent and his or her family as they are able to talk with other families who are farther along in treatment.

Earlier this year, another group of researchers focused on one aspect of family-based treatment: family meal session (White & Haycraft et al., 2015). Their study showed that parents played a significant role in the success or failure of the family meal in terms of food consumption by the AN patient. They analyzed what type of prompts, both verbal and non-verbal, parents used to try to get their child to eat during the family meal and which types were most successful. The use of direct food related prompts, both physical and verbal, were most successful in improving eating by the patient; even when they were met with negative hostile commentary and actions by the patient (White, Haycraft, Madden, Rhodes, Miskovic-Wheatley, Wallis, Kohn, & Meyer, 2015). This study shows that when given the proper role and guidelines,

parents can have a positive effect on their child and help in the recovery process from AN. Based on these findings, family meal sessions lead by parents with therapist guidance should be incorporated in family treatments of adolescent AN.

Alongside the details of therapy recommended to adolescent patients with AN, the environment in which the treatment is provided has been much debated. Most studies support moving AN treatment out of long-term hospital settings and into residential or day programs. Girz and colleagues (Girz, et al., 2013) studied the benefits of strategic FBT within a day hospital program lasting several months. Day treatment programs are more likely to get families involved in treatment, which enables families to create environments at home where therapeutic characteristics can be maintained and consistently measured. The family component of FBT day programs can help in the successful recovery of an adolescent with AN, as they better prepare families for what to expect during the course of treatment. Eisler (2005) studied the benefits of having family and individual therapies administered in the context of day therapy. While differences in the specific therapies exist, Eisler and Girz and colleagues (2005) agree that adolescents with AN should be treated in a day program together with their parents and families.

In summary, all three family treatments for AN have unique benefits suggesting that a combination of the most effective parts of all three would most benefit adolescents. In BFST, the family is treated as a system with multiple parts and personalities, whereas FBT focuses on facets of dysfunction such as communication and problem solving within the family. Expanding treatment to a multi-family therapy level seems to provide a network of support and comfort for families in all phases of treatment. Though it is still unclear what the important and effective ingredients in these treatments are and which aspects are tertiary and unvalued by patient and

their families, family-based treatments are no doubt helpful to the adolescent and his or her family.

It seems best for adolescents with AN and their families to receive family therapy which combines the application of BFST principles with the FBT treatment of specific aspects of dysfunction and the benefits of multi-family therapy. This therapy model should consider incorporating Girz and colleagues' suggestion to expand and promote day hospital settings for these patients, allowing adolescents to return to their home environments each day. This form of day treatment addresses aspects of family dysfunction that may have played a part in the development of AN and helps families to practice solution strategies in the home. Facets of treatment found effective, such as a family meal, should be implemented into the core of treatment (Girz, et al., 2013).

Applying the McMaster Model of family functioning, it seems that the main focus in current family treatments for AN involves the dimensions of Communication and Roles. Surprisingly, the dimension of Affective Involvement has not yet been included in family interventions for AN. Throughout current family treatments, the focus is on how specific language is used and communication patterns are altered in order to ensure that all members of the family are being fully heard and understood. Negative, threatening language and tone is actively eliminated from dialogue so as to open up a freer communication environment. Current treatments for AN pay special attention to family roles and to redefining all members' roles over the course of treatment. For example, early in treatment parents are assigned the role of monitoring food intake and making decision about adolescents' nutrition. With further treatment, this role is transferred to the adolescent herself.

A comprehensive approach to family treatment of AN should focus on a combination of multiple dimensions of family dysfunction including emotional and behavioral displays, problem solving practices, and proper parental authority. Specifically, treatment models should focus more on McMaster's dimensions of Affective Involvement. A main area of dysfunction in families of adolescents with AN involves parents who display an inordinate amount of interest in, to even obsession with their child's appearance and weight. This clearly can have a direct impact on the development of an eating disorder like AN. The inclusion of interventions aimed at normalizing involvement levels in families of adolescents with AN might benefit the long-term treatment outcomes in this population.

While the specific interventions and treatment modalities for AN are highly debated among clinicians in the field, it is clear that the most effective treatments include interventions aimed at families of adolescents with AN. Involving family in the diagnosis, treatment, and long-term recovery of the patient ensures that adolescents diagnosed with AN have a greater chance to lead a healthy life after treatment. Recently, studies have been published citing that, "four to five years after treatment, eighty to ninety percent of family-based therapy patients have fully recovered with only ten to fifteen percent still seriously ill" (Robin & Grange, 2010 pg. 10). However, these promising recovery rates do not consider whether problematic family dynamics involved in fostering AN have also improved. Simply reducing symptomatic behaviors in the patient is not sufficient in eliminating the disease or reducing the risk of relapse. Treatment consistently involving families is beginning to revolutionize not only the psychiatry field but also how the health care field treats adolescent patients with AN. Involving parents and families at all stages of treatment is not only vital to promoting long-term health for the patient, but important

for fostering and maintaining family cohesiveness and helping AN patients can get better in less time.

### **Conduct disorder: Treatment Options**

Similar to treatments for AN, family involvement was not initially a focus in the treatment of adolescent patients with conduct disorder (CD). Once thought to be a behavior problem with poor prognosis by clinicians in the psychiatric field, conduct disorder is no longer seen as a chronic disorder impossible to treat in the adolescent patient. Conduct disorder is a disorder that can emerge during childhood or well into late adolescence. Usually CD is evident in children as defiant acts; but eventually turns into antisocial behaviors that become unmanageable during adolescence. Not every adolescent patient with CD exhibits symptoms in all known symptom areas, but a majority of cases have at least two clearly identifiable symptoms. Conduct disorder is diagnosed in one to almost four percent of the adolescent population in the United States alone (Woolfenden, William, & Peat, 2002). Parenting style and home environment are often implicated in the etiology of CD, making family involvement in treatment that much more paramount.

Today, there are two main types of treatment for CD: family therapy in various forms and individual therapy for patients alone. Similar to individual therapy for AN, individual treatments of CD also focuses on the specific patient symptoms and works toward symptom reduction. Individual therapy focusing on distortions of beliefs is highly recommended to help the adolescent fully understand that the symptoms they exhibit are not only dangerous but often destructive. The practice of “alternative thinking,” – learning to be mindful of inappropriate and destructive thoughts when they come to mind, is a commonly used technique in individual therapy. Paralleling the increased inclusion of families in treatments for AN, treatments for CD

have also begun to incorporate families and have found family involvement to be highly effective. Since the etiology of CD includes family disorganization and harsh, inconsistent, and negligent parenting practices, parent management training, multi-systemic family therapy, and functional family therapy are commonly used forms of family treatments of CD today.

Parent management training is based on teaching and coaching parents to limit positively reinforcing child misbehavior while monitoring their children at all times (Bailey, 1996). The training focuses on establishing limits, supervision, and proper discipline methods that are otherwise lacking in the family. Various programs use videos of correct and incorrect parent practices with groups of parents lacking managerial and proper discipline skills were also found to be effective in changing parenting behavior. This training helps parents learn how to foster a more accommodating environment for the healthy development of their adolescent. It also helps parents restructure or establish boundaries that might not have been present, resulting in the onset of CD.

Aside from the more behavioral approaches used in parent behavior management training, other forms of family therapy involved counseling parents about using clear communication and reinforcing positive behaviors with their children. Family therapy for CD also frequently includes work on improving parent-child attachment relationships, as they have been found to be severely disrupted or inappropriate among family members of adolescents with CD. This disruption in attachment has been found to manifest itself in affect regulation, which has been shown to have a direct impact on escalation of family violence (Keiley, 2002). Family structure, parental monitoring, and parent-child communication exert important influences on adolescents' life choices and treatments focusing on these aspects of functioning have been found to be effective.

There are two prevailing types of attachment based family therapy utilized in treating CD in the field today: multi-systemic family therapy (MST) and functional family therapy (FFT). In both treatment types the therapist resolves attachment problems in the family to ensure that parents and children develop more secure attachment relationships with one another (Keiley, 2002). Multi-systemic family therapy is a novel form of home-based therapy in which therapists observe the breakdown of family functioning in the family's natural environment. Each family in MST has a specific treatment plan utilized by their treatment team. Not only do therapists focus on family dynamics, such as parenting style and family organization, but they also help in addressing any problems external to the family such as peer or school problems affecting the patient (Keiley, 2002).

Functional family therapy focuses on CD patients' actions as functions of their families. Therapy reorganizes family relationships to promote a healthier environment for all family members. Family therapy for CD is sometimes structured with parents as co-therapists. Therapy engages parents and their children in discussing what events led up to inappropriate behavior, the behavior itself, and its consequences (Keiley, 2002).

The best way to ensure a therapeutic living environment has been broadly labeled the "family process model" (Lee, et al., 2009). There are many different variations of this model, which generally attempts to change family processes and dynamics through a combination of parent training, family therapy, and the application of social learning theory. Social learning theory involves the idea that individuals can learn by imitating and modeling others (Bandura, 1977). Social learning theory is used in parent management training as well as components of MST and FFT. By imitating models depicted in videos and role playing parent management techniques, parents are able to practice effective and appropriate parenting techniques.



Several studies have compared individual versus family treatments of CD. Hawes and colleagues (2014) found that family therapy is the most effective intervention for adolescents with CD. These researchers report that it was important for parents to be well informed on how to positively interact with their children. However, this is not accomplished through parent training as previously thought, but rather through an evaluation and refocusing of the parent-child relationship through strategic family therapy (Hawes et al., 2014). This study underlined the necessity for healthy environments to be reinstated in families when an adolescent is in treatment for CD (Hawes et al., 2014). If adolescents with predispositions towards developing conduct disorder return to nurturing, supportive family environments, their odds of relapsing are lower compared to adolescents living in neglectful and conflictual environments.

Family therapy for CD has been found to be effective even in a particularly disturbed subset of adolescents labeled as juvenile delinquents. “Juvenile delinquent” is a legal term used for the two percent of the adolescent population that come into contact with the criminal justice system every year and often meet the criteria for CD (Woolfenden, Williams, & Peat, 2002). In a meta-analysis of family and parenting treatment of CD in this subset of most disturbed adolescents Woolfenden and colleagues (2002) found that family intervention, specifically MST and parent management training, significantly reduced the probability of recidivism and prolonged incarceration time. On average, incarceration in institutions was found to be reduced by over 50 days after family treatment when compared to individual treatment group (Woolfenden, et al., 2002). This is a significant reduction in time that can clearly help adolescent patients with CD and their families. Multi-systemic family therapy and parent management training improve adolescents’ symptoms and also change home environments so that they will support adolescents’ continued recovery. Family treatment of CD has been shown to not only

reduce symptomatic behavior, but also have a positive effect on family functioning and parental effectiveness as a whole.

Current family treatments for CD focus on the McMaster Model dimensions of Behavioral Control and Roles, though other dimensions of family functioning such as Communication, Affective Responsiveness, and Affective Involvement would also be helpful to include in family therapy for CD. Psychoeducational programs could focus on improving family communication and affective responsiveness by all family members in order to foster an environment of understanding and cooperation between the adolescents and their families (Chabra, Sodhi 2012). More effective family communication, better role allocation, and appropriate boundaries between parental and child subsystems could improve areas of dysfunction not currently addressed by treatments for adolescents with CD.

In summary, a combination of MST or FTT and parent management training would most likely provide the most effective treatment form. The family process model, adolescents, parents, and therapists all work together to reduce symptoms, alter potentially toxic familial environments, and safely redefine roles within family units.

Overall, the general concepts underlying family treatments of adolescents with AN and CD are similar. Both families with AN and CD have problems with the McMaster dimensions of Affective Involvement and Behavioral Control. However, while parents of adolescents with AN are often overextending themselves, trying to control every aspect of their adolescent's life, the opposite is true for most parents of adolescents with CD. These parents are often found not to provide enough structure and authority in supervision and guidance of adolescents' behaviors. Family therapy for AN focuses also on the dimension of Communication within the family unit,

while family therapy for CD focuses more on the reallocation of power to parents and on responsibilities of members within the family, representing the dimension of “Roles”.

Regardless of the specific interventions involved in the treatment of AN and CD, it is recommended that treatments for both disorders include the patients’ families. Similar to AN, involving families in the assessment, treatment, and long-term recovery of the patient with CD ensure that these adolescents receive better treatments and have a greater chance to avoid relapses. Simply reducing symptomatic behaviors in the patient is not sufficient in eliminating symptoms or reducing the risk of relapse for either AN or CD patients. Involving parents and families at all stages of treatment is not only vital to promoting long-term health for the patient, but important for fostering and maintaining family cohesiveness.

### **Depression: Treatment Options**

Depression in adolescence was not taken seriously until around thirty years ago as it was once seen as part of the adolescent's experience. The older school of thought was that dramatic mood swings and even deep sadness were normal in adolescence. Experts and parents used to agree that while adolescents are moody, they would persevere and eventually outgrow their dark moods. Today, depression is a widely recognized problem as it afflicts around six percent of the adolescent population in America alone (Hughes & Asarnow, 2011). Part of the reason that depression is so prevalent in the adolescent population is the large number of stressors that accompany this developmental stage today – changes in schools, hormones, and physical appearance, added to conflictual friendship groups, problems in finding identity, academic pressures, and increasingly complex temptations to engage in high-risk behaviors.

There are four different levels of depression, ranging from depressed mood to clinical depression, and all need to be treated in adolescents (Petersen et al., 1993). Depressed mood usually stems from a specific problem in an adolescent's life, where as a depressive syndrome and clinical depression involve longer lasting and more severe symptoms and even chronic feelings of negativity. Clinical depression is diagnosed as Major Depressive Disorder of MDD (APA, 2013) and is the most severe as it usually involves thoughts and even acts of self-harm, including suicide.

Lack of familial support, education, and understanding in times of great stress are often cited as important factors in the etiology of adolescent depression. In one study conducted by Morano, "experienced loss and low family support were the best predictors of serious suicide attempts by adolescents" (1993 pg. 861). Researchers at Michigan State University reported that difficulties in the relationships with parents correlated with adolescents' self-representations of

themselves and their experiences of their depression (Frank, Poorman, Egeren, & Field, 1997). Unresolved perseverating breakdowns in family dynamics including parental marital distress, divorce, and absence have been linked to a higher incidence of depression in adolescence (Petersen, Compas, Brooks-Gunn, Stemmler, Ey, & Grant, 1993). ) If negative family interactions, relationships, and support are so regularly coexisting with adolescent depression, education of family members seems like the first logical step in the recovery process.

Depression in adolescence is frequently treated with a combination of therapy and medication. Anti-depressant medications are usually added to adolescents' treatments because they work well in the short term. However, medication is not a long-term solution, as they tend to have high relapse rates in addition to unwanted side effects. Today, there are a variety of treatments available for adolescents with depression other than medications.

Cognitive behavioral therapy (CBT) has been identified as highly effective treatment for clinical depression. CBT aims to change the adolescent's thought processes and self-images and teaches positive ways to cope and regulate emotions. CBT can be administered in individual or group settings and may include parent involvement. Group CBT is seen as the most beneficial to adolescent patients who often find solace in others their age experiencing similar emotions (Clarke & DeBar, 2010). A group environment also allows for patients to focus on interpersonal communication difficulties that often accompany adolescent depression (Stark et al., 2006).

Another recommended form of therapy is Interpersonal Therapy for Adolescents (IPT-A). The primary therapeutic goals of IPT-A are to decrease depressive symptom and to improve interpersonal functioning in problem areas such as grief, interpersonal role disputes and deficits, role transitions, and living in a single-parent family. The therapist works with the adolescent and parent to ensure that the youth is socially engaged in the family, in school, and with friends.

Family members are asked to encourage the patient to engage in age appropriate activities.

Studies showed that adolescents who received IPT-A reported significantly fewer depressive symptoms and eventually recovered from their depression (Stark et al., 2006).

There is disagreement in the field whether family involvement and education should be a part of therapy for depressed adolescents. However, systemic behavior family therapy (SBFT) has been shown to effectively treat adolescents' depression. SBFT aims to identify dysfunctional behavior patterns in families, including communication problems and teaches problem-solving skills to eliminate negative disruptive patterns. The therapist presents the adolescent's depression as a problem not just for the individual patient, but for the whole family system. Dysfunctional interaction patterns and inappropriate relationships within family members are also addressed (Weersing & Brent, 2010). Comparing SBFT and individual support therapy, no differences were found in recovery or recurrence rates between the two patient groups after two years. However, SBFT patients reported greater improvements post-treatment (Hughes & Asarnow, 2011). Compared to SBFT, CBT was found to have a more positive treatment outcomes right after treatment completion, though no significant differences in long-term effects (Weersing & Brent, 2010).

Another form of family therapy, attachment based therapy (ABFT), has been found to be effective in the short-term with adolescents who have depression. This therapy is based on the assumption that the adolescent's attachment to the family, specifically parents, has been broken and trust has been continuously violated. ABFT has been shown to reduce criticism in family, improve trust between the patient and parents, and work to mend attachment breaks (Curry 2014). According to the APA, ABFT aims to "repair attachment rupture and reestablish the parents' good care giving and the adolescents' desire for emotional protection" (APA, 2013, p.1).

Therapists are taught to rapidly focus on core family conflicts, relational failure, and vulnerable emotions to improve attachment security in adolescents. As attachment is restored, the adolescent comes to trust the family more as a base and becomes more a part of family life as a whole. ABFT is seen as the premier therapy form for short-term treatment (Curry, 2014). However, ideally, treatment should be focused on both short-term corrections to stimulate recovery and long lasting ideals instilled in both patients and parents.

In summary, many current and effective treatments for depressed adolescents included some parent treatment component, but SBFT and ABFT actually involved family therapy. The American Academy of Child and Adolescent Psychiatry highly recommends that families are involved in the treatment of adolescent depression (APA, 2013). Family involvement can occur in a variety of ways including: educating family members about depression to cultivate an environment of understanding, addressing any parental depression, which is a common factor associated with adolescents' depression, and resolving any family conflict that could additionally be contributing to an adolescent's depression (Hughes & Asarnow, 2011). Consistent with Family systems theory, studies have shown that families have significant impact on the remission and recovery from depression in one of their family members. Findings suggest that a family environment embroiled in conflict and turmoil generates dependent interpersonal peer stress; in addition, individuals who view themselves as flawed or deficient may blame themselves for their turbulent family environment as well as peer relational difficulties, which contributes to higher levels of depressive symptoms (Mash & Berkley, 2006).

Therapies for adolescent depression mainly focused on repairing thought processes within the patient. Current depression treatments for adolescents focused more on the McMaster Model dimensions of Communication and Roles within the family, though treatments should

also address the dimensions of Affective Responsiveness and Affective Involvement.

Adolescents with depression are often unable to properly express their feelings of despair in their families, and their families may display a larger proportion of negative rather than welfare emotions. In addition, depressed adolescents are likely to withdraw from their families and physically and emotionally isolate themselves making it important for family therapists to work on these families' affective involvement.

As depression is often comorbid with other disorders, including anorexia nervosa and conduct disorder, treatment for comorbid depression is usually combined with treatments for the other disorder, making it difficult to determine the long-term effects of treatment on solely depression (Curry, 2014). Given the high comorbidity, depression treatments should be adapted to best suit the unique needs of adolescents and their families that include a comprehensive focus on various dimensions of family functioning likely to maintain the depression.



## Conclusion

In today's fast paced world, mental illness has become a global epidemic. Adolescents are particularly affected by mental illness, as one out of every five adolescents on average has a diagnosable mental illness that can affect every aspect of their young life. There are many reasons why adolescent mental illness has become an invisible elephant within family structure, but it is possible to expose and eliminate this elephant in order to not only help the adolescent recover permanently, but to also provide a more nurturing and functional family environment for all members.

Three of the most prevalent mental disorders found in the adolescent population are Anorexia nervosa, conduct disorder, and depression. While these are fairly widespread disorders, there is no reason for an adolescent's life to be completely and permanently altered after diagnosis. A thorough review of the literature, reveals that there are many effective treatment options currently available for all three disorders. Family therapy is most widely found in the treatment of AN, as it has become inconceivable to the field to exclude the family from treatment. Treatment of adolescents with CD has also largely focused on family treatment in the form of parent management training as authority and roles with the family system are very much focused on in treatment. Treatment of adolescents with Depression has a variety of treatment options available as some of treatments entail a family component, while others focus only on the individual adolescent. Conclusively, there are just as many family treatments as individual treatments available to families with an adolescent with a mental illness.

Overall, the literature demonstrates that having family members' involvement in the treatment of adolescents is preferable and more effective than treatments not involving the family. This is due to a variety of reasons. Whether adolescents are willing to admit it or not,

they spend a majority of their life with their family. Families are an important source of support and influence on each other and especially to adolescents during this tumultuous adjustment stage of life. Families have the unique opportunity of being able to directly help an adolescent maintain their recovery from a mental illness as families whom are involved in treatment will know how to best provide a safe and nurturing home environment adolescents can return home to in treatment. Family members' roles within treatment include working directly with therapists in treatment as co-therapists, being present and available throughout treatment as a supportive system for the adolescent, and being students in treatment, learning about their child's illness. Family-based therapies for all three disorders provide both short and long-term benefits for the adolescent and his or her family.

Overall, treatments should not focus only on symptom reduction, but also on altering various dimensions of family dysfunction. Using the McMaster Model of family functioning as context for viewing treatment outcome studies for the three different disorders uncovers a shortcoming of current family treatments. Current family therapies focus only on a limited number of dysfunctional family dimensions, namely Communication, Roles, and Problem Solving. These components of treatment are crucial in the treatment of all three dimensions helps to redefine family functioning and provide for a more nurturing home environment. The components of Affective Involvement, Behavioral Control, and Affective Responsiveness are not commonly included in family therapies, but should be. Families with an adolescent with a mental illness all display dysfunctions in how over or under involved and responsive they are in each other's lives. Family therapists interested in recruiting the invisible elephant in adolescent disorders for the benefit of long-term recovery should include more comprehensive interventions that cover all dimensions of family dysfunction in treatments of adolescents' AN, CD, and depression.

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<sup>i</sup> \* Criteria based on DSM-IV-TR, which is still widely used in publications dating prior to DSM-V (APA, 2013).