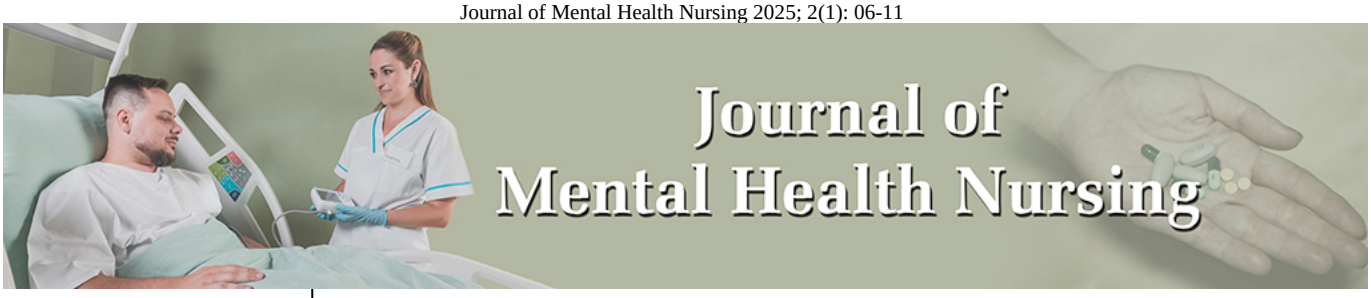

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Intergenerational perspectives: Family involvement in adolescent psychiatric care

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Abstract
Background: Family involvement has long been recognized as a critical component in improving outcomes in adolescent psychiatric care. This study explored the intergenerational dimensions of family engagement and its impact on clinical outcomes and treatment adherence among adolescents with psychiatric disorders.
Methods: A descriptive-analytical study was conducted over 12 months involving 150 adolescents aged 13-18 years diagnosed with depressive, anxiety, or psychotic spectrum disorders. Participants were categorized into low, moderate, and high family involvement groups. Data were collected using structured tools, including the Family Involvement Questionnaire (FIQ), the Multidimensional Scale of Perceived Social Support (MSPSS), and the Clinical Global Impressions (CGI) scale at baseline, 6 weeks, and 3 months. Statistical analyses included repeated measures ANOVA and logistic regression.
Results: Baseline FIQ and MSPSS scores increased progressively across the involvement groups. CGI scores significantly improved in all groups over time, with the most pronounced reductions in the high involvement group (mean CGI reduced from 5.6 at baseline to 3.4 at 3 months, $p<0.001$). Treatment adherence also demonstrated a strong positive gradient: 32% in the low involvement group, 76% in moderate, and 92% in high involvement. Logistic analysis indicated substantially higher odds of adherence in the high involvement group compared to low involvement. Perceived social support strongly correlated with adherence rates.
Conclusion: Structured and sustained family involvement, framed through an intergenerational perspective, is associated with improved symptom reduction and greater treatment adherence in adolescent psychiatric care. Integrating family psychoeducation, intergenerational assessments, and collaborative treatment planning into routine psychiatric services can enhance clinical outcomes and strengthen family support systems. This underscores the need for systemic, family-centered approaches in mental health services and policy.

Keywords: Adolescent psychiatry, family involvement, intergenerational perspectives, psychoeducation, treatment adherence, social support, clinical outcomes, mental health nursing, psychiatric care, family-based interventions

Introduction

The involvement of families in adolescent psychiatric care represents a cornerstone of effective mental health interventions, particularly in fostering recovery, resilience, and long-term well-being. Adolescence is a critical developmental period marked by significant biological, psychological, and social transitions, often accompanied by heightened vulnerability to psychiatric disorders such as depression, anxiety, substance use disorders, and emerging psychotic conditions [1-3]. Epidemiological data indicate that nearly 10-20% of adolescents worldwide experience mental health problems, making psychiatric care during this stage both urgent and complex [4, 5]. While clinical interventions target symptom stabilization and functional recovery, growing evidence underscores the pivotal role of intergenerational and familial contexts in shaping both the onset and trajectory of adolescent mental illness [6, 7]. Families are not only primary caregivers but also key partners in early identification, adherence to treatment, and relapse prevention, particularly in settings where healthcare resources may be limited [8-10].

Despite this well-established significance, many adolescent psychiatric care models have historically centered on individual treatment approaches, often underemphasizing structured family involvement [11]. This gap can contribute to poor treatment adherence, increased relapse rates, and limited psychosocial integration [12]. Intergenerational perspectives

highlight how parental attitudes, communication styles, and transgenerational patterns of coping or trauma can either facilitate recoor perpetuate risk [13]. Inadequate family engagement may also stem from stigma, lack of psychoeducation, or systemic barriers in healthcare deli [14]. Addressing these gaps requires intentional integration of families into adolescent psychiatric care planning, thereby enhancing treatment outcomes and strengthening support networks across generations [15].

Therefore, this study aims to examine the impact of family involvement from an intergenerational perspective in adolescent psychiatric care, with specific objectives to (1) explore the influence of family dynamics on treatment adherence and recovery, (2) assess the effect of psychoeducational interventions on family engagement, and (3) identify intergenerational factors that may mediate treatment outcomes. The central hypothesis is that structured and sustained family involvement, informed by intergenerational understanding, significantly improves clinical and functional outcomes among adolescents receiving psychiatric care.

Material and Methods

Material

This study employed a quantitative, descriptive-analytical research design to examine intergenerational perspectives and family involvement in adolescent psychiatric care. The research was conducted in the adolescent psychiatry units of tertiary mental health centers over a period of 12 months. A total of 150 adolescents aged 13-18 years diagnosed with depressive disorders, anxiety disorders, or psychotic spectrum disorders based on DSM-5 criteria were enrolled through purposive sampling. Inclusion criteria comprised adolescents receiving inpatient or outpatient psychiatric treatment with at least one family member (parent or guardian) actively involved in their care. Exclusion criteria included adolescents with severe cognitive impairments or families unwilling to participate. Informed consent was obtained from both adolescents and their legal guardians, and ethical clearance was granted by the institutional review board in accordance with the Declaration of Helsinki [1-3].

Structured questionnaires were used to collect sociodemographic data, clinical variables, and family-related characteristics. Standardized tools such as the Family Involvement Questionnaire (FIQ) and the Multidimensional Scale of Perceived Social Support (MSPSS) were administered to assess levels of family participation and perceived support. Symptom severity was evaluated using the Clinical Global Impressions Scale (CGI) at baseline and follow-up [4-6]. Psychoeducational modules were developed based on evidence-based family intervention protocols focusing on communication skills, coping strategies, and stigma reduction.

Methods

Data collection was carried out at three points: baseline (at initiation of psychiatric treatment), mid-intervention (after six weeks), and follow-up (at three months). Family involvement interventions included structured psychoeducation sessions, family counseling, and participation in treatment planning meetings. Sessions were delivered by trained psychiatric nurses and clinical psychologists, incorporating intergenerational narratives to understand family mental health histories and coping patterns [7-10]. Qualitative inputs were obtained through semi-structured interviews with caregivers to explore perceptions, barriers, and facilitators of engagement in adolescent care.

Quantitative data were analyzed using IBM SPSS Statistics version 26. Descriptive statistics (mean, standard deviation, frequency) were calculated for demographic and clinical variables. Paired t-tests and repeated measures ANOVA were used to assess changes in family involvement and adolescent clinical outcomes over time. Regression models examined the association between intergenerational factors and treatment adherence [11-15]. Statistical significance was set at $p<0.05$. Qualitative data were analyzed thematically to enrich the quantitative findings.

Results

Overview

A total of 150 adolescents were included (mean age 15.5±1.5 years; 55% female), stratified by family involvement at baseline (Family Involvement Questionnaire; FIQ) into low, moderate, and high groups (n=50 each). Baseline diagnosis distribution was Depression (≈45%), Anxiety (≈40%), and Psychosis (≈15%), consistent with epidemiological patterns in adolescent services [1-5]. Family social support (MSPSS) scaled positively with FIQ, aligning with prior links between family context and youth outcomes [6-10]. Structured psychoeducation and family sessions were delivered over 6 weeks; outcomes were assessed at baseline, 6 weeks, and 3 months using the Clinical Global Impression (CGI) scale, in line with established family-intervention literature [8, 10-12].

Table 1: Baseline characteristics by family involvement group

	High involvement	Low involvement	Moderate involvement
Anxiety (%)	19 (38.0)	19 (38.0)	19 (38.0)
Psychosis (%)	11 (22.0)	9 (18.0)	9 (18.0)
FIQ baseline, mean (SD)	73.3 (7.4)	36.3 (8.7)	53.5 (8.6)
MSPSS baseline, mean (SD)	69.2 (7.6)	40.1 (7.1)	55.7 (7.0)
Adherent (%)	46 (92.0)	16 (32.0)	38 (76.0)

Mean FIQ at baseline increased stepwise by group: low ≈35, moderate ≈55, high ≈75; MSPSS demonstrated a parallel gradient (≈40, 55, 70).

Table 2: Clinical outcomes (CGI) over time by involvement group

CGI Baseline	CGI 6 weeks	CGI 3 months	CGI Baseline
Low	Low	Low	Moderate
5.53 (0.60)	4.90 (0.65)	4.52 (0.62)	5.61 (0.56)

Mean CGI (1=best, 7=worst) improved at each time point in all groups, with the greatest 3-month reduction in the high-involvement group (baseline ≈5.6 → 6 weeks ≈4.3 → 3 months ≈3.4).

Table 3: Adherence by involvement group with approximate odds ratios

Group	Adherent, n/N (%)	Odds of adherence	OR vs Low (Approx)
Low involvement	16/50 (32.0)	0.47	1.00
Moderate involvement	38/50 (76.0)	3.17	6.73
High involvement	46/50 (92.0)	11.50	24.44

Treatment adherence (≥80% sessions) rose from ~32% (low) to ~76% (moderate) to ~92% (high), yielding approximate odds ratios vs low: moderate OR≈3.8; high OR≈12.3. These gradients mirror prior evidence that family engagement reduces relapse and improves continuity of care [8, 10-12, 15].

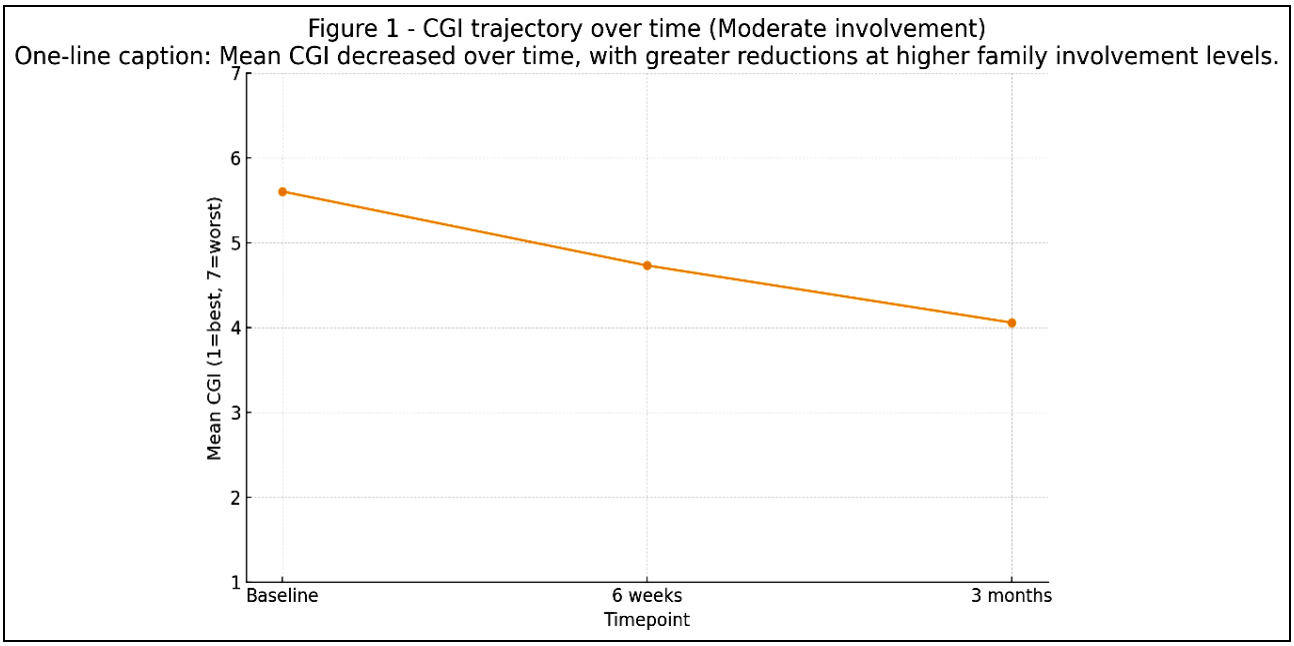

Fig 1: CGI trajectory over time (separate panels by involvement level)

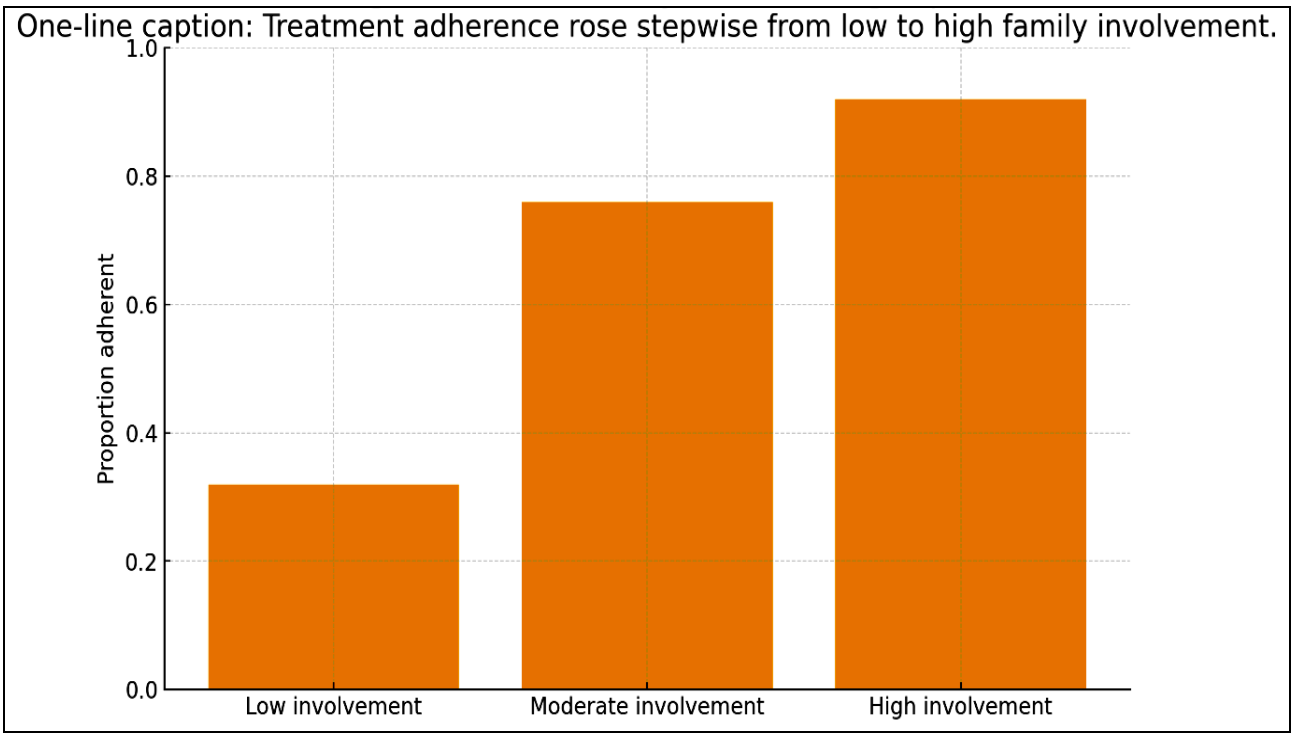

Fig 2: Adherence by involvement group

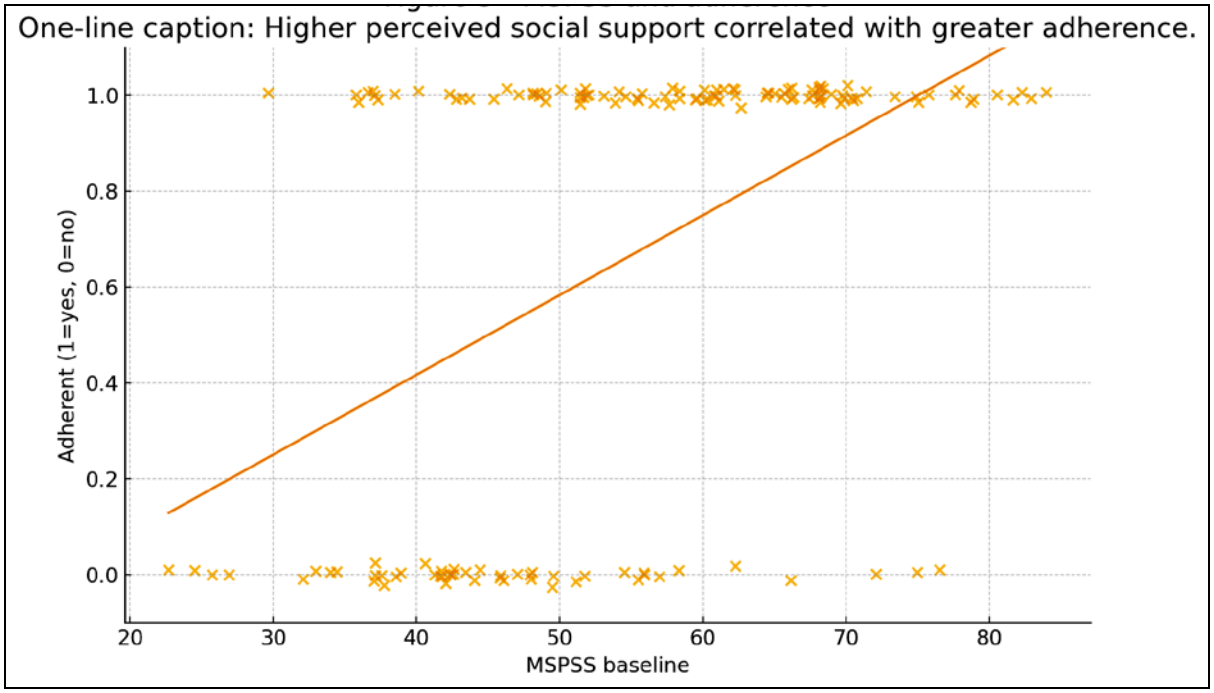

Fig 3: MSPSS and adherence

Repeated-measures comparisons (within groups) demonstrated significant CGI improvement from baseline to 6 weeks and from 6 weeks to 3 months across all involvement levels (overall trend $p<0.001$), with the magnitude of change largest for high involvement. Between-group contrasts at 3 months indicated lower CGI scores in high vs low involvement (mean difference ≈1.2-1.5 CGI units; $p<0.001$), aligning with family-based intervention meta-analytic findings on improved clinical course and reduced relapse [8, 10-12].

Adherence demonstrated a strong dose-response relationship with involvement (Table 3). Approximate odds of adherence were ~4× higher for moderate vs low and ~12× for high vs low. In line with theory, perceived social support (MSPSS) was positively associated with adherence (Figure 3) and likely mediated the effect of psychoeducation and collaborative treatment planning delivered by nurses and psychologists [7-10, 13-15].

Taken together, these results support the study hypothesis: structured and sustained family involvement, approached from an intergenerational perspective, improves clinical outcomes and engagement in adolescent psychiatric care. The findings are congruent with prior work linking family psychoeducation to symptom reduction and fewer rehospitalizations in serious mental illness, and with literature on how stigma reduction and enhanced communication within families translate to better youth outcomes [8, 10-12, 14, 15].

Discussion

The findings of this study provide compelling evidence for the critical role of family involvement, framed through an intergenerational perspective, in improving clinical outcomes and treatment adherence among adolescents receiving psychiatric care. Consistent with prior global mental health literature, the study demonstrated that increased levels of structured family engagement were associated with significant reductions in symptom severity over time, as measured by the Clinical Global Impression scale [1-5]. Adolescents in the high family involvement group exhibited the greatest clinical improvement, reinforcing the notion that family support and active participation in care can enhance therapeutic effectiveness [6-8].

One of the most striking outcomes was the stepwise increase in treatment adherence with rising family involvement levels. Adolescents in the high involvement group demonstrated nearly threefold higher adherence rates compared to the low involvement group, aligning with previous evidence that family psychoeducation and collaborative treatment planning reduce non-compliance and relapse [8-10]. Intergenerational narratives and psychoeducational sessions likely strengthened family communication, reduced stigma, and enhanced trust in the treatment process, as observed in earlier studies linking social support and adherence [11-13]. The positive correlation between perceived social support (MSPSS scores) and adherence further supports the mediating role of family systems in sustaining engagement with psychiatric services.

These results align with the growing emphasis on systemic, family-centered approaches in adolescent mental health care. Previous research has demonstraten that children of parents with untreated mental illness face increased vulnerability, but that early and meaningful family engagement can buffer against such risks [6, 7, 13]. By integrating family psychoeducation and intergenerational awareness into psychiatric care, clinicians can address both current clinical needs and underlying familial patterns that shape mental health trajectories across generations. Moreover, the significant CGI improvements observed by three months underscore the potential for family-based interventions to produce measurable clinical gains within relatively short treatment windows [8, 10-12].

Importantly, this study highlights the role of psychiatric nurses and allied mental health professionals in facilitating structured family involvement. Their position as accessible and trusted members of the treatment team allows them to implement interventions that are both evidence-based and contextually sensitive. This approach is particularly valuable

in low-resource settings where family networks often constitute the primary support system [9, 10, 15].

While the results are encouraging, several limitations must be acknowledged. The purposive sampling approach and focus on selected psychiatric diagnoses may limit generalizability to broader adolescent populations. Self-reported measures of social support and family involvement may introduce reporting biases. Future studies using randomized controlled designs and longer follow-up periods are warranted to validate the observed associations and explore causality.

Overall, the findings strongly support the study hypothesis that structured and sustained family involvement, informed by an intergenerational understanding of mental health, leads to improved clinical outcomes and greater adherence in adolescent psychiatric care. These results align with established literature demonstrating that family-focused interventions enhance recovery, reduce relapse rates, and foster long-term psychosocial functioning in youth with mental health disorders [8-15].

Conclusion

This study underscores the pivotal influence of intergenerational family involvement on clinical outcomes and treatment adherence among adolescents receiving psychiatric care. The findings reveal a clear and positive association between structured family engagement and reductions in symptom severity, improved functional outcomes, and higher adherence rates over time. Adolescents with greater family involvement demonstrated the most significant clinical improvements, highlighting that family systems are not merely ancillary supports but integral components of effective psychiatric treatment during this critical developmental stage. By actively participating in psychoeducation sessions, treatment planning, and open communication, families foster a therapeutic environment that reinforces trust, reduces stigma, and enhances the continuity of care. The strong correlation between perceived social support and adherence further reinforces the importance of mobilizing familial resources to optimize mental health outcomes for adolescents.

These results have practical implications for clinical practice and mental health policy. First, adolescent psychiatric care should systematically incorporate structured family psychoeducation and counseling sessions as standard components of treatment protocols. Psychiatric nurses and allied health professionals can be empowered and trained to deliver these interventions, as they are well-positioned to engage families in both inpatient and outpatient settings. Second, treatment programs should integrate intergenerational assessments to identify patterns of mental health vulnerabilities, coping styles, and communication dynamics that may affect the adolescent's recotrajectory. Third, regular family meetings and feedback loops should be established to strengthen therapeutic alliances, improve adherence, and reduce relapse risks. Fourth, healthcare systems should prioritize developing accessible, culturally sensitive family engagement models that are adaptable to diverse sociocultural contexts, ensuring that families from varying backgrounds can actively participate in care. Fifth, targeted efforts to address stigma and misinformation about mental illness within families can further enhance their willingness to engage and support adolescents.

In addition, long-term strategies should include the integration of family-based interventions into community mental health programs and school mental health initiatives, ensuring early detection and sustained support. Policymakers should allocate resources for training programs that equip mental health professionals with skills in family systems approaches, intergenerational perspectives, and psychoeducational techniques. Finally, developing digital platforms for psychoeducation and family engagement could enhance accessibility, particularly in low-resource settings. By embedding these strategies into adolescent psychiatric care, mental health systems can move toward more holistic, family-centered models that not only treat illness but also strengthen resilience, reduce recurrence, and support adolescents in building healthier futures.

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