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Integrating family work into the treatment of young people with severe and complex depression: a developmentally focused model

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## Abstract

**Aim:** While models of family intervention are clearly articulated in the child and early-adolescent literature, there is less clarity regarding family intervention approaches in later-adolescence and emerging adulthood.

**Methods:** This paper provides the rationale and intervention framework for a developmentally sensitive model of time-limited family work in the outpatient treatment of complex youth depression (15-25 years).

**Results:** Derived from current practice in the Youth Mood Clinic (YMC) at Orygen Youth Health, Melbourne, a stepped model of family intervention is discussed. YMC aims to provide comprehensive orientation, assessment and education to all families. For some, a family-based intervention, delivered either by the treating team or through the integration of a specialist family worker, offers an important adjunct in supporting the recovery of the young person. Developmental phases and challenges experienced by the young person with respect to family/caregiver involvement are discussed in the context of two case studies.

**Conclusions:** A developmentally sensitive model is presented with particular attention to the developmental needs and preferences of young people. Formal evaluation of this model is required. Evaluation perspectives should include young people, caregivers, the broader family system (i.e., siblings) and the treating team (i.e., case manager, doctor, family worker) incorporating outcome measurement. Such work will determine how best to apply a time-limited family-based intervention approach in strengthening family/caregiver relationships as part of the young person's recovery from severe and complex depression.

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The treatment of young people presenting with severe and complex depression – characterised by symptomology, suicidality, past treatment failures, and comorbidity – typically requires the involvement of family or caregivers. This article presents a model for integrating families and caregivers into time-limited treatment, based on current practice at the Youth Mood Clinic (YMC), a specialist stream within Orygen Youth Health, a tertiary youth mental health service in North Western Melbourne for young people aged 15-25. The intake criteria for YMC reflect complex depression, that is, either moderate-to-severe major depressive disorder (with a Patient Health Questionnaire<sup>(1)</sup> [PHQ-9] score  $\geq 15$ ) or non-psychotic bipolar disorder, plus suicide risk (i.e., a recent attempt or significant ongoing ideation). ***Treatment of complex depression and rationale for family work***

Young people accepted for treatment with YMC typically present with complex mental health needs, and multi-morbidity is common. Frequently co-occurring conditions include anxiety disorders, autism spectrum disorders, personality, eating, and substance use disorders. The YMC treatment model<sup>(2-4)</sup> provides specialist multidisciplinary, time-limited treatment (typically six months). Treatment is primarily delivered on an outpatient basis and includes weekly sessions of evidence-based psychotherapy<sup>(5)</sup> (i.e., cognitive behavioural therapy, interpersonal therapy) and integrated case management, regular psychiatric review, access to a group-based psychosocial recovery program<sup>(6)</sup>, integrated after-hours crisis care and brief inpatient treatment when needed. Referrals to the clinic are received from health practitioners, families and caregivers, the education sector, or out-of-home care sector.

As a tertiary mental health service, most YMC clients have a history of failed mental health treatment or incomplete response. Given the heritability of mood disorders and the

impact of intergenerational transmission of mood dysregulation<sup>(7)</sup>, a high proportion of YMC clients have a significant family history of mental ill health. While YMC clients share common features (i.e., diagnosis, clinical risk) heterogeneity in symptom presentation requires a flexible treatment model. It is common that YMC clients have substantial relational<sup>(8)</sup> or familial functioning<sup>(9)</sup> problems that precipitate or perpetuate their symptoms, or inhibit treatment progress. Initial assessment includes an appreciation of family of origin, ideally from a multigenerational perspective, informing an understanding of early working models that may influence current relationship patterns. This assessment also looks to determine resources and opportunities within the broader family or caregiver system to support the young person's recovery.

Given the critical importance of families and caregivers in facilitating and supporting psychotherapeutic intervention with young people, their involvement is seen as an important component of treatment<sup>(10)</sup>. While many young people live at home, almost all will have significant and ongoing contact with family. As a youth-specific mental health service, involving families in appropriate and meaningful ways is core to the work. Where done constructively and helpfully, such involvement is likely to improve engagement and outcomes for young people<sup>(11)</sup> as families and caregivers that feel confident in their skills and ability to support their young person are more likely to do so.

### ***Current practice gap***

The years from mid-adolescence to emerging adulthood are noticeably distinct from other developmental stages (i.e., childhood and adulthood)<sup>(12, 13)</sup>. Developmental challenges between mid-adolescence and emerging adulthood relate to forming a cohesive sense of self

(identity formation), establishment of independence and autonomy, and development of close relationships with and across gender. In comparison to childhood and adolescence, symptom presentation in young people (15-25 years) tends to take a more severe trajectory, with a higher likelihood of suicidal ideation, plan, and attempt<sup>(14)</sup>, significant risk-taking behaviour<sup>(15)</sup>, or comorbid substance use<sup>(16)</sup>. As such, existing models of family intervention, based on a child and adolescent framework<sup>(17, 18)</sup> are unlikely to be suitable for those in the age range of 15-25 years. As the youth mental health early intervention model increasingly expands worldwide<sup>(19)</sup>, there is a need to establish family-based practices that are developmentally appropriate and effective.

During the years of mid-adolescence to emerging adulthood there are typically significant transitions for families in terms of structure, membership, and roles. During this transition period, changes may not always occur smoothly, and may be the result of major shifts in autonomy, or a reaction to stressors demanding adaptation<sup>(20)</sup>. The family system is left to deal with these developmental tasks and/or unforeseen problems. From a family life cycle perspective<sup>(21)</sup>, there is a need for increasingly flexible boundaries and a move towards the development of adult-to-adult relationships between young people (emerging adults) and their parents. It is incumbent on those involved in the provision of treatment to young people to acknowledge young peoples' individuation by seeking consent for family contact and prioritising client confidentiality (see below), notwithstanding issues of duty of care, throughout treatment.

### *Theoretical considerations*

Historically, family therapy literature has conceptualised psychological problems as being embedded and sustained in systems wider than an individual, with symptoms occurring within the context of social interactions<sup>(22)</sup>. Such models assert that families should be viewed as active change agents, and as competent (or potentially competent) partners in the young person's recovery process<sup>(23)</sup>. Communication patterns within families can serve to buffer against, or perpetuate depression and/or suicidality, hence the need for a family-mediated interpersonal perspective<sup>(24)</sup>. In instances where there is excessive emotional distance and disengagement within the family system, strengthening the relational bonds between caregivers and the symptomatic young person can serve to create a protective and secure base for subsequent development in later adolescence or emerging adulthood<sup>(25)</sup>.

In order to facilitate reparative attachment experiences, family-based interventions may integrate aspects of emotion focussed, or emotion coaching approaches, where caregivers focus on enhancing their emotional attunement. In instances of enmeshment within families, emphasis may focus on facilitating the autonomous development of the symptomatic young person, enabling them to develop their own feelings, preferences and sense of self<sup>(26)</sup>. Greater awareness, expression and self-management of caregiver emotions, through emotion-focussed communication, may assist the young person to develop a more competent and adaptive internal dialogue about their emotional experience, aiding in the regulation of emotion and behaviour<sup>(27)</sup>. The automatic reactions to, and expression, understanding and regulation of emotional states in caregivers is typically informed by their own family of origin experiences<sup>(28)</sup>, and acknowledgment and awareness of these experiences may be beneficial for the family system. Finally, family work for young people

with complex depression is likely to be distinct from that undertaken in non-affective disorders given the specific focus on suicidality and emphasis on family collaboration and involvement with safety planning<sup>(25)</sup>.

The background model underpinning family work in YMC draws on contemporary family therapy, which is predominantly integrative, combining elements of structural and systems therapies. While the best type and format of family-based intervention for first-episode mental illness remains unclear<sup>(29)</sup> the YMC approach provides a hierarchical, stepped spectrum of family services and options<sup>(30, 31)</sup> designed meet the ranging needs of families.

### **Levels of Intervention**

The YMC stepped intervention approach<sup>(32, 33)</sup> is designed to respect the needs and preferences of the young person and their family/caregivers, and the various service responses associated with these needs<sup>(34)</sup> (See Figure 1). This approach broadly covers 3 levels of intervention; universal service, service provided to most families/caregivers, and service provided to some families/caregivers. Though beyond the scope of the resources available within YMC, some families may also be referred on to external services for more formal, longer-term family therapy.

*Insert Figure 1 here*

**Figure 1:** Levels of family support and intervention<sup>(32)</sup>***Universal Service***

YMC aims to provide comprehensive support to all families/caregivers. All families receive information about the service, provided verbally and in written format. This includes an outline of the aims of the clinic, treatment modalities used, expected course of treatment, and psychoeducation regarding depression and other comorbidity with a particular focus on recovery, and eventually, relapse prevention. Contact with families at key points is also emphasised including; intake, review, safety planning and discharge.

Information is gathered from an assessment perspective. In addition to collateral information regarding the young person and detailed family history, assessment also includes identifying skills and resources of the family/caregiver in supporting the young person in their care. This may uncover information or additional supports that may benefit the family. For some families/caregivers, the path to accessing support for their young person may have been challenging and protracted, and clinicians having an understanding of the journey to service can be helpful in forming a positive alliance.

Families/caregivers should be involved in establishing a shared formulation or explanatory model of their young person's difficulties. This collaboration aids in cohesive treatment and promotes recovery as shared understanding, likely to enhance family/caregiver confidence and support for treatment.

***Service provided to most***

Most families/caregivers will be involved in regular meetings with the treating team to maintain open communication, problem solve challenges to recovery and to monitor progress. The format for this may vary based on the needs of the family/caregiver and include a mix of in-person and phone contact. While this level of intervention is recommended for all families/caregivers, engagement cannot always be achieved. As much as possible, barriers to family or caregiver involvement are addressed. This may include flexibility in appointment scheduling, provision of certificates of attendance regarding carers leave, and exploring longstanding patterns of avoidance or anxiety for parents or caregivers.

### ***Family peer support***

Given the demands of caring for a young person with complex depression, contact with a Family Peer Support service is also strongly encouraged to facilitate emotional support, and provide specific information to the family/caregiver in their own right<sup>(35)</sup>. Such models of family-centred care and peer-to-peer contact are associated with improved outcomes, including efficient use of services, satisfaction, and improved family functioning<sup>(36)</sup>. While all families are informed of the family peer support service at orientation, YMC specifically refers families who may benefit (i.e., those with few other supports, or those who are particularly distressed). The family peer support program at Orygen Youth Health enables families and caregivers to access peer support from recent carers of young people who have sought treatment for mental ill health. This support is offered by phone, or face-to-face, and includes caregivers having access to a family resource room<sup>(37)</sup>. While family peer support workers are not mental health clinicians, they receive training and ongoing supervision from experienced clinicians<sup>(29)</sup>. The family peer support

workers offer general support and reassurance to families and caregivers experiencing similar challenges based on their own experiences of having a relative with a mental illness. The family peer support program is designed to be friendly and supportive, with family peer support workers freely sharing their own experiences as parents and carers, helping caregivers to normalise anxieties and uncertainty, and providing mentorship from one caregiver to another<sup>(35, 38)</sup>. Family peer support workers may suggest other services including carer respite and ongoing carer support groups.

***Case study 1: Cara***

*Cara, 16 years old, was referred with symptoms of depression, suicidal ideation, and ongoing superficial self-harm (i.e., cutting) of her forearms. She was frustrated that her parents and teachers were so concerned about her self-harm, which she considered normal for people her age. She said that her parents were “driving her crazy” with all the checking-up on her. Cara’s parents told the therapist that they no longer trusted Cara, and were worried her self-harm would quickly escalate into attempting suicide. The therapist appreciated how anxious and alone Cara’s parents felt, and referred them for family peer support.*

*The therapist initially empathised with Cara, agreeing that having people check up on her must be really annoying. After acknowledging Cara’s world view in this way, her therapist gently and off-handedly put it to her that any good parent would be concerned if their child was engaging in self-harm behaviour. She then asked Cara what she thought the minimum change in her behaviour might be for her parents and teachers to “get off her back”. With Cara’s assent, the therapist initially met with her*

*parents to discuss the cause and function of self-harm, distinguishing it from a suicide attempt. At this meeting the therapist shared their observation that both parents seemed calmer than at the initial appointment – to which they attributed to the opportunity to talk with a fellow parent through family peer support, who had experienced similar concerns with their 18-year-old son.*

*Over a series of relatively brief phone calls between Cara's parents and the therapist, the therapist negotiated that Cara would let them know when she was upset, rather than just retreating to her room. Cara and her therapist focussed their next sessions on understanding emotions, affect regulation, and self-soothing, and over time Cara slowly reduced the frequency and intensity of self-harming behaviours. Cara's parents developed confidence that she was able to keep herself safe gradually, and they were able to demonstrate this by leaving her alone for longer time periods. A similar approach was subsequently used to address Cara's remaining depressive symptoms so that her parents would stop "sending her for treatment".*

### ***Service provided to some***

For some families, a time limited, family-based intervention may be indicated. This is assessed on a case by case basis. Primary indications are ongoing difficulties in family relationships, communication styles that the young person believes may be impacting on their recovery, and/or, family/caregiver contact with the service that exceeds available service resources. Family-based interventions may be delivered by the treating team (i.e., case manager and doctor). However, a specialist family worker may be allocated in instances where it is considered that the therapeutic alliance with the young person may be

compromised, or where the addition of a family based intervention is beyond the resources of the treating team. If this is the case, the specialist family worker collaborates closely with the case manager regarding the focus and planning of family work, and overall progress of the young person. Where possible, all key people in the family/caregiver relationship are encouraged to attend family work sessions. This may include both parents/guardians, and also siblings, grandparents or extended family members, depending on cultural and developmental considerations. Family structure and key supports will vary from family to family.

Sessions for family based intervention are contracted with the family/caregivers. At the conclusion of the initial family work session there is allocated time for reflection, and then an additional 2-sessions are typically contracted. At the conclusion of the initial three sessions, progress is reviewed and a further 3 sessions may be considered. Subsequent booster sessions may be scheduled by agreement. Although more intensive models of family intervention exist<sup>(39)</sup>, due to limited resources, specialist family workers can only provide time-limited support. However, even brief support can commence the process of adaptive change within the family system regarding relational or communication patterns<sup>(31, 40)</sup>. The young person may, or may not be involved in some or all of the family-based sessions, and this is determined on a case by case basis. In such cases, it is important to establish prior agreement with the young person regarding matters to be discussed and not discussed, and a plan established prior to the session for managing potential distress that may arise.

### **Intervention Considerations**

#### ***Developmental influences***

Consent for family involvement and information sharing is sought from the young person. This is an essential component of maintaining the young person's trust, empowering them, and validating their decisional capacity<sup>(41, 42)</sup>. In practice, this conversation may need to be revisited if the client initially refuses family contact, often with subsequent negotiation and agreement regarding the extent and nature of any parental contact. When on occasion a young person maintains their resistance to involvement of the family, this should be respected. However, such a decision does not necessarily mean an end to the discussion about how better understanding the young person's family might help in recovery. In fact, such resistance to family involvement is usually a potent signal that family relationships are likely to be particularly important.

An open discussion regarding limits of what can and cannot be passed on to family members is required. For example, the young person might want sensitive issues such as drug use and sexuality to be withheld. The limits of confidentiality need also to be discussed, such that the young person knows that their parents are likely to be informed of significant concerns that the clinician has about acute suicide risk. A flexible approach to family work is used, depending on identified needs, and this can be delivered in different formats (i.e., phone contact, in-person sessions with the young person being given a choice of whether to be present or not).

Attention to developmental considerations of the client is essential. For younger clients (i.e., 15-17 years), key developmental issues typically include individuation, boundary negotiation and associated conflict. Given parent-child conflict is a common precipitant of depression and suicidality in younger adolescents<sup>(43)</sup>, working with caregivers to improve

validation, interpersonal and communication skills<sup>(44)</sup> or collaborative problem solving skills<sup>(45)</sup>, may assist in defusing general conflict, setting appropriate boundaries and enhancing opportunities for family connectedness (i.e., shared activities). Distinct family dynamics tend to occur for older YMC clients (i.e., 18-25 years) as they move towards experiencing major role transitions (i.e., completion of secondary education, career planning) and relational maturity (i.e., accepting responsibility for actions, redefining relationship with parents as equal adults)<sup>(46)</sup>. Given this, the nature of family work differs for emerging adult clients. For example, in instances of longstanding parent-child conflict, emerging adult clients may have moved out of the family home at a relatively young age.

### ***Scene setting and goals***

Where possible, family work with YMC includes assessing the impact of the presenting problem on the family, each family member as an individual, and the relationships between all family members. It may be useful to assess the impact of family relationships and dynamics on the problem<sup>(47)</sup>, and to support to develop and enhance protective and supportive ways of relating. All family work undertaken at YMC is recovery/goal oriented, whether it is undertaken by the treating team or a separate clinician. Goals may include improving shared understanding of the young person's symptoms and treatment needs, decreasing parental anxiety, improving adaptive communication patterns or expressed emotion (i.e., communication skills training) and enhancing problem solving skills within the family system. Goals may be framed relationally (rather than behaviourally), and a useful question

to pose may be “*What will be different for each of you, and in your relationship with each other, if mum has a better understanding of your symptoms?*”

There may be a need to explore low expectations, learned helplessness, fear of being blamed, or feelings of guilt with families and caregivers, and how these may impact on the treatment progress of their young person. Given the challenges faced, families and caregivers may feel under significant pressures and regularly have their own complex needs (i.e., having multiple family members of different generations they are caring for, past experiences of feeling blamed by services, or adapting to stages of change in the family life cycle<sup>(21)</sup>). Alternatively, families may believe that they need to advocate loudly or assertively in order to receive support from services.

### ***Session structure***

A psychologically safe environment must be provided, considering the emotional needs of all parties. Setting an agenda and session ground rules (respectful communication, an emphasis on listening) can assist in this process, and the session should be facilitated in such a way to avoid parties assigning blame. As indicated above, a recovery/goal oriented approach is taken. It may be necessary to ‘check-in’ with attendees throughout the session, mindful to each individual’s window of tolerance for strong emotions. All attendees should be given opportunity to contribute to the session, and the therapist may need to be appropriately assertive to ensure this is the case. Throughout sessions it is important to reemphasise the significant role of family and caregivers at all stages in the recovery process. This can be facilitated by reinforcing efforts to change within the system, acknowledging successful attempts of enacting changes, and collaborative problem solving regarding ways to

overcome barriers to change. Towards the conclusion of each family work session, there is typically a focus on gathering agreement from those present regarding action plans (i.e., homework tasks) to enable the implementation of new ideas and skills between sessions<sup>(32)</sup>.

### ***Case study 2: Robert***

*21-year-old Robert presented with affective instability, a history of anger outbursts, unemployment and an unclear vocational pathway. Over the previous 8-months he had been hospitalised twice due to severe suicidal ideation in the context of major depression, exacerbated through episodes of substantial alcohol intoxication. At the same time, Robert's family were experiencing significant financial strain, and both parents were working extended hours to make ends meet. Following his most recent hospital admission, Roberts's parents started to make daily contact with his therapist, seeking advice and reassurance. Unable to adequately respond to these requests for contact, a referral was made for a specialist family worker to provide additional support to the family. Although Robert was ambivalent about his parent's involvement, he consented nonetheless and three family work sessions were contracted.*

*Each session started with agreed goals. After the first session it was clear that Robert's depression coincided with major changes to the family life cycle. According to his parents, Robert's older sister was angry at Robert for "wrecking the family and stressing everyone out". His sister rejected the depression diagnosis, and thought that Roberts's parents were perpetuating the situation by lowering their expectations of him. Robert's parents felt the need to defend Robert, consistently putting them at odds*

*with his sister, who had recently moved out of the family home to live with her partner.*

*The second session with Roberts parents explored external triggers to Roberts's anger – one example was his father speaking to him using a sarcastic tone. Using a role play approach the family worker modelled alternative communication styles, and Robert's parents were set the task of implementing and monitoring the effects of changing their communication style. Robert's sister attended the third session, with the aim of further improving communication and developing a shared understanding. Robert's sister expressed her anger at Robert's parents for letting Robert do whatever he liked, including giving him money. The parents acknowledged their role in this, but were also able to communicate how worried they were that Robert may attempt suicide again if he was pushed too much to get a job at the moment. Although his sister remained sceptical of the diagnosis of depression, she acknowledged that Robert did have difficulties managing strong emotions. Despite a heated start to the session, everyone felt as though they had been listened to. Three further sessions were contracted for the parents with the goals of more actively supporting Robert's recovery and continuing to improve communication. Robert and his therapist joined the final session, which focussed on reviewing progress for the family, identifying areas still requiring work, and maintaining the positive changes made.*

### ***Safety planning with families***

A collaborative approach to safety planning is required for young people at risk of suicide<sup>(10)</sup> and along with the young person and relevant treating professionals, caregivers

should also be part of the safety planning process<sup>(2)</sup>. Involving families in the safety planning process also provides an opportunity to obtain crucial collateral information regarding the young person's day-to-day functioning that would otherwise be unavailable to the treating team<sup>(42)</sup>. It is important to note that the safety planning process may be distressing for caregivers. As such, a non-blaming approach, providing reassurance and psychoeducation is required. The family system should understand that they are managing the young person in a broader network of clinical support, and that acute and emergency services are available if needed. Some families may find it difficult navigating the safety planning process in the context of confidentiality and limited information sharing, where clinicians must balance the privacy needs of the client with the understandable needs of the family. Providing clarity to parents and caregivers regarding specific signs and symptoms of elevated risk may allay anxiety. Conversely, caregiver hostility regarding increased suicidal ideation or a suicide attempt will likely be perceived by the young person as invalidating, and may impede treatment progress<sup>(43)</sup>. Ongoing contact with family during periods of lower risk, reflecting on treatment gains and progress may also reduce the likelihood of families feeling as though they are only contacted at times of crisis<sup>(48)</sup>.

### ***Termination***

Time-limited family work may uncover broader issues within the family system. In instances of particularly complex family dynamics, referral may be suggested to specialist family support services, or formal longer-term family therapy, able to offer more comprehensive ongoing family support. Referral to specialist family services may also be included in discharge planning. As families caring for young people experiencing mental ill

health are known to experience higher rates of depression, anxiety and social isolation<sup>(34)</sup>, referral may also be required to support individual family members.

### ***Model evaluation***

Service evaluation is critical to informing continuous improvement and quality development, and perspectives from all partners (i.e., clients, caregivers, broader family members, and clinicians) are critical to this<sup>(49)</sup>. While informal reports from young people, families, and clinicians provide preliminary support for the YMC family work model, lack of formal evaluation data is a significant current limitation. Planning is underway to address this through a quality assurance study that informs ongoing model development. This study will capture data on the unique perspectives and outcomes for young people, caregivers, the broader family system (i.e., siblings, grandparents) and treating team (i.e., case manager, doctor, and where applicable, the specialist family worker). Evaluation will also include a retrospective review of clinical notes of specialist family workers to evaluate the focus of family work<sup>(29, 35)</sup> including number of sessions offered/provided, barriers and facilitators to attendance, general clinical impressions associated with the work, and termination and referral processes. Broad evaluation outcomes will include impact on symptoms and functioning, client satisfaction, and family-related communication. In the longer term, analysis of resourcing and cost effectiveness<sup>(50)</sup> will need to be undertaken.

### ***Conclusions***

The treatment of young people experiencing severe and complex depression is multifaceted, and family work is a central component. Young people who feel connected to their family are

less likely to experience depression<sup>(43)</sup> and time-limited intervention, undertaken by family peer support workers, the treating team, or a specialist family worker can improve systems functioning. Consideration of, and sensitivity to the developmental stage of the young person themselves, broader transitions within the family lifecycle, and factors that promote shared understanding of symptoms and facilitators of change are important components in the recovery process. Overall, it is emphasised that families be viewed as potential mediators, drivers and agents of change. Wherever possible, empowering families to enact adaptive changes is an important aspect of treatment for young people experiencing severe and complex depression.

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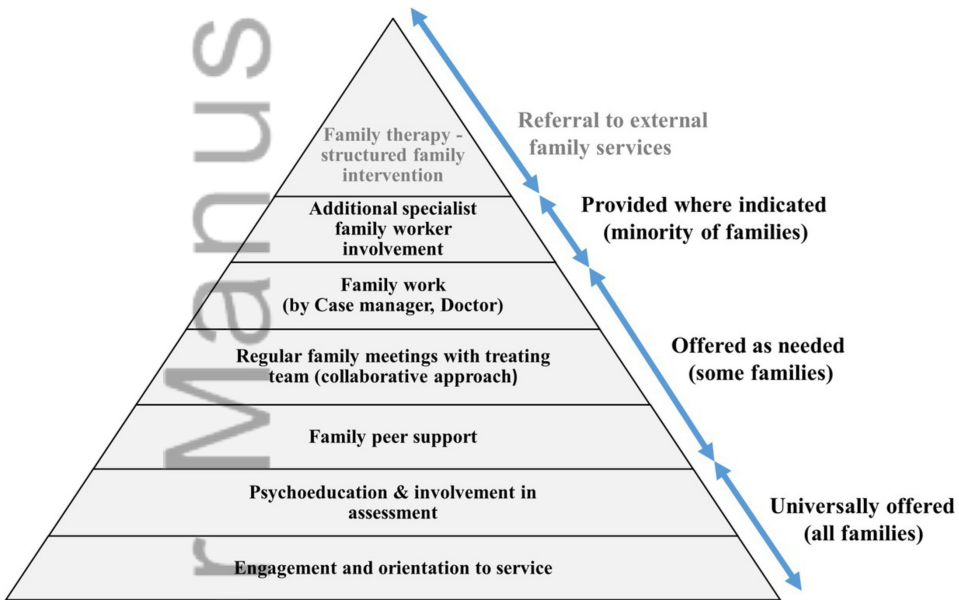


Figure 1: Levels of family support and intervention<sup>(27)</sup>

Figure 1 - 3May.jpg

**Integrating family work into the treatment of young people with severe and complex  
depression: A developmentally-focussed model**

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