1

Introduction

Louis (age 16) is locked in a bitter battle with his father. Every discussion turns into an argument. Meanwhile, Louis's grades continue to slip and the relationship between his parents is becoming tenser.

Caleb (age 13) can't go to bed until he performs an elaborate ritual that is taking more and more time each night. His parents are afraid to stop him because he becomes terrifyingly agitated if his ritual is interrupted.

Tina (age 16) has lost over 20 pounds in the past 6 months because she won't eat. Her divorced parents, Bill and Rose, seem more interested in fighting with one another than in finding a way to help their daughter.

Jenny (age 15) ingested a handful of acetaminophen tablets minutes after what both she and her mother described as a pleasant conversation over dinner.

Keith (age 15) is staying out all night and using drugs. He threatens his parents with violence if they try to impose any restrictions or consequences. As a result, his terrified parents shrink from confronting him.

This book is about adolescents like Louis, Caleb, Tina, Jenny, and Keith. Along the way, we will meet other young people like them: Bart (age 16), whose intractable abdominal pain allowed him to say "no" to his overbearing father; Tyrone (age 17), on the verge of leaving for college, who can't seem to follow his mother's simple rules about curfew; and Tammy (age 14), whose sexual promiscuity terrified her parents. If

you are a therapist who works with adolescents, the stories I tell will have a familiar ring. If you are a therapist who is looking for a compass to orient you through the sometimes frustrating journey of working with teenagers and their families, I hope to provide one in this book.

In one sense, working with adolescents is no different than working with any person who comes to us for help. The basic principles of family systems thinking that guide my work can be applied to problems that arise at any point in the human life cycle. On the other hand, work with adolescents poses particular challenges because of the developmental processes that are occurring during this period of life. For this reason, I believe that therapists who work with adolescents must be familiar with the typical developmental changes that are occurring during adolescence. In Chapter 2, I review the basics of normal adolescent development and provide guidance on how to differentiate normal adolescent behavior from atypical or problematic behavior. One of the major trends that is at the forefront during this phase of life is the push–pull between dependency and independency. How the parents and the adolescent negotiate this balance is a critical factor to determining how successful their passage through adolescence will be.

I discuss and illustrate many techniques that are useful in work with adolescents and their families. However, techniques must be embedded in a clear map for what the therapist hopes to accomplish. Techniques are like tools: The more you have, the more options for getting a job done—but you have to know what you are building first. Familiarity with a variety of techniques can give a therapist security in versatility, but relying on techniques without a formulation can lead to haphazard and reactive treatment that frustrates both the therapist and the family.

Many therapists find theories too abstract and therefore not particularly relevant to what they are trying to accomplish in their work with families. Seeing the merits in a number of different schools of therapy, many therapists consider themselves "eclectic," which usually means that they have refrained from committing themselves to a particular model. Unfortunately, eclecticism can breed hopeless confusion, leaving the practitioner a "jack of all trades, master of none," with no guidance on how to weave together ideas from a variety of theories into a coherent whole.

I hope to address this dilemma in this book by striking a balance between theory and technique. What I hope to offer are pragmatic solutions for common clinical problems. I have tried to spell out my rationale for my suggestions, and illustrate their use in clinical case examples. Sometimes, I recommend a step-by-step approach. I trust that readers will realize that steps and phases are rarely discrete or invariably sequential in all cases, and so will exercise sound clinical judgment in applying these ideas.

MY ORIENTATION AND INFLUENCES

The fundamental guiding beacon for my work is family systems theory. Thus, my focus is not on the individual alone, but on the network of relationships in which individuals participate. A basic premise of the family systems perspective is the idea that problems and symptoms occur in an interpersonal context. These problems are not internal to any single person, but rather arise and are maintained by particular, repetitive patterns of interactions among those who are in close contact with the person who exhibits the symptom or problem. I elucidate on these ideas in Chapter 3, when I discuss the concept of the *symptomatic cycle,* and in Chapter 4, when I describe a number of techniques derived from a family systems perspective.

There have been a number of important theoretical influences in my work and my thinking about adolescents and families. From structural family therapy (Minuchin, 1974, 1984; Minuchin & Fishman, 1981; Minuchin, Nichols, & Lee, 2007), I borrow many of the concepts that describe how a family is organized: subsystems, boundaries, hierarchy, and alignments. I also borrow from structural family therapy many techniques associated with this model, including joining, enactment, using complementarity, and unbalancing. I discuss these techniques in more detail in Chapter 4.

From Jay Haley (1987), I borrow the basic framework for conducting an initial session. From models of therapy termed "strategic" I borrow the idea that people get caught up in cycles that keep a problem alive, and that their efforts to solve the problem often make the problem worse (Fisch, Weakland, & Segal, 1982). From narrative therapy, I borrow the insight that language shapes our experience of reality, and the value of talking about problems as if they were external forces influencing all family members rather than defects or deficiencies within individuals (White & Epston, 1990).

My work has also been influenced by ideas that were originally developed within the context of psychodynamic theory. In particular, I find value in the work that has explored the importance of emotional attachments during the lifespan (Ainsworth, 1989; Bowlby, 1988). In particular, I believe that the emphasis on promoting adolescents' independence from parents has paid insufficient attention to the ways in which adolescents continue to need parental support and nurturance (Mackey, 1996). In this vein, I appropriate some of the ideas and methods from emotionally focused therapy (Johnson, 2004), particularly the emphasis on uncovering and emphasizing the "softer" emotions such as hurt and sadness that are often obscured behind angry interactions (see also Micucci, 2006). Also relevant in this context is the importance placed by

contextual family therapy on mutual accountability and loyalties within families (Boszormenyi-Nagy & Spark, 1973).

In addition, I believe that a number of techniques that are traditionally associated with individual models of therapy could also be helpful in work with families. Many parents can benefit from training in parenting skills based on behavioral methods. There is much evidence that cognitive-behavioral techniques can be helpful in modifying symptoms of depression and anxiety (Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004; Lewinsohn, Clarke, Hops, & Andrews, 1990). Recently, attention has been given to supplementing cognitive-behavioral techniques with mindfulness and acceptance of negative feeling states (Segal, Williams, & Teasdale, 2002). These methods are not incompatible with a family systems perspective, and, in fact, integrating a family-based component with cognitive-behavioral treatments has been found to be effective in treating children and adolescents (Bogels & Siqueland, 2006; Kendall, Hudson, Gosch, Flannery-Schroeder, & Suvey, 2008).

DIAGNOSIS AND LABELING

The use of diagnostic labels from the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000) can have value if used appropriately. Diagnostic labels can facilitate communication among therapists and help to alert therapists to aspects of a problem that might not be readily apparent from the presenting complaint. Labels such as these become problematic only when they are used to pathologize individuals and imply that the problem is "owned" by a single person rather than by the whole family. They are also problematic when they are viewed as the most important or defining characteristic of the individual, as, for example, when a parent says, "My son *is* ADD." For this reason, extreme care should be exercised when sharing diagnostic labels with families.

The same argument can be applied to the use of the term *dysfunctional* in reference to families. This term has been used to describe certain families who repeatedly engage in problematic interactions and in which a family member is symptomatic or functioning inadequately. Used in this way, the term is purely descriptive and can be innocuous. Unfortunately, the term can also be used to label or pathologize families in the same way that individual diagnostic labels can pathologize patients. For this reason, I prefer not to use the term *dysfunctional* as applied to a family. Instead, I think the term is more aptly used to describe interactional patterns that are unproductive in that they promote or sustain symptoms.

In contrast, *functional* interactions are those that promote conflict resolution, stimulate growth, or strengthen the connection among the family members. If the term is used in this way, it is clear that families engage in a mixture of functional and dysfunctional interactions. One of the ways to help families change dysfunctional patterns is to help them utilize their functional interactions more creatively.

BIOLOGY, MEDICATIONS, AND SYSTEMS

There is evidence that some emotional and behavioral symptoms are linked to brain physiology and neurochemistry. The subjective suffering associated with some of these syndromes can be reduced through the use of medications. Knowing how to recognize these patterns and syndromes when they occur can help nonmedical practitioners make a reasoned assessment of the need for a consultation from a medical practitioner. It does not mean that the therapist abandons a systemic perspective, but rather recognizes that biological factors can play a role in influencing emotions and behavior. It will enable the therapist to guide the family toward changing what they are able to change rather than expending energy trying to change something that is likely to be more resistant to change because of biological influences.

Even in cases where a strong biological influence is assumed, such as schizophrenia and severe mood disorders, family interactions influence the severity of the symptoms and the probability of relapse (Hooley, 2007; Rice, Harold, Shelton, & Thapar, 2006). Thus, in those cases where treatment with medications seems warranted, work on family interactions will help to reduce symptom severity and promote better functioning in the long run. For example, in the case discussed in Chapter 9, medications helped to relieve a girl's subjective suffering as a result of psychosis. The therapy, however, was focused on the intense conflict between the mother and grandmother that created stress for the girl and inhibited the adults from helping the girl to function to her full potential.

On the other hand, the use of medications has a downside, not the least of which is the presence of side effects, the unknown long-term effects of taking medications for many years, and the potential dangers of failing to comply with the prescribed dosage. Families can become overly reliant on medication and less motivated to do the hard work involved in changing the ways they interact with one another. Therapists can become overly focused on assessing symptoms and identifying disorders, rather than listening to people and trying to understand them. If the therapist is not the prescriber, conflicts between the therapist and psychiatrist can arise and undermine both the family therapy and the pharmacology.

To avoid these pitfalls, it is important to maintain a holistic perspective that views all potential influences on a problem as interacting with one another. This perspective advocates a *both/and* rather than *either/or* approach. Thus, while biological factors might play a role in the problem, they are not privileged as the sole or primary "cause" of the problem. The same can be said for a traumatic life experience, environmental deprivation, cultural prejudice, or family interactions. No single factor can be isolated as causative, but rather all factors work together. A systemic perspective calls attention to the ways in which multiple influences on a particular problem interact and mediate one another. So, by focusing on family interactions in this book, I do not intend to imply that these are the main "cause" of the problems of adolescents. However, I hope to show that viewing problems from a family systems perspective can provide a very useful lens, one that opens up options for promoting change and growth that go beyond what other models provide.

THE PARADOX OF CONTROL

Efforts to control other people are often at the core of the problems that are brought to the attention of therapists. Families come to therapy because someone in the family is behaving in an undesirable way. Other members of the family try to convince this person to change, using a variety of methods, such as reasoning, arguing, begging, bribing, criticizing, threatening, or punishing. These methods have not been effective in producing the desired change, hence the visit to the therapist, who is presumed to have special expertise in changing people.

One problem with this approach is that people are less likely to change when they feel they are being controlled or manipulated against their will. These efforts at control contribute to disconnection, estrangement, and resentment. Rather than feeling motivated to change in order to please another person whose feelings matter to them, people who feel controlled try to escape the feeling of being controlled and/or assert their autonomy by resisting the efforts to change them. In effect, they are placed in a bind: If they change in response to the efforts made by others to change them, they are giving up a part of themselves and acknowledging that their acceptance in the family is conditional on their changing.

As a further complication, the more the other family members direct their attention to changing or controlling the behavior of the symptomatic member, the more their behaviors are governed by the symptom. Unsuccessful attempts to eliminate the symptom breed more (unsuccessful) attempts, and the range of interactions in the family constrict to those that are organized around the symptom. The more this happens,

the more the relationships in the family suffer. The more the family members concentrate on changing someone else, the less they concentrate on changing themselves. The more they focus attention on the symptom, the less they attend to important qualities of their relationships with each other and with the person who is showing the symptom. As I elucidate in Chapter 3, this process is called the *symptomatic cycle* and constitutes the basic dilemma faced by families who come to treatment.

HARNESSING THE POWER OF RELATIONSHIPS

In my view, the most powerful resource for helping a person change is the relationships in which he or she participates. It's about as close as we get to an axiom in therapy that the quality of the therapeutic relationship is a key determinant of the success or failure of therapy. Certainly, our relationships with clients are critically important. But I'm talking here not only about the therapeutic relationship, but about the healing potential of the natural relationships in a person's life.

As I discuss in Chapter 3, families who come to therapy are often experiencing profound isolation and disconnection in their relationships with one another. Perhaps they have become so focused on solving the problem that brought them to therapy that they have lost sight of other aspects of their relationships. Perhaps they have followed a policy of conflict avoidance for so long that they have concealed parts of themselves from one another, only to realize one day that they no longer feel connected to one another.

The relationships in these families are no longer sustaining. The family members see each other as obstacles rather than resources. They have settled into patterns of interaction that inhibit growth. Sometimes, relationships outside the family can compensate for unfulfilling family relationships. But all relationships are poisoned to some degree by the absence of a "secure base" in the family (Bowlby, 1988).

One of the features that differentiates individual therapy from family therapy is the relative emphasis placed on the relationship with the therapist versus the relationships with people in one's life. Family therapists view the therapeutic relationship as a means to an end rather than as an end in itself. The purpose of the therapeutic relationship is to help family members change their relationships with one another, from relationships that inhibit growth to relationships that promote growth. Family therapists see beyond the problematic patterns in the family to the potential healing power of family relationships.

It is in the context of a relationship with the therapist that family members experience aspects of themselves that had been suppressed in

family interactions. For example, when a father and his teenage son are locked in conflict, I use my relationship with the father to encourage more tenderness from him, and my relationship with the son to encourage more restraint. In this way, both father and son will experience underutilized aspects of themselves that can provide the seed around which new relationship patterns can crystallize.

In my view, the purpose of therapy is to enable individuals to experience sustaining and growth-enhancing relationships with the real people in their lives. In the case of troubled adolescents who are still living with their families of origin, my goal is to help the family members become better resources to the youngster and to one another. If an adolescent is not living with his or her family, and instead resides in a group home or residential facility, my goal is to help him or her make better use of the available relationships in his or her life. If an individual client is disconnected and isolated from other people, I cultivate a relationship with the client that will inspire him or her to seek out sustaining relationships with others.

I consider therapy successful when the family members (or individual clients) have discovered ways to get what they need from their relationships with the people in their lives, so that their relationship with me is no longer necessary to sustain them. Like a chemical catalyst that facilitates a reaction between two other substances, the therapeutic relationship catalyzes the transformation of relationships in the lives of clients. But the real healing takes place not in the therapeutic relationship but in the client's relationships with significant others.

THE ARCH

I suggest that therapists pay particular attention to cultivating relationships with each member of the family and to use these relationships as springboards for facilitating change. Minuchin (1974) has called this process *joining*. But joining is not simply a technique. It requires an experiential change on the part of the therapist and is achieved by making a conscious and deliberate effort to engage each family member in a relationship. To join effectively, therapists must listen carefully to each family member, try to see the problem from each family member's unique point of view, and find something about the person that they like. Then, the relationship is maintained just like any other relationship that is important to the therapist, by communicating what I like to call the ARCH of therapy: Acceptance, Respect, Curiosity, and Honesty.

- *Acceptance* means appreciating the family's struggles and understanding that they are all affected by the problem and suffering as a result

of their problematic interactions. Acceptance does *not* mean communicating that it is "OK" for people to be verbally or physically abusive to one another. It means refraining from judging people and reducing them to only one particular facet of their complex selves.

• *Respect* means treating everyone in the family as a unique individual with his or her own opinions, needs, and feelings. Finding something about each family member that we generally like or admire can help promote respect. The therapist makes a commitment to the relationship, and by holding the relationship in high esteem conveys to the other person the expectation that he or she also will hold the relationship with the therapist in high esteem. This is particularly important with adolescents, who often feel as if adults don't respect them and don't care what they think.

• *Curiosity* means maintaining an open mind and expressing genuine interest in understanding people and why they do what they do. Curiosity means avoiding rigid attachment to a particular hypothesis and instead always remaining open to new information. It also means that therapists feel free to ask whatever questions will help them understand the family members better.

• *Honesty* applies both to oneself and to others. Being honest with oneself means acknowledging and dealing with feelings that could interfere with our ability to help the family. Being honest with others means (respectfully) communicating to them information about how they are coming across.

ADOLESCENTS NEED NURTURANCE

This brings me to another point, and one that has been a major goal of mine in writing this book: the importance of strengthening the adolescent's relationship with the parents and other family members. Some writings on treating adolescents stress the importance of promoting greater individuation and encourage the therapist to serve as midwife to the separation of the adolescent from the family. Parents may be encouraged to "back off" and give adolescents space to define themselves as separate and autonomous individuals. However, by emphasizing adolescent autonomy and independence, too little attention can be paid to the adolescent's ongoing need for nurturance, guidance, and support from the parents.

Susan Mackey (1996) is one of the few authors who have addressed the importance of strengthening the quality of the relationship between parents and the adolescent as an essential component of treatment:

> I believe that a secure attachment to parents may lessen the influence of peers and consequently increase the likelihood that the adolescent will respond to parental limits. Similarly, I believe that secure attachment allows the parents to feel safer about the normal acting-out behavior which is characteristic of adolescents and thus less prone to overreactions. Because they feel that their children are attached, they have greater trust that the children will contact them when they find themselves in situations they cannot handle. Therefore, it may be a mistake to guide parents who may already be feeling insecure in their attachment to the adolescent to "back off" without first addressing the relationship issues to increase security within the attachment. (pp. 497–498)

Other authors have also emphasized the importance of attachment and its role in adolescent development (Allen & Land, 1999). Feminist scholarship has noted that the equation of maturity and separation does not apply to women, who strive to maintain continuity in relationships even as they develop a clearer conception of a personal identity (Gilligan, Lyons, & Hanmer, 1990; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; Josselson, 1987). The emphasis on independence and invulnerability has been cited as contributing to difficulties in the psychological development of boys as well (Bergman, 1995; Pollack, 1998). Olga Silverstein and Beth Rashbaum (1994) have pointed out that parents, especially mothers, are wrongly encouraged to pull away from their teenage sons to avoid stifling their masculinity. They write:

> Often, of course, in the teenage years just as in the earlier phases of our sons' lives, we don't recognize that it is we who are doing the withdrawing. There's a reciprocity to this dance of withdrawal that has been going on for so long, and there's our firmly held and culturally mandated belief that it is the inexorable destiny of the adolescent male to move away from his parents. If for some reason he doesn't—if he's not ready yet to make that move, or if he is comfortable and happy enough within his family circle not to see the necessity of making it—we become very alarmed. And then we are likely to force the issue, with results ranging from disappointing to disturbing to disastrous. (pp. 123–124)

In order to be appropriately nurturing—neither smothering nor overestimating the adolescent—the parents must be able to *empathize* with the adolescent. The "good-enough" parents for an adolescent will be attuned to the adolescent's needs and respond accordingly. It is for this reason that "how to" books on parenting adolescents can offer no more than general guidelines. Like a good therapeutic relationship, the essence of good parenting is a connection; one grounded in empathy and resting on the ARCH—Acceptance, Respect, Curiosity, and Honesty.

THE PLAN OF THIS BOOK

In the next chapter, I present a brief overview of current knowledge about normal adolescent development. I believe that familiarity with the literature on adolescent development is essential for any therapist who is working with this population. Therapists must be familiar with what is typical or atypical in adolescence in order to assess the severity of a presenting problem and to provide proper guidance to parents.

In Chapters 3 and 4, I present in more detail my framework for helping families. In Chapter 3, I present the foundations of the model, which rests on the concept of the *symptomatic cycle*. In Chapter 4, I outline a general framework for assessing and treating families that is based on this model. In Chapters 5 through 11, I apply these principles to problems that families with adolescents commonly present to therapists: eating disorders, depression and suicide, anxiety, defiant and disruptive behavior, psychosis, school-related problems, and problems associated with "leaving home." In Chapter 12, I discuss common pitfalls encountered in work with families with limited financial resources and multiple problems, and suggest ways to avoid these pitfalls. Along the way, I present case examples, some detailed and some brief, which highlight the challenges and delights of working with adolescents and their families.