Family Therapy

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Introduction

Family therapy is an approach to clinical practice that involves conceptualizing individual psychological problems and their treatment within a family context (Fiese et al., 2019; Wampler, 2020). It is one of a number of interventions for child and adolescent problems in which parents play a key role (Carr, 2019). Other family-based interventions include parent-child psychotherapy and parent training. These are considered elsewhere in this volume.

Family therapy emerged simultaneously in the 1950s in the USA and the UK within a variety of different professional, therapeutic, and research traditions (Carr, 2012, 2015). The central insight that intellectually united the pioneers of the family therapy movement was that psychological difficulties are essentially interpersonal, not intrapsychic. Therefore, their resolution requires an approach to intervention which directly addresses relationships between people. This insight contravened the prevailing view that all psychological problems are manifestations of essentially individual disorders and so require individually focused psychodynamic, behavioral, client-centered, or biomedical interventions.

Family therapy was developed partly in response to the ineffectiveness, in some cases, of individually oriented treatment approaches, and partly in response to research findings which indicated that family factors contribute to the etiology of psychological disorders. To inform their approach to clinical work with families, the pioneers of family therapy drew on insights from general systems theory and cybernetics. Ludwig von Bertalanffy (1968), in general systems theory, proposed that in any biological or social system the whole is more than the sum of its parts. Therefore, any element of a system can best be understood with reference to the system as a whole. Applied to families, this principle suggested that one family member's problematic behavior, beliefs, or feelings, can most usefully be understood with reference to the behavior, beliefs, or feelings of other family members.

Norbert Wiener (1961), in his cybernetic theory, proposed that mechanical systems use feedback to remain stable (i.e., to maintain homeostasis) or to adapt to new circumstances so as to achieve goals (i.e., to achieve morphogenesis). The implication of this principle for family systems is that families use feedback to balance the tendency to maintain stability with the need to adapt to the changing

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demands of the family life cycle. In line with this principle, family therapy pioneers suggested that in some instances problematic behavior, beliefs, or feelings of one family member may serve the useful function of helping the whole family maintain stability when it lacks the resources for adaptive change. For example, a child's behavior problems may motivate parents experiencing marital distress to postpone separation, so as to jointly manage their child's problematic behavior.

In the early years of the family therapy movement, there was no single shared unified, integrated overarching framework. Rather, a range of models of family therapy were developed by a number of skilled clinicians, drawing on insights from systems theory and cybernetics combined with observations made while conducting family therapy in clinical practice. These models may be classified into three groups in terms of their primary emphasis (Carr, 2012). Some models focused predominantly on problem-maintaining relational patterns and methods of disrupting these rigid repetitive cycles of family interaction. For example, structural and strategic family therapy (Haley, 1976; Jackson & Landers, 2020; Minuchin, 1974). Others addressed family members' belief systems, scripts, and narratives about the causes of and solutions to psychological problems and the most appropriate way for family members to manage distress and conduct their relationships which underpinned problem-maintaining relational patterns. For example, social constructionist and narrative approaches to family therapy (Anderson, 1997; Chenail et al., 2020; White & Epston, 1990). A third focus of therapeutic concern in some early family therapy models was understanding and addressing the broader historical and social context out of which problem-related belief systems, scripts, and narratives and rigid problem-maintaining relational patterns had emerged. For example, transgenerational and psychoanalytic family therapy approaches (Boszormenyi-Nagy & Spark, 1973; Bowen, 1985; Hargrave & Houltberg, 2020; Slipp, 1988). Early models of family therapy laid the foundation for contemporary integrative, research-informed, or evidence-based models of family therapy practice, which are the main focus of this chapter. Contemporary models are integrative in that they synthesize ideas and practices from a range of earlier family therapy models. They are also evidence-based, and/or research-informed, unlike early models which relied predominantly on clinical observation and case studies. Pioneers of family therapy trained the next generation of family therapists who developed contemporary models through a process of live demonstration and live supervision using video recording and one-way mirrors (Liddle et al., 1988). This approach to training and supervision was a major innovation in the wider field of psychotherapy.

The effectiveness of family therapy for child and adolescent clinical problems is supported by a growing evidence base. In a meta-analysis of 56 studies, Riedinger et al. (2017) found that family therapy was an effective intervention for a range of child and adolescent problems including externalizing behavior problems such as disruptive behavior and substance use disorders, internalizing behavior problems such as depression and anxiety, and eating disorders. Family therapy showed small-to-medium effects in comparison with waiting list control groups and alternative interventions after treatment and at follow-up. At follow-up, longer interventions produced larger effect sizes. These results are consistent with those of extensive narrative and systematic reviews (Carr, 2019; Retzlaff et al., 2013; von Sydow et al., 2013). There is preliminary evidence to support the provision of family therapy online using video-conferencing technology (McLean et al., 2021).

A number of factors common to many different models of family therapy for different types of disorders across the lifespan may underpin its effectiveness (D'Aniello & Fife, 2020). These include convening regular family sessions; establishing therapeutic alliances with, and between family members; reframing child-focused problems in relational terms; disrupting dysfunctional problem-maintaining, relational patterns; mobilizing family members to collaborate in resolving the presenting problem; and empowering families to use lessons learned in family therapy to prevent relapse. Of these common factors that contribute to the effectiveness of family therapy, establishing a therapeutic alliance with, and between, family members has a particularly strong evidence base. For example, in

a meta-analysis of studies of 40 samples involving over 4000 families, Friedlander et al. (2018) found moderate correlations between therapeutic alliances with, and between, family members on the one hand, and therapy outcome on the other.

While common factors contribute to the effectiveness of family therapy, these operate through model-specific factors. For example, the common factor of disrupting family-maintaining relational patterns is operationalized in different ways in functional family therapy (FFT) for conduct problems (Sexton, 2019) and attachment-based family therapy (ABFT) for depression (Diamond et al., 2016). This is partly because different types of relational patterns maintain depression and conduct problems. Most contemporary evidence-based or research-informed models of family therapy have been developed to address specific clinical problems. In the remainder of this chapter, some examples of such models will be presented with reference to supporting evidence.

Delinquency and Disruptive Behavior Disorders

FFT (Sexton, 2019) and Multisystemic Therapy (MST, Henggeler & Schaeffer, 2019) are two family therapy models that were developed initially to treat juvenile delinquency and adolescent disruptive behavior disorders. FFT was the first clearly articulated integrative evidence-based model in the field of family therapy, having emerged in the 1970s. MST was developed in the 1980s and currently has the largest evidence base of any family therapy model.

Functional Family Therapy

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; Robins et al., 2016; Sexton, 2011, 2019). It was designed to prevent recidivism in young offenders. FFT is disseminated by FFT-LLC (http://www.fftllc.com) and FFT associates (http://www.functionalfamilytherapy.com).

FFT is based on an ecological multifactorial model which highlights the role of risk and protective factors in the etiology of delinquency and prosocial behavior (Alexander et al., 2013; Sexton, 2019). Recursive relational interaction patterns within the family are assumed to maintain adolescent prosocial and antisocial behavior. Family members' vulnerability to engaging in these interaction patterns are assumed to be influenced by experiential-developmental and biological-constitutional factors. Factors within the wider social network (including the extended family, school, peer group, and community) also are assumed to influence the development and maintenance of adolescent prosocial and antisocial behavior.

The FFT theoretical model is informed by five core principles (Sexton, 2019). First, all family members' behavior, including adolescent antisocial behavior, occurs as part of a relational system with multiple, mutually interactive components including adolescents, parents, siblings, extended family members, and the community. Adolescent problem behavior is more likely to occur in families and social systems where the influence of risk factors is greater than that of protective factors, whereas a preponderance of protective factors supports the development of prosocial behavior. Second, relational patterns are a central feature of family relationships. Relational patterns are behavioral sequences among family members that, over time, become routine ways of interacting. Families develop relational patterns in an attempt to adapt to life events. Some such events are normal, for example, family life-cycle transitions such as the birth of the first child. Others are abnormal, for example, trauma. Clinical problems are maintained by relational patterns that incorporate a family's ineffective attempts to adapt to life events. For example, parents may unsuccessfully attempt to reduce

adolescent aggression with corporal punishment, which inadvertently maintains the young person's aggression. Third, family members' attributions and narratives about relational patterns in which problem behaviors occur contribute to the development and maintenance of clinical problems. For example, parents may attribute a child's aggressive behavior to the child's wish to annoy them or inappropriately get their attention. They may also attribute the child's failure to respond to corporal punishment with less aggressive behavior as an indication that the child needs more severe physical punishment in order to become less aggressive. This narrative about "a bad attention-seeking or willful child needing more severe corporal punishment in order to learn how to be less aggressive" may contribute to the maintenance of the relational pattern that maintains the child's aggressive behavior. This narrative keeps the family "stuck." Fourth, young people's clinical problems are essentially family problems, because they are embedded in relational patterns. For example, a young person's aggressive behavior may be embedded in a family relational pattern, such as receiving corporal punishment from a parent for behaving aggressively. This relational pattern may be subserved by a family narrative that physical punishment is the appropriate solution for the child's problematic aggression. These sorts of family relational patterns tend to become very stable once established and maintain the young person's clinical problem. FFT adopts a family-based approach to intervention to disrupt these problem-maintaining relational patterns and subserving attributions and narratives. Fifth, homeostatic problem-maintaining relational patterns remain stable because they fulfill relationship functions for family members. In FFT, it is assumed that families vary in the level of (1) emotional connection and (2) relational hierarchy that they require for family stability. The relational patterns that family members engage in have the function of helping them maintain the level of emotional connection and relational hierarchy that they feel comfortable with. Some families feel comfortable with a high level of connection (high emotional closeness and intensity). Others will feel comfortable with a low level of connection (high emotional independence and low emotional intensity). A third type of family feels comfortable when their relational patterns help them to "midpoint" by achieving both emotional closeness and emotional independence. With regard to relational hierarchy, some families feel comfortable with a set of relationships in which power is shared equally. In this context, power may be economic, physical, or role-related. Other families may feel comfortable with relationships in which one or more family members have greater power than other family members. In FFT, there is no attempt to change a family's preference for high or low levels of connection or hierarchy. Rather, therapists assess the function of problem-maintaining relational patters in helping a family achieve certain levels of connection and hierarchy. They then help families maintain their preferred levels of connection and hierarchy, by facilitating the use of other relational patterns that do not involve maintaining the young person's antisocial behavior. For example, in a family where corporal punishment is used to address adolescent aggression, and this relational pattern meets the family's need for a low level of emotional connection and a high level of relational hierarchy, contingency contracting may be offered as an alternative way of fulfilling these relational functions. However, in a family with similar problems, but where the relational pattern meets the family's need for a high level of emotional connection and a moderate level of relational hierarchy, fulfilling these relational functions could be met by facilitating regular periods of parent-adolescent quality time in addition to contingency contracting.

The FFT clinical intervention model which guides treatment incorporates concepts and practices from attribution theory (Jaspers et al., 1983) and a variety of earlier models of family systems therapy. These include behavioral family therapy (Merrill et al., 2019), the Mental Research Institute brief therapy (Fisch et al., 1982), Milan systemic family therapy (Selvini-Palazzoli et al., 1978), and social constructionist family therapy (Anderson, 1997). The FFT clinical intervention model is based on five principles (Sexton, 2019). First, successful intervention involves developing a strong alliance with each family member and between members of the family. Helping family members develop shared

goals is central to strengthening the alliances between family members. Second, therapeutic change occurs in phases. These include the initial engagement and motivation phase; the behavior change phase in which new skills are developed; and the concluding generalization phase in which families apply competencies developed in the middle phase of treatment to challenging new situations. (The phases of FFT will be elaborated below.) Third, treatment goals are achievable; fit with clients' priorities, values, and culture; and modify risk and protective factors relevant to the presenting problems and relational patterns that maintain them. These goals may appear to be small, for example, reducing blaming within the family, or increasing positive parental monitoring of adolescents behavior. However, such goals can have a significant, cumulative, long-term impact on family functioning and presenting problems, by, for example, reducing the frequency and intensity of episodes of family violence. Fourth, in FFT therapists and clients form a collaborative expert team. Therapists are experts on therapeutic change. Clients are experts on their own lives, including their culture, values, style, and unique characteristics, history, and goals. Fifth, families are helped to achieve their goals by using web-based session-by-session measures of progress to inform clinical decision making. Where session-by-session measures indicate that little progress is being made, reasons for this are explored and interventions to address obstacles to progress are implemented.

The FFT clinical intervention model consists of three phases: engagement and motivation, behavior change, and generalization (Sexton, 2019). In the engagement and motivation phase, there is a focus on building alliances with, and between, family members. Therapists use empathy, positive regard, and other interpersonal skills to form strong alliances with family members, so that each family member experiences the therapist as understanding and supporting them. Therapists facilitate alliances between family members and reduce intrafamilial negative attributions and blame through relational reframing. Problematic behaviors and interaction patterns are reframed to reflect noble, yet misguided intentions. For example, anger and criticism may be reframed as expressions of emotional hurt, love, and concern. Over the course of therapy, relational reframing is repeatedly used in FFT to help families construct and "own" positive relational themes such as parents being invested in supporting their adolescent's wish to achieve greater independence and young people looking for ways to express a need for autonomy. Therapists also facilitate alliances between family members by helping them negotiate shared goals.

In the behavior change phase, therapists help families develop specific behavioral competencies such as communication and problem-solving skills, conflict management, contingency contracting, and parenting skills to disrupt maladaptive relational patterns which maintain problem behavior. These skills are not taught as a step-by-step curriculum. Rather, families are coached in using these skills to address day-to-day problems that they mention in therapy sessions. Therapists match the competences and protective factors that they help families develop to family needs. They also help them develop ways of using skills that meet the levels of relational connection and hierarchy that they feel comfortable with.

In the generalization phase, the skills acquired in the behavior change phase are generalized to contexts beyond those involved in the family's initial presenting problems and to anticipated future challenges. Families are supported to apply problem-solving, communication, and conflict management skills learned for addressing adolescent antisocial behavior, to managing other conflictual relationships, for example, with members of the extended family. Relapse prevention, and managing "slips" so they do not snowball into full-blown relapses, is central to the generalization phase of therapy. Future challenges are anticipated and planned for, and other relevant community supports are accessed if necessary. Protective factors and skills developed in the second phase are consolidated. The aim of the generalization phase is for families to stabilize gains made in the second phase and develop a sense of mastery about their capacity to manage novel challenges. In each phase of FFT, therapists alternately assess and intervene to reduce risk factors and build on family strengths and

protective factors, with the overall aim of increasing adolescent prosocial behavior and reducing antisocial behavior.

In FFT, a secure web-based information system – FFT-Care4 – is used to aid clinical decision making and session planning. Each week therapists receive web-based feedback from family members, based on their responses to short measures of symptoms, session impact, and progress. Feedback is presented on a "dashboard" which gives the status of the young person's symptoms, session progress, and family functioning; clinical alerts, for example, running away; and detailed reports showing change in symptoms, therapy impact, and progress of each family member.

FFT is usually provided by teams of 3–8 therapists. Therapists carry caseloads of 12–15 families. Whole family sessions are conducted on a weekly basis. Treatment spans 8–30 sessions over 3–6 months. Sessions are convened in clinic, home, and community locations. To ensure treatment fidelity, therapists are trained and supervised by FFT training organizations. Adherence to the FFT model is assessed regularly in telephone supervision sessions.

FFT is a well-validated, evidence-based, widely disseminated, and strengths-oriented secondary prevention program for adolescent delinquency (Alexander et al., 2013; Hartnett et al., 2017; Robbins et al., 2016; Robbins, & Turner, 2019; Sexton, 2019). It is widely disseminated, supported by over 30 outcome evaluations, and a dozen economic evaluations. There are more than 340 FFT dissemination sites in 12 countries serving more than 50,000 families annually, and independent economic analyses indicated that communities served by these FFT sites save over a billion US dollars annually from avoided incarcerations and four billion US dollars in avoided victim-related costs (Robbins & Turner, 2019).

In a meta-analysis of 14 published and unpublished FFT trials involving over 1600 cases, Hartnett et al. (2017) found that FFT led to significant reductions in antisocial behavior compared with untreated controls and well-defined alternative treatments such as cognitive behavior therapy, other models of family therapy, and individual and group therapy for adolescents. In a systematic review of 27 FFT-published and unpublished clinical trials involving over 2800 cases, Alexander et al. (2013) concluded that FFT is effective in reducing recidivism by up to 70% in adolescent offenders from a variety of ethnic groups over follow-up periods of up to 5 years, compared with those receiving routine or alternative services. It also leads to a reduction in antisocial behavior in siblings of offenders. Other positive outcomes included reduced adolescent substance use and improved adolescent and family adjustment. In a review of large-scale effectiveness studies, Sexton (2016) found that FFT was significantly less expensive per case than juvenile detention or residential treatment and also led to crime and victim cost savings. He also concluded that, in a large-scale effectiveness study, the drop-out rate from functional family therapy was about 10% compared to drop-out rates of 50–70% in routine community treatment of adolescent offenders. A final conclusion was that better outcomes occurred where therapists implemented the FFT model with a high degree of fidelity. Against this backdrop of positive outcome results, it is worth noting that there has been controversy about the methodological quality of reviews of the evidence base for FFT (Robbins & Turner, 2019; Weisman & Montgomery, 2019a, b). My opinion on this controversy is that while there is supportive evidence for the effectiveness of FFT in reducing adolescent antisocial behavior, more well-designed large-scale studies would enhance support for this model.

Multisystemic Therapy

MST was developed at the Medical University of South Carolina by Scott Henggeler and his team initially as a treatment for juvenile delinquency (Henggeler et al., 2009). MST has subsequently been adapted to help families of adolescents with a range of problems including substance use, sexual

offending, severe mental health problems, self-harm, nonadherence to regimes for managing chronic medical conditions including diabetes, asthma, HIV, and obesity, and families at risk of child abuse (Henggeler & Schaeffer, 2019). MST is disseminated by MST services (http://mstservices.com).

Following Bronfenbrenner's (1979) social ecological theory, in MST it is assumed children's psychological problems are affected by a range of risk and protective factors in multiple nested social systems (like Russian dolls). These nested systems include the child, family, peer group, school, medical, social and juvenile justice systems, and neighborhood. In MST, relevant risk and protective factors are assessed in real-world settings (the home, school, and neighborhood) using information from multiple sources (child, parents, teachers, and involved professionals). Interventions involving the child, family, and members of the child's social system are implemented to enhance protective factors and reduce risk factors.

For example, in cases of delinquency the most common factors that maintain adolescents' antisocial behavior are ineffective parenting, deviant peer group membership, and underachievement in school. MST interventions help parents develop effective parenting practices; young people develop skills to avoid deviant peer group membership and engage with prosocial peers; and schools improve the fit between young people's educational needs and the way that they are instructed. Parents are supported to overcome barriers to effective parenting such as substance use and low motivation. The effects of interventions are monitored regularly. Where interventions are ineffective, they are modified until success is achieved. Families are supported to sustain effective interventions to prevent relapse.

In MST, intensive family therapy is combined with individual skills training for adolescents and intervention in the wider school and interagency network. Interventions must fit with the child's social ecology and stage of development and be based on empirically validated pragmatic therapeutic practices. Structural (Minuchin, 1974), strategic (Haley, 1976), and behavioral (Merrill et al., 2019) family therapy interventions are used to enhance family functioning. Systemic consultations are used to enhance co-operative interagency working where professionals from multiple agencies are involved. Individually focused components of treatment programs commonly include cognitive behavior therapy (CBT) to improve self-regulation of anxiety, depression, and impulsivity (Friedberg & McClure, 2015). CBT and social skills training are conducted to enhance adolescents' ability to resist deviant peer group influences and engage with prosocial peers. When required, remedial tuition and study skills training are used to promote academic attainment. Contingency management is incorporated into MST for substance use (Henggeler et al., 2012). Safety planning is incorporated into MST for families at risk for child maltreatment (Swenson & Schaeffer, 2012) and families of adolescents with problem sexual behavior (Borduin et al., 2009) or significant mental health problems such as psychosis and suicidality (Henggeler et al., 2002). For chronic health conditions including diabetes (Ellis et al., 2012), asthma (Naar-King et al., 2014), HIV infection (Letourneau et al., 2013), and obesity (Naar-King et al., 2009), MST incorporates interventions to target barriers to medical treatment adherence.

Clinical practice in MST is individualized to meet the specific needs of particular families. It is guided by nine treatment principles (Henggeler & Schaeffer, 2019). First, therapists assess how presenting problems (and successes) "fit" or make sense within the context of the family and the wider social system. They help adolescents, families, and involved professionals understand how adolescents' problems are maintained by recursive sequences of interaction within the youngster's family and social network. Second, there is a focus on the role of strengths in facilitating positive change and recovery. That is, individual and family strengths are used to develop and implement action plans. Third, interventions are designed to increase responsible behavior of family members. Fourth, interventions help family members identify actions that may be taken to solve clearly defined problems. MST focuses on the present rather than facilitating insight into the past. Fifth, interventions aim to change sequences of behavior of members of the family and social system that maintain presenting

problems. New skills are developed to disrupt problem-maintaining patterns. Sixth, interventions are designed to be appropriate to the developmental needs of the young person. Seventh, interventions are designed to require regular daily or weekly effort leading to rapid change. This provides opportunities for frequent corrective feedback and more success experiences. Adolescents, parents, carers, and young people are supported to follow through on action plans. Eighth, in MST clinicians continuously evaluate intervention effectiveness and accept responsibility for promoting recovery. They do not label families as unmotivated or blame them for not recovering. Ninth, interventions empower family members, especially parents and caregivers, to sustain changes after leaving treatment. Families are encouraged to use newly learned skills and insights to handle new problem situations. These nine MST principles are implemented by following a recursive process of assessment, formulation, intervention development, intervention implementation, and reevaluation to help families achieve treatment goals.

MST is delivered by teams of two to four master's level therapists and a half-time doctoral or advanced master's level supervisor (Henggeler & Schaeffer, 2019). Teams are trained by the MST training organization. MST therapists receive ongoing supervision. Supervisors and therapists have periodic contact with an MST consultant. Treatment fidelity is maintained through the use of treatment and supervision manuals and regular assessment of treatment adherence. Parents or caregivers regularly complete a therapist adherence measure; therapists complete a supervisor adherence measure; and therapists and supervisors complete an MST consultants adherence measure. A web-based platform supports adherence data collection and processing. Multisystemic therapy involves regular, frequent home-based family and individual therapy sessions with additional sessions in school or community settings over 3–6 months. MST is intensive and may involve up to 100 h of direct contact with young people, their families, and members of their wider social system. Therapists carry low caseloads of 4–6 families and provide 24-h, 7-day availability for crisis management.

MST has the largest evidence base of any family therapy model and is one of the most widely disseminated (Henggeler & Schaffer, 2019). Over 50 MST outcome, implementation, and benchmarking studies have been conducted, most by independent investigators. These have yielded more than 100 peer-reviewed articles (http://mstservices.com/files/outcomestudies.pdf). There are more than 500 MST dissemination sites in 16 nations serving more than 20,000 families annually.

In a meta-analysis of 22 international studies involving over 4000 families, van der Stouwe et al. (2014) found that compared with treatment as usual, MST led to small but significant reductions in delinquency, substance use, psychopathology, out-of-home placement, family disorganization, and engagement with antisocial peers. MST was most effective for young Caucasian adolescents under the age of 15, with severe problems and in which treatment led to improvement in parenting skills. The positive effects found in this large meta-analysis by van der Stouwe et al. (2014) were smaller than those found in previous meta-analyses of fewer studies (Curtis et al., 2004, Littell, 2005). These meta-analytic findings are consistent with those from narrative reviews by Henggeler's group which showed that MST had positive effects in multiple domains including delinquency and drug misuse up to 20 years after treatment and led to significant cost saving in placement, juvenile justice, and crime victim costs (Henggeler & Schaeffer, 2016, 2017, 2019). However, Multisystemic Therapy is not more effective than treatment-as-usual in all contexts. In a large UK independent randomized controlled trial involving 684 cases, Fonagy et al. (2020) found that Multisystemic Therapy was no more effective than treatment-as-usual in reducing out-of-home placements of delinquent youth at 18 months or 5 years follow-up.

Randomized controlled trials (RCT) of adaptations of MST have shown that compared with routine services, it is an effective intervention for a number of other problems besides juvenile delinquency. These include the prevention of child maltreatment (Swenson et al., 2010), adolescent substance misuse (Henggeler et al., 2002), adolescent sexual offending (Letourneau et al., 2013), ado-

lescent mental health problems including psychosis and suicidality (Henggeler et al., 1999, 2003; Huey Jr. et al. 2004), and nonadherence to medical regimes for chronic health conditions including diabetes (Ellis et al., 2012), asthma (Naar-King et al., 2014), HIV infection (Letourneau et al., 2013), and obesity (Naar-King et al., 2009).

Substance Use Disorders

Brief Strategic Family Therapy (BSFT; Szapocznik & Hervis, 2020) and Multidimensional Family Therapy (MDFT; Liddle, 2016) are two evidence-based family therapy models that were developed in the 1980s to treat adolescent substance use disorders.

Brief Strategic Family Therapy

BSFT was developed at the Centre for Family Studies at the University of Miami by Josè Szapocznik and his team (Anderson et al., 2019; Szapocznik & Hervis, 2020). It is disseminated by the Family Therapy Training Institute of Miami (https://brief-strategic-family-therapy.com/what-we-do/). BSFT aims to resolve adolescent drug misuse by improving family interactions that are directly related to substance 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. BSFT incorporates principles and clinical practices from structural and strategic family therapy (Haley, 1976; Jackson & Landers, 2020; Minuchin, 1974). The first principle is that families are usefully understood as systems in which the actions of one member affect all members. The second principle is that families engage in repetitive interaction patterns that are linked to adolescent drug use. Therapeutic interventions alter moment-to-moment family interactions to achieve therapeutic change. The third principle is that treatment is problem-focused and planned. Practical interventions are used to promote adaptive interactional patterns and alter maladaptive interactional patterns directly linked to adolescent problem behaviors.

The main techniques used in BSFT are engaging or joining with families, identifying or tracking maladaptive interactions and family strengths, reframing the meaning of family interaction patterns, and restructuring maladaptive family interactions. Validation, which involves showing empathy and respect, is the main technique used to join with each family member. Enactment is one of the main techniques used to track adaptive and maladaptive interaction patterns. During enactments, therapists encourage family members to talk to each other, rather than to the therapist. When the therapist observes repetitive patterns that emerge, they highlight aspects of them. For example, "Is it usually the case that then Mum and Dad talk, Anne interrupts or Jamie distracts them?" When tracking and diagnosing maladaptive interactional patterns, structural family therapy concepts are used, for example, unclear family hierarchies characterized by problematic cross-generational alliances between one parent and one child against another parent; enmeshed or overinvolved relationships; and disengaged relationships. Reframing is used to reduce conflict caused by expression of negative affect. For example, "I hate your drug use and your dirty friends!" may be reframed as "You are concerned for your son. You worry for his future. You are sacred his friends are leading him away from a good future. Tell your son how much you care about his future and how worried you are." Reframing in this way reduces negative affect and maladaptive conflictual interaction patterns. It opens the possibility for developing more adaptive interactional patterns. Restructuring is used to change maladaptive interaction patterns. Where family members typically withdraw from negotiations before a compromise is reached, with restructuring they are encouraged to continue until a compromise is agreed. Where

adolescents have more power than either parent alone, and so each parent finds they cannot effectively set limits, restructuring may be used to help parents form a strong parenting team and jointly set effective limits.

Where there are difficulties engaging with whole families, in BSFT an intervention referred to as strategic engagement is used (Coatsworth et al., 2001; Santisteban et al., 1996; Szapocznik et al., 1988). Therapists work with motivated family members to engage less motivated family members in treatment, or directly contact other family members and invite them to a meeting to address issues that are of concern to them. This latter approach is particularly effective in two scenarios. In the first, one parent (usually the mother) attends therapy and indicates that the other parent (usually the father) would have little to contribute to treatment. In such cases, strategic engagement involves phoning the father, forming an alliance with him in the phone conversation, and respectfully inviting him for a meeting to discuss his concerns about his teenager. In the second scenario, the parents attend therapy, but the adolescent does not. In such cases, strategic engagement involves phoning the adolescent, forming an alliance with them in the phone conversation and respectfully inviting them for a meeting to discuss their concerns about conflict at home, or whatever is their main concern.

BSFT was developed initially for use with minority Hispanic families. It has been disseminated to agencies that provide services to ethnically diverse communities. BSFT typically involves 16 weekly 60–75-min sessions. While it was developed for the treatment of adolescent drug use, it may also be used to address delinquency and conduct problems. BFST is supported by at least six evaluation studies. In thorough reviews of BSFT research, conducted largely in the US, Horigian et al. (2016) and Anderson et al. (2019) concluded that BSFT was effective at engaging and retaining adolescents and their families in treatment, reducing drug misuse, and improving family relationships. Therapist adherence to the BSFT clinical practice model was associated with better outcomes. Better adherence occurred in agencies that supported implementation of BSFT. A systemic model for introducing BSFT into agencies has been developed.

Multidimensional Family Therapy

MDFT was developed by Howard Liddle and his team at the Centre for Treatment Research on Adolescent Drug Abuse at the University of Miami (Liddle, 2002, 2016). It is primarily a treatment for adolescent drug misuse, although it has a positive impact on delinquency, mental health problems, and family functioning. It is disseminated by the MDFT Program (http://www.mdft.org/MDFT-Program/What-is-MDFT)**.**

MDFT is based on systems theory (von Bertalanffy, 1968), family and developmental psychology (Fiese, 2019), and structural and strategic family therapy (Haley, 1976; Jackson & Landers, 2020; Minuchin, 1974). Ten principles guide clinical practice in MDFT (Liddle, 2002). First, adolescent drug misuse and its effective treatment are multidimensional. Drug use is influenced by personal and contextual risk and protective factors. Risk factors may be characteristics of the young person such as emotion regulation difficulties, aspects of their family such as conflict and lack of parenting teamwork, and features of the wider social system, such as membership of a drug using peer group, lack of coordination among involved health and social care agencies, and living in a socioeconomically deprived community. Protective factors may be personal strengths such as academic or athletic ability, family factors such as supportive adolescent-parent relationships, or features of the wider system, such as supportive school placements. In MDFT, the therapist assesses and modifies the balance of risk and protective factors. This involves engagement with the adolescent, parents, other relevant family members, and involved extrafamilial agencies. Second, problem situations or crises provide important assessment information and are also opportunities for clinical intervention. In MDFT, therapists

capitalize on disruption of family routines that occurs during crises, for example, adolescents being arrested or overdosing, which may be platforms for therapeutic changes within the family. Third, therapeutic change is multidetermined and multifaceted. It is determined by multiple factors within the young person, their family, their wider social system, and the therapy process. It involves changes, not only in the young person, but also in their relationships with members of their social network including the family, school, peer group, and involved agencies. Therefore in MDFT, therapists facilitate therapeutic change through multiple pathways toward multiple interrelated goals. Fourth, motivation is malleable. For adolescents, their parents, and members of their wider social systems, receptiveness to engage in therapeutic change waxes and wanes. In MDFT, therapists accept resistance as a normal part of therapy, because adolescents and families find making lasting lifestyle changes challenging. Fifth, outcome-focused working relationships are central to effective treatment. In MDFT, therapists develop these relationships by enquiring about individual and family developmental tasks and articulating relational and life themes that are significant for family members. Sixth, interventions are individualized so as to alter the balance of specific risk and protective factors unique to each case and facilitate the achievement of particular therapy goals, specific to that case. Seventh, case formulations are used flexibly to plan treatment. Formulations and plans are not fixed and may be modified in light of families' responses to interventions. Eighth, treatment is conceptualized by the therapist as consisting of phases, but in practice phases are linked together so clients experience the therapeutic process as continuous. Ninth, therapists are responsible for engaging and motivating clients; assessing families and creating a therapeutic focus; developing, implementing, and evaluating the impact of interventions; and revising ineffective interventions. Tenth, therapists adopt an optimistic outcome-oriented attitude and are advocates for both adolescents and parents.

MDFT is organized into four modules and three stages (Liddle, 2002). MDFT stages refer to practices that occur as families progress through treatment. They include (1) engaging families in treatment and developing a case formulation; (2) prompting families to take action to address substance use and working with family themes central to recovery; and (3) consolidating treatment gains and disengagement. MDFT modules are sets of practices for working with four subsystems of the adolescent's overall social system. These are: (1) the adolescent, (2) the parents and other family members, (3) interactions within the family, and (4) the extrafamilial system, for example, the school, courts, and health and social service agencies. In MDFT, therapists convene periodic whole family therapy sessions and these constitute the family interactions module. Structural and strategic family therapy techniques are used in these sessions. These include joining, relational reframing, enactment, using distress to strengthen motivation, building family strengths, and cultivating optimism. In MDFT, therapists arrange for adolescents to have weekly urinalysis drug screening tests and results of these tests are discussed with the young person and parents in family sessions. Modules with the adolescent and with the parents and other relevant family members prepare them to participate constructively in whole family sessions. In the adolescent module, therapists conduct individual sessions with the young person to engage them in MDFT, identify their goals associated with the developmental transition from childhood to adulthood, and develop self-regulation, communication, and problem-solving skills to help them work toward these goals. Reducing excessive drug use may be identified as an obstacle to achieving valued goals such as performing well at school, work and in sports, and dating. In the module for parents and other relevant family members, therapists work with parents (and those who support parents) to empower them to facilitate the teenager's recovery and to overcome personal obstacles such as depression or interpersonal obstacles such as inefficient parental teamwork that impede progress. The module for parents enhances their feelings of love and commitment toward their teenager and strengthens their capacity to consistently set age-appropriate limits for remaining drug free, attending school, and engaging in prosocial activities. In the extrafamilial module, the focus is on engaging with the school, juvenile justice, health, and social agencies to develop a coordinated

approach to supporting the young person achieve normal developmental goals and reduce substance use. However, the extrafamilial module may also involve case management strategies that support parents and teenagers. For example, helping parents deal with complex bureaucratic procedures for obtaining health, social welfare, and public housing benefits; or organizing transportation for the adolescent to attend job training or self-help programs.

MDFT is delivered and supervised by mental health professionals with at least a master's level qualification. Therapists and dissemination site supervisors are initially trained by MDFT program faculty. Subsequently therapists receive ongoing supervision. Treatment fidelity is maintained through the use of treatment and supervision manuals and regular assessment of treatment adherence. MDFT is conducted over 16–25 one- to two-hour sessions spanning 4–6 months. Treatment sessions may include adolescents, parents, whole families, and involved professionals. Sessions may be held in the clinic, home, school, court, or other relevant agencies. Treatment is intensive. Multiple contacts may occur in a week. Frequent telephone contacts with the adolescent, family members, and members of the extrafamilial system are used to establish and maintain strong working alliances and consolidate work done in face-to-face sessions.

In a meta-analysis of 19 studies (including one very large multi-country European study), van der Pol et al. (2017) found that compared with alternative treatments, MDFT led to small but significant reductions in substance misuse, antisocial behavior, psychopathology, and family disorganization. The effects were greatest for families of adolescents with severe substance use and conduct problems. These meta-analytic results are consistent with those from other meta-analyses and narrative reviews (Filges et al., 2018; Liddle, 2016), notably that of Liddle (2016) who concluded that MDFT has positive short and long-term effects in multiple domains including drug misuse and delinquency and leads to significant cost savings.

Attachment-Based Family Therapy for Depression

ABFT was developed at the University of Philadelphia and Drexel University, Philadelphia, by Guy Diamond and his team, beginning in the late 1990s (Diamond et al., 2014, 2016). ABFT was developed as a treatment for adolescent depression and suicidality. It is disseminated by the Centre for Family Intervention Science at Drexel University (https://drexel.edu/familyintervention/abft-training-program/overview/).

ABFT is based on attachment theory (Bowlby, 1982). In ABFT, it is assumed (without ignoring biological factors) that adolescent depression and suicidality may be caused, maintained, or exacerbated by parent-adolescent interactions that promote attachment insecurity (Diamond et al., 2014). These interactions include conflict, detachment, separation, abandonment, loss, harsh criticism, neglect, and abuse. The negative effect of these family processes on adolescent mood is compounded when parents do not adequately comfort and support their teenagers. This is addressed in ABFT by facilitating supportive parent-adolescent interactions. This corrective attachment experience increases adolescents' attachment security and reduces their depression and suicidality. It helps adolescents experience their parents a safe haven that protects them from challenging life stresses, and a secure base from which to develop autonomy as they move toward adulthood.

ABFT integrates ideas and practices from a number of schools family therapy. From MDFT (Liddle, 2002), it takes the idea that targets for change in family therapy, for example, attachment insecurity, should be research informed. From emotionally focused couple therapy, it takes the idea that emotional processing is central to therapeutic change (Greenberg, 2015). The idea that the reestablishment of trust is essential for family problem-solving is taken from transgenerational family therapy (Boszormenyi-Nagy & Krasner, 2013). From structural family therapy (Minuchin, 1974),

ABFT takes the practice of enactment as particularly impactful procedure for facilitating the development of positive relational patterns.

In ABFT there are five therapeutic tasks which facilitate repairing parent-adolescent attachment ruptures (Diamond et al., 2014). The first task is relational reframing and occurs in the first session. The family is helped to understand that the young person's depression and suicidality is most usefully conceptualized as a relationship problem involving the parents and the adolescent. When the young person needs comfort and support from their parents, they are unable to effectively elicit it. Also, the parents have difficulty recognizing and responding to the adolescents' unmet attachment needs. The therapist helps family members to access their longing for greater closeness and agree to rebuild trust during therapy so that greater closeness will be possible. Building an alliance with the adolescent is the second task and spans two to four sessions. In individual sessions with the adolescent, the therapist helps them to identify and articulate their experiences of their parents' failure to meet their attachment needs and commit to discussing their unmet attachment needs with their parents in conjoint family sessions. Building an alliance with the parents is the third task and spans two to four sessions. Parents are encouraged to consider how their family-of-origin experiences have affected their parenting style, and the difficulty they have in identifying and meeting their adolescent's attachment needs. This leads to them developing greater empathy for their adolescent's experiences. Repairing attachment is the fourth task and the task which is central to the effectiveness of ABFT in alleviating adolescent depression. This task may span one to four sessions. When adolescents and parents are ready, in conjoint family sessions, the therapist facilitates a series of discussions between them about the adolescents concerns. In enactments, adolescents articulate their unfulfilled attachment needs. Therapists help them to express feelings of sadness, hurt, and loss to their parents. These primary emotions are often masked by secondary emotion, especially anger. Therapists encourage expression of primary, but not secondary emotions. In response, parents are guided by therapists to empathize with their adolescent, as they become more willing to consider their own contributions to family conflict. Although the adolescent-parent attachment insecurity may not be fully resolved during enactments, this respectful and emotional dialogue between adolescents and parents is usually a "corrective attachment experience" that increases the adolescent's trust in that their parents will meet their attachment needs in future. The fifth ABFT task is promoting autonomy and may span one to ten sessions. As the parent-adolescent relationship becomes closer and more supportive, adolescents are encouraged to engage in prosocial activities at school, work, sports, and hobbies that will give them a sense of increasing autonomy. They may also be encouraged to discuss other factors contributing to their depression such as divorce or bullying and identity formation topics such as race, sexual identity, and religion. Parents are helped to serve as the secure base and safe haven from which their teenager can receive comfort, advice, support, and encouragement as they explore these new opportunities and issues.

In a narrative review, Diamond et al. (2016) concluded that a series of five Non-unit numbers (from "one" to "ten") should be spelled out in the text outcome studies and a number of process studies supported the efficacy and effectiveness of ABFT for adolescent depression in suicidality. Most participants in these studies were of low socioeconomic status and African American ethnicity. Compared with waitlist-control groups and treatment as usual, ABFT led to significant reductions in depression and/or suicidal ideation, with gains maintained at 6 months follow-up.

Cognitive Behavioral Family Therapy for Anxiety

Cognitive behavioral family therapy (CBFT) is an umbrella term for clinical practice models in which the principles of CBT are used to inform family-based treatment of clinical problems (Dattilio, 2009; Lan & Sher, 2019). A large number of CBFT clinical practice models have been developed to treat a

very wide range of clinical problems across the lifespan. There are CBFT approaches for most externalizing and internalizing behavior child and adolescent problems. In this section the focus will be on CBFT for disorders where anxiety is a central feature. These include separation anxiety, selective mutism, phobias, social anxiety disorder, generalized anxiety disorder, obsessive compulsive disorder, and posttraumatic stress disorder. All are characterized by excessive fear of particular internal experiences or external situations and avoidance of these anxiety-provoking stimuli. In CBFT, it is assumed that the child's behavioral avoidance of external anxiety-provoking stimuli; suppression of anxiety-provoking memories, thoughts, and feelings; and threat-amplifying negative automatic thoughts, assumptions, beliefs, and cognitive distortions maintain anxiety. However, this behavioral and experiential avoidance and threat-amplifying cognition are maintained by parents' or other caregivers' inadvertent reinforcement of the child's avoidance and threat-related cognition (Norman et al., 2015). A central treatment strategy of CBFT for childhood anxiety disorders is to encourage parents and other caregivers to stop inadvertently reinforcing avoidance and threat-amplifying cognition; and instead to reinforce the child for approaching feared stimuli and engaging in threat-reducing cognition and coping (Wood & McLeod, 2008; Rapee et al., 2008). In a large study of synthesized individual case data from 18 separate trials, Manassis et al. (2014) found that CBFT in which parents were helped to use contingency management to reinforce children's "brave behavior" for coping with exposure to anxiety-provoking stimuli was particularly effective in helping young people maintain treatment gains a year after treatment had ended. This type of CBFT was significantly more effective in the long-term, than CBT where parents had limited involvement, or where they had extensive involvement which did not require them to use contingency management to reinforce children's "brave behavior."

In CBFT for child and adolescent anxiety disorders, a range of formats are used. However, the following features are common to most programs. Children and parents attend preliminary assessment sessions and periodic conjoint treatment sessions, as well as parallel sessions for children and parents. Children attend individual or group sessions with other children who have anxiety disorders to learn CBT anxiety management and coping skills; develop hierarchies of anxiety-provoking stimuli; and engage in exposure to these while using anxiety management and coping skills to tolerate distress during exposure tasks. Concurrently, parents attend individual or group psychoeducation sessions about CBT for child and adolescent anxiety and their role in promoting their child's recovery. Conjoint family sessions are held in which therapists help parents and children practice and plan to use contingency management to reinforce children's "brave behavior" when exposed to increasingly anxiety-provoking stimuli.

In CBFT, the classes of stimuli to which children are exposed depend on their particular anxiety disorder. The use of CBFT to effectively treat a range of anxiety disorders is supported by a growing body of evidence. For separation anxiety with school refusal, school reentry and attendance are reinforced (Maynard et al., 2018). For selective mutism, speaking in the presence of adults in school is the treatment target (Zakszeski & DuPaul, 2017). For generalized anxiety, parents may reinforce exposure to multiple targets and also engaging in planned periods of worry, where children fear they have lost control of the worrying process (Kolomeyer & Renk, 2016). For OCD, parents reinforce children for engaging in exposure and response prevention activities (McGrath & Abbott, 2019). That is, exposure to cues that elicit obsessional anxiety and prevention of compulsive rituals which reduce anxiety. For PTSD, parents reinforce young people for engaging in exposure to trauma-related cues, while not suppressing traumatic memories (Lenz & Hollenbaugh, 2015). Trauma-focused CBFT also involves helping young people process traumatic memories and, in cases of child abuse, developing safety skills and more supportive relationships with the non-abusing parent (Cohen et al., 2017).

Family-Based Therapy for Eating Disorders

Family-based treatment (FBT) is a contemporary family therapy model for treatment of adolescent anorexia nervosa, bulimia nervosa, and other eating disorders (Le Grange and Lock 2007; Lock & Le Grange, 2005, 2013; Loeb et al., 2015). The manuals for the model, developed and written by James Lock at Stanford University and Daniel Le Grange at Chicago University in the 1990s and 2000s, are based on the Maudsley model (Eisler et al., 2016), developed in the UK in the 1980s, which was inspired by the structural family therapy model (Minuchin et al., 1978) developed at the Philadelphia Child Guidance Clinic in the 1970s. FBT is disseminated by the Training Institute for Child and Adolescent Eating Disorders (http://train2treat4ed.com).

FBT is an intensive outpatient family therapy program for adolescents under 16 with anorexia or bulimia that has not persisted for more than 3 years. In FBT, the family of the adolescent with an eating disorder is viewed primarily as a treatment resource for promoting recovery. In FBT, parents are helped to restore their child's weight or eating pattern to normal, hand control over eating back to their teenager, and encourage normal adolescent development. FBT has three clearly defined phases spanning 15–20 sessions over 12 months (Le Grange & Lock, 2007; Lock & Le Grange, 2013).

The aim of the first phase is to establish a strong positive working alliance with all family members and to maximize the parents' motivation to cooperate with refeeding the young person if they have anorexia, or normalizing their eating pattern if they have bulimia. This is done by raising parents' anxiety about the medical risks associated with the child's condition, e.g., cardiac dysfunction, and the efficacy of FBT in helping adolescents recover from eating disorders. The therapist externalizes the eating disorder, framing it as a condition that the whole family (including the patient, siblings, and parents) will have to work together to overcome, and commits to supporting the parents in their joint attempt to restore their adolescent's weight. In cases of anorexia nervosa, the therapist invites the family to have a meal during a therapy session in the first phase of FBT. This allows the therapist to observe the family's typical interaction patterns around eating and provides the therapist with an opportunity to support the parents as they encourage their adolescent to eat a little more than they were prepared to. The therapist helps the parents adopt a noncritical attitude and express sympathy and understanding concerning the adolescent's ambivalence about recovering from their eating disorder, while at the same time insisting that starvation is not an option. The therapist models this noncritical attitude toward the adolescent by expressing support and empathy for their predicament of entanglement with the eating disorder that they are trying to overcome. The first phase of FBT typically spans about 10 weekly sessions. During weight restoration, the adolescent stays at home from school, and parents create a rotational system so that one of them is at home supervising the young person throughout the weight gain program and preventing vomiting, laxative use, overexercising, and binging in the case of bulimia.

There is a transition to the second phase of treatment when the adolescent accepts the parental request for increased food intake and achieves a target weight of 90% of the expected weight for their age, height, and gender or, in the case of bulimia, demonstrates an ability to avoid dieting, binging, and purging. This is accompanied by an improvement in family mood associated with relief at parents having taken charge of the eating disorder. In the second treatment phase, parents are encouraged to help their teenager to take more control over eating so that by the end of the second phase adolescents are fully responsible for their own eating and weight. In early sessions of this phase, there is discussion about how parents can support the adolescent to develop autonomous control of their eating. There is also discussion of adolescent eating in multiple contexts including the home, at school, with peers, and when dating romantic partners. The second phase typically spans 6 sessions spaced at 2–3 weekly intervals. Eating disorders constitute an interruption of normal adolescent development. In the first phase of FBT, normal adolescent physical development is resumed with the normalization

of eating, weight, and other bodily functions such as menstruation. During the second phase, normal adolescent social development is resumed. The family is invited to support the adolescent in returning to school, socializing with friends, and dating.

Transition to the third phase of FBT occurs when the adolescent reaches 95–100% of normal body weight, efforts at self-starvation or dieting, binging, and purging have abated, and the adolescent has achieved autonomous control of their eating and weight. The aim of this phase is to help the adolescent develop a healthy identity and facilitate disengagement from treatment. The therapist helps the family review progress; make relapse prevention plans; and support normal adolescent development. The third phase typically spans 4 sessions spaced 4–6 weeks apart.

Schlegl et al. conducted a systematic review of FBT for anorexia and bulimia nervosa in adolescence. In five RCTs involving 560 cases of anorexia nervosa, remission rates were 21–42% at posttreatment and 29–49% at 12-month follow-up. In two RCTs involving 210 cases of bulimia nervosa, remission rates were 39% at posttreatment and 49% at 1 year follow-up. Richards et al. (2018) reviewed a number of augmentative versions of FBT that have been developed to meet the needs of cases judged to require more or less intensive treatment, more accessible treatment, or a format appropriate for families in which a high level of criticism was directed toward the adolescent, as this is associated with poorer outcome. In these versions of FBT, the duration of sessions and the overall program were modified (e.g., fewer more intensive day-long sessions, larger or smaller number of contact hours); additional components were added (e.g., individual or group psychotherapy, CBT, or dialectical behavior therapy for adolescents, or training sessions for parents); a format other than outpatient treatment was used (e.g., teletherapy, multifamily therapy, or partial inpatient therapy with additional multidisciplinary health care); or parents and adolescents were invited to separate sessions. In a review of 30 studies of augmentative FBT approaches for anorexia and other restrictive eating disorders, Richards et al. (2018) found that all reported significant posttreatment improvements in weight and eating disorder symptoms. In nine comparative studies, augmentative FBT approaches were at least as effective as standard FBT for anorexia and other anorexia-like restrictive eating disorders.

Psychoeducational Family Therapy for Psychosis

Psychoeducational family therapy (PFT) for psychotic disorders refers to a collection of practice models in which families of people with psychosis are engaged in multimodal treatment programs that include both antipsychotic medication and family therapy to facilitate the recovery of the person with psychosis (Day & Petrakis, 2017; McFarlane, 2016). The development of PFT was informed by research which showed that high levels of negative expressed emotions including criticism, hostility, and over-involvement among family members of people with psychosis contributed to relapse (Amaresha & Venkatasubramanian, 2012; Butzlaff & Hooley, 1998). High levels of negative expressed emotion are typically elicited by psychotic symptoms such as delusions, hallucinations, disorganization, and impaired motivation, which family members find aversive. They may attribute these symptoms to the psychotic person being "lazy," "crazy," "dangerous," or "disabled." One of the aims of PFT, therefore, is to help family members reduce their expression of negative emotions, and in doing so prevent or delay relapse.

In PFT, the expression of negative emotions is reduced by helping families understand psychosis as a condition that arises when vulnerable individuals are exposed to life events, ongoing relationships, or situations that they appraise as stressful, threatening, or overly demanding. PFT also helps family members understand how to facilitate recovery by supporting the person with psychosis. This support involves communicating simply, clearly, and respectfully with the person with psychosis in a

low-key way that takes account of the cognitive constraints and emotional vulnerability associated with psychosis. It involves taking a systematic approach to problem-solving to address challenges that arise in the day-to-day life of the person with psychosis. Support may be offered by family members prompting the person with psychosis to adhere to their medication regime, to use effective coping strategies for managing stress and symptoms, and to follow relapse prevention plans in risky situations. Family members may also offer support by helping the person with psychosis establish a meaningful social and occupational role in life that takes account of their wishes, strengths, and vulnerabilities.

PFT may be offered in multiple formats. Single families may be treated in a series of conjoint family therapy sessions (Falloon et al., 1984; Kuipers et al., 2002). Groups of four to seven families may be treated in multifamily therapy attended by all family members (McFarlane, 2002). Alternatively, young people with psychosis and their parents may be treated in parallel groups. PFT integrates ideas and practices from many schools of family therapy, notably CBFT (Dattilio, 2009) and structural family therapy (Minuchin, 1974). PFT typically spans 9–12 months. It is usually offered in a phased format with initial sessions occurring more frequently than later sessions and crisis intervention as required. Early sessions focus on engagement of families in treatment and establishing a collaborative partnership with family members. Families are offered psychoeducation based on stress-vulnerability or bio-psycho-social models of psychosis. This provides a rationale for the central role of family support for the young person's recovery. It also provides a rationale for family skills training which occurs in the middle phase of treatment. Families are helped to refine their communication, problem-solving, coping, and medication management skills. Skills training commonly involves modeling, rehearsal, feedback, and discussion. In PFT, an emphasis is placed on blame-reduction and the importance of families building social networks to support the parents and the young person with psychosis. In the final phase of PFT, the recovery process is reviewed and relapse prevention or crisis management plans are developed. Throughout PFT, there is an opportunity to address issues such as loss and stigma associated with psychosis.

Reviews and meta-analyses of over a dozen controlled trials of PFT for psychosis in adolescence or young people at risk of psychosis lead to the following conclusions (Bird et al., 2010; Claxton et al., 2017; Day & Petrakis, 2017; Ma et al., 2018; McFarlane et al. 2012, 2016; Onwumere et al., 2011). Combining antipsychotic medication with PFT leads to significantly better outcomes than routine treatment with antipsychotic medication. For young people, better outcomes include a reduction in psychotic symptoms and relapse rates. For family members, better outcomes include improvement in carer well-being, reduction in carer burden, and reduction in patient-directed negative expressed emotion, particularly criticism and hostility. The reduction in patient-directed criticism and conflict may lead to young people experiencing less stress or more support, and this may facilitate recovery. Compared with single family therapy, multifamily psychoeducational therapy may be particularly effective, possibly because it provides families with a forum within which to experience mutual support, shared learning, and a reduced sense of isolation and stigmatization. PFT is more cost effective than treatment as usual, because it led to reduced use of medical care services. Models of PFT have been developed for other disorders, notably bipolar disorder (Miklowitz, 2008; Miklowitz & Chung, 2016).

Closing Comments

Evidence-based family therapy is recommended in many best practice guidelines for the treatment of child and adolescent disorders covered in this chapter (Kreyenbuhl et al., 2010; Hilbert et al., 2017; NICE, 2007, 2013a, b, c). Family therapy is an effective clinical intervention for a wide range of common child and adolescent difficulties and disorders not covered in this chapter (Carr, 2019). These

include, for example, somatization disorders (Hulgaard et al., 2019), child maltreatment (Kolko & Swenson, 2002; Rynyon & Deblinger, 2013), adjustment to chronic medical conditions (Pratt et al., 2020), and addressing problems associated with autism spectrum disorders/conditions (Patrini 2021). The central strength of family therapy is that it provides a conceptual and clinical framework for drawing on the family as a resource in treating children's problems.

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