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Transforming Negative Parent-Adolescent Interactions: From Impasse to Dialogue*

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This treatment development, process research study focuses on resolving in-session, parent-adolescent conflicts characterized by negative exchanges, emotional disengagement, and poor problem solving. These processes have been empirically linked to poor developmental outcomes, and clinically linked to poor therapeutic progress. Specifically, we examined how a shift of therapeutic focus from behavior management to interpersonal relationship failures could resolve this impasse and resuscitate therapeutic momentum. A task analysis approach was used to verify the presence of the impasse, to illuminate its core features, and to define the therapist and client behaviors associated with resolving it. In Part 1 of this two-part series, we presented the final performance map that represented that family's cognitive, emotional and behavioral interactions necessary to resolve the impasse. This article, Part II, focuses on the theoretical foundation of the intervention strategies, the phenomenology of the impasse, and the therapist's skills needed to facilitate it.

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THE empirical foundation of family therapy has changed dramatically over the past decade. Considerable evidence demonstrates family therapy's efficacy for a variety of clinical problems (Baucom, Shoham, Mueser, et al., 1998; G.S. Diamond, Serrano, Dickey, & Sonis, 1996; Pinsof & Wynne, 1995), including child and adolescent behavior problems (Chamberlain & Rosicky, 1995; Estrada & Pinsof, 1995), and adolescent drug abuse (Liddle & Dakof, 1995a; Stanton & Shadish, 1997). Although the volume and

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quality of outcome studies have increased, only moderate progress has been made in identifying important factors that are amenable to change (Alexander, Holtzworth-Munroe, & Jameson, 1994; Friedlander, 1998). Family therapy models provide hypotheses about targets and mechanisms of change (Hoffman, 1981), but empirical development of these theories has been limited (Pinsof, 1989). Family therapy researchers have just begun to examine the relationship between specific problem states, intervention techniques, therapeutic processes, and outcomes (G.S. Diamond & G.M. Diamond, in press; Friedlander, Wildman, Heatherington, & Skowron, 1994). Illustrative studies in this process research tradition include work on parent resistance (Patterson & Chamberlain, 1994), cross-generational boundaries (Mann, Bourduin, Henggeler, & Blaske, 1990), improving and sustaining engagement (Friedlander et al., 1994; Szapocznik, Perez-Vidal, Brickman, et al., 1988), and the relationship of reframing to changes in targeted interactional domains (Robbins, Alexander, Newell, & Turner, 1996).

This article presents an analysis of an essential component of the Multidimensional Family Therapy (MDFT; Liddle, 1991; Liddle, in press). As part of a new generation of empirically based, family interventions for adolescent drug problems (Liddle & Dakof, 1995b; Waldron, 1997; Weinberg, Rahdert, Colliver, & Glantz, 1998; Winters, Latimer, & Stinchfield, in press), MDFT is a comprehensive, multicomponent, multisystemic, integrative, and family-focused treatment (Liddle & Hogue, in press). Randomized trials have established MDFT's efficacy with an adolescent drug abusing population (Liddle, Dakof, Parker, et al., 1998; Stanton & Shadish, 1997). Several process studies have investigated core components and processes of the treatment. These studies have examined the links between changes in parenting and reductions in adolescents' drug and behavior problems (Schmidt, Liddle, & Dakof, 1996); improving poor therapist-adolescent alliance (G.M. Diamond & Liddle, 1996); predictors of treatment completion (Dakof, Tejeda, & Liddle, 1998); the impact of culturally syntonic themes to engage African American males in therapy (Jackson-Gilfort, Liddle, & Dakof, 1997); gender-based treatment issues (Dakof, 1998); and the family's in-session patterns of change associated with the resolution of parent-adolescent conflict (G.S. Diamond & Liddle, 1996). This current article extends the last study, by focusing on: a) the theoretical foundations of the intervention strategy, b) the phenomenology of this type of conflict (the impasse), and c) the specific therapist's actions that guided the family's resolution process.

Overall, this study investigated a core aspect of MDFT, a "shift intervention," developed to resolve in-session impasses—conflictual, negative, and frequently escalating parent-adolescent arguments about behavior management issues (G.S. Diamond & Liddle, 1996). How to address these acrimonious exchanges is a major challenge to any therapist working with adolescents and their parents. Accusatory, hostile, and defensive discussions about taking phone messages, breaking curfews, completing chores, or a teenager's friends can turn therapy discussions sour. When these negative exchanges persist, family members feel hopeless about change and dissatisfied with treatment. From this juncture, the likelihood of noncompliance or early termination increases (Firestone & Witt, 1982; McMahon, Forehand, Griest, & Wells, 1981; Patterson, 1982).

To counter this in-session negativity, usually a prevalent family transactional pattern, we used the shift intervention to

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transform the therapeutic focus, that is, to shift the family's attention from unproductive disagreements about day-to-day behavior management issues toward discussions of core relationship conflicts between the parent and teenager. We hypothesize that ruptures in the adolescent-parent attachment/caregiver relationship fuel hostility and resistance in the behavioral realm. Attachment conflicts usually concern problems of trust, commitment, power, protection, and love. They frequently relate to long-standing histories of neglect, betrayal, abandonment, and abuse. When effective, the shift intervention moves the conversation from the parent blaming the adolescent to the adolescent disclosing feelings about attachment disruptions or failures. Focusing on the adolescent's concerns reduces the teenager's negativity, promotes his or her engagement into treatment, and increases the possibility of a more meaningful conversation with the parent(s) (G.M. Diamond, Liddle, Hogue, & Dakof, 1997; Jackson-Gilfort et al., 1997; Liddle & G.S. Diamond, 1991). Our aim is not simply to reframe or reinterpret the conflict. Rather, our objective is to create a new in-session content/affect focus that can circumvent stagnant, unproductive dialogue. When core conflicts are identified, the shift gives parents a new perspective on and experience of their teenager. This helps rekindle parents' empathy toward their child, and encourages adolescents to identify and express a wider range of emotions and concerns.

A brief case vignette illustrates the shift event. In one session, Ms. Jones and her daughter viciously fought about seemingly innocuous topics, such as chores. The mother asserted that her daughter needed more supervision, while the daughter repudiated her mother's authority. The exchange escalated, negative emotional tone increased, problem solving stagnated. Rather than continue to discuss chores, the therapist asked why this topic generated such extreme hostility ("What's getting in the way of deciding on chores?"). Dropping her guard for a moment, the mother said she felt rejected by her daughter: "She won't let me be her mother." Bursting into tears, the girl screamed that her mother deserved to be rejected. With the articulation of this common relationship theme (payback or retribution), the first phase of the shift had occurred. Staying focused on the theme, the therapist helped the daughter express, for the first time, her resentment about being placed in a group home for a year because of conflicts between herself and her mother's boyfriend. The mother's initial response to her daughter's accusations was defensive. The therapist, however, kept the conversation focused on relationship themes of abandonment, retaliation, and forgiveness. As the daughter maturely articulated her resentment, the mother increasingly acknowledged the daughter's position and began to express remorse about her own decision. These themes remained a major focus of conversation over the next several therapy sessions.

THEORETICAL FOUNDATION

The proposed mechanisms of the shift event may be understood from several vantage points. For example, Wynne's (1984) epigenetic model of relationship development makes a case for why one might shift from a behavioral focus or problem-solving attempts to an attachment focus. In his framework, attachment and caregiving serve as the foundation upon which the success of other essential interpersonal behaviors (communicating, problem solving, and mutuality) depends. Wynne argues that family members must have a fundamental basis of trust and attachment before they are willing to learn communication skills and seek mu-

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tually supportive solutions to problems. Consequently, a premature in-session focus on behavior control or management that ignores assessment and repair of the attachment bond may lead to stagnant therapeutic process. Family systems and adolescent development researchers have found empirical support for the fundamental role that parent-adolescent attachment relationship plays in healthy adolescent development (Armsden & Greenberg, 1987; Doane & Diamond, 1994; Ryan & Lynch, 1989; Youniss & Smollar, 1985). Even after problem behavior begins, parenting practices and a family environment of continued connectedness and support with appropriate autonomy can decrease adolescent deviance, including drug abuse (Schmidt et al., 1996; Steinberg, Fletcher, & Darling, 1994; Wills, 1990).

Theory and research on cognitive attributions also enhances our understanding of the shift event's possible mechanisms of change. Negative and blaming problem definitions, based on internal, stable, and global dispositional factors are common in distressed relationships—for example, "She is a bad, mean person"—(Fincham & Bradbury, 1988; Gottman, 1979). In fact, conduct-disordered youth are much more likely to perceive a hostile intent when it is not there, compared to other teenagers (Dodge, Price, Bachorowski, & Newman, 1990). Interventions that target and change one's cognitive set can influence behavior—by reducing overt hostility and blame—and affect—by increasing expectations for change (Mas, Alexander, & Turner, 1991; Robbins et al., 1996; Schmidt et al., 1996). The shift intervention attempts to redefine the belief that behavioral conflict is solely rooted in personality traits, and helps family members attribute aspects of these problems to disruptions in interpersonal relationships.

Contemporary thinking about the role of affect in psychotherapy provides additional insight into the possible therapeutic mechanisms of the shift event. Like Emotionally Focused Couples Therapy (Greenberg & Johnson, 1988), the success of the shift partially rests on the therapist's ability to evoke softer, more vulnerable or empathic feeling states (G.S. Diamond & Liddle, 1996; G.S. Diamond & Siqueland, 1998). Developing empathy between adolescents and parents is a classic and powerful therapeutic strategy. For example, the therapist might say to the adolescent, "You have a right to be angry about your father not showing up on Sunday. But I wonder if he knows how hurt you feel when he does this repeatedly?" Accessing primary emotions such as fear, sadness, anger, and resentment, motivates clients to consider alternative cognitive schemas regarding self and others (Greenberg & Safran, 1987). In addition, when used with sensitivity and skill, the expression of vulnerable emotions in one family member can reduce hostility and elicit support and compassion from other family members (G.S. Diamond & Liddle, 1996). The shift event elicits primary emotions about relationship distress and failures. These feelings, such as disappointment and resentment, are often expressed indirectly through a lack of cooperation or anger when discussing day-to-day behavior management issues.

EMPIRICAL FOUNDATION

Empirical evidence on adolescent development also provides support for the value of interventions that repair the attachment relationship and reduce excessive conflict and negative affect (Liddle, Rowe, Dakof, & Lyke, 1998). Research has demonstrated that appropriate parent-adolescent interdependency throughout adolescence establishes a foundation for healthy adolescent and parental development (Grotevant & Cooper, 1983; Hauser,

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Powers, Noam, et al., 1984; Montemayor, 1986). When parents remain secure attachment figures, adolescents more readily explore their own competency and autonomy (Bowlby, 1969; Kobak, Cole, Ferenz-Gilles, & Fleming, 1993). A teenager's relationship with his or her parents continues to be important throughout the adolescent years. A good relationship serves a protective function against negative peer influences and deviance and the development of antisocial behavior (Hawkins, Catalano, & Miller, 1992; Wills, 1990). But to achieve a positive parent-adolescent relationship, parents must gradually transform their use of authority from a unilateral approach to one of cooperative co-construction (Youniss & Smollar, 1985). Failure to accomplish this transition frequently results in family conflict and negative developmental outcome for adolescents.

Although some conflict is normal, frequent, intense, and unresolved conflict between parents and adolescents is not (Montemayor, 1986). As Cooper (1988) states, "When family conflict is hostile, impulsive, consistent and prone to escalate to high intensity, children feel neglect, lack of love, and tend to avoid interaction with parents" (p. 183). Unfortunately, intense conflict is highly characteristic of the family environments of adolescent drug abusers and delinquents. These families are chaotic, disengaged, high in conflict, low in warmth, and excessive in their use of coercive parenting (Baumrind, 1991; Mann et al., 1990; Olsen, Russell, & Sprenkle, 1983; Patterson, 1986; Shedler & Block, 1990), all of which lead to poor developmental outcomes (Campbell, Adams, & Dobson, 1984; Hauser et al., 1984; Papini, Sebby, & Clark, 1989). Clinically, chronic negative emotional expression during sessions maintains the memories of negative experiences of each other, reduces flexibility in problem solving, lowers expectancies for change (Liddle, Dakof, & Diamond, 1991; Teasdale & Fogarty, 1979), and has been associated with poor treatment outcome (see Alexander, 1973; Mann et al., 1990; Robbins et al., 1996).

In sum, Hoffman's (1981) call for greater specificity about our clinical change targets can now be addressed on an empirical basis. Basic research in developmental psychology and developmental psychopathology reveals clues about how to define, orient, and structure treatment. Given the frequency and serious consequences of chronic, severe parent-adolescent conflict and negative affect, clinical methods, such as the shift intervention—specifically tailored to change these processes and enhance the developmental competence of the parent-adolescent relationship—could enhance treatment retention and effectiveness (Miller & Prinz, 1990).

METHOD

We used a change event, process research methodology, to study the shift intervention (Horowitz, 1979; Luborsky, 1984; Rice & Greenberg, 1984). This research tradition uses qualitative and quantitative techniques to search for patterns of therapist and client behaviors during a specific therapeutic change event. Greenberg (1984) noted that change events consist of a problem state (an in-session impasse between family members), an intervention (the shift), and a resolution (a focus on interpersonal content). This approach requires the definition of specific clinical tasks and related change processes that are believed to contribute to treatment progress (for example, increasing parental cooperation, improving problem solving, and so on). The intensive study of these clinical tasks and associated interactional processes results in complex maps that define the clinical terrain in a systematic and generic way.

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In a previous research report (G.S. Diamond & Liddle, 1996), we presented a performance map of the client behaviors, emotions, cognitions, and interactions necessary to resolve this impasse. We also presented the broad strokes of the therapist intervention strategies that directed the shift. These findings were based on descriptive analysis and observational rating of successful and unsuccessful shift events. In the present report, we focus our descriptive analysis on patient behaviors during the impasse and the micro, moment-by-moment, therapist skills that help facilitate the shift theme. Although a full description of the research procedures can be found in G.S. Diamond and Liddle (1996), we provide a brief summary of the design and methods of the study.

Population Characteristics

In the sample (N = 10), the age of the adolescents averaged 15.4, with a range from 14 to 17. Six of the adolescents were female, and four were male; eight were Caucasian, and two were African American. Four of the adolescents were on formal probation, and three of these were court-ordered to treatment; all ten teenagers had juvenile justice system involvement. Two adolescents lived with both biological parents, and eight came from divorced homes. Of these eight, five were living with their mothers, and three lived with their mother and stepfather. All but two of the parents had full-time jobs. Five different therapists participated in the ten shift events used in this study. They had at least a Master's degree, 5 years of clinical experience, and several months of training in Multidimensional Family Therapy (Liddle, 1998). The cases were seen as part of a controlled trial testing the efficacy of MDFT compared to group therapy and a multifamily educational intervention.

Procedures

In brief, during a randomized clinical trial for treating adolescent substance abuse (Liddle, Dakof, et al., 1998), we collected 25 videotapes of therapy sessions that contained attempted shift events (identified by therapists or supervisors). We then selected five successful and five unsuccessful episodes for intensive descriptive study. Success was defined as at least one family member identifying a core interpersonal conflict and engaging in a positive conversation about that conflict.

The change event divided into three phases: the problem state (the impasse), the intervention (the shift strategy), and the outcome (resolution of the impasse). In order to verify the occurrence of the three phases in the tape segments, two manuals were developed. One manual operationalized the therapists' expected behaviors when initiating the shift (Diamond, 1991a). The other manual operationalized the families' expected behaviors when the impasse was resolved (Diamond, 1991b). Undergraduate psychology students were trained to identify these behaviors. Using Cohen's coefficient of agreement (kappa), raters reached an average of .93 agreement on identifying the initiation of intervention (therapist marker), and an average of .95 agreement on identifying the beginning of the resolution (family marker). The average change event episode lasted 7.6 minutes, with a range of 1 to 14 minutes.

Descriptive Procedures

Data collection began with the first author performing an intensive examination of videotapes and transcripts of all ten episodes. The MDFT theoretical model (Liddle, 1991; Liddle et al., 1991) guided a moment-by-moment, line-by-line exegesis of each episode. Each episode required approximately 15 hours of review. Each

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episode was then coded with eight scales from the Beavers Timberlawn Family Evaluation Scale (Lewis, Beavers, Gossett, & Phillips, 1976). For this procedure, each taped episode was edited into its three phases, using the therapist and family markers as division points. All 30 segments were then randomized and coded. Coders obtained adequate reliability on all eight scales ($\leq$.69, Pearson). We used this empirical data as additional descriptive information to assist in the model development, and not to verify the effectiveness of the intervention.

RESULTS

Part I of this study (G.S. Diamond & Liddle, 1996) provided a sequential performance map of the family and therapist behaviors during successful and unsuccessful shifts. The current article will first present descriptive findings regarding the phenomenology of the impasse. Eight content themes are presented that characterize the complaints of the parents and the adolescents during the impasse phase. These themes can provide clinicians with a road map to guide them to the core themes and issues that characterize this problem state. Data in Part I also presented the general themes of the therapist intervention. This report will focus on the more subtle and elusive therapist skills needed to orchestrate this complex therapeutic dialogue.

Phenomenology of Impasses

Parental Frustration: "I can't take this anymore": Nearly all the parents complained that their adolescent showed extreme disrespect for their authority. They reported feeling abused, neglected, and taken for granted. Several parents claimed that if their child would show at least some respect, they could tolerate the stresses of childrearing more easily. An adolescent's indifference to parental authority has been identified as a core component of ineffective parenting and dysfunction in relationships in clinical families (Allen, Hauser, & Borman-Spurrell, 1996).

Mom: Well, the most difficult thing is the disrespect I get. I cannot stand it. You talk to me like I am a piece of shit. You yell, you scream, you act like I am your child. You tell me what I am supposed to do. . . This is my house. I pay the bills here. I buy the groceries. You are the kid and I am the parent. You don't tell me what I am supposed to do.

Parental Helplessness: "There is nothing I can do": Most parents expressed feeling inadequate and ineffective in managing their child. They often feared for their child's wellbeing, yet felt unable to protect them or control their behavior. Frequently, the parents expressed their helplessness as anger (Volk, Edwards, Lewis, & Sprenkle, 1989). The emotional reactions of the adults to their experience of parenting these adolescents is decidedly negative. Under the best of circumstances, parenting teenagers is a challenge. Parenting teenagers who show the kinds of problems demonstrated by clinical adolescents is an enormously difficult job. These problems do not develop overnight; they evolve gradually over many years, creating chronic stressors and tension in families (Loeber, 1988). The toll that these stressors take on parents is tremendous (Dix, 1991).

Mom: I mean, it has gotten to the point where she tells me what she wants to do. Like, when I get home around eight o'clock, she tells me, "Oh, by the way, I'm going out. I'll be back at eleven."

Adol: No I didn't. I said I was gonna go out with Ray to the city if it's all right with you. And then you said no. And I said "What can I say? He's already on his way."

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Mom: Right. I said "no," and you said, "Well, he is already on his way, so what can I do?" So it doesn't matter if it's all right or not. You still did what you wanted to do, regardless of what I said.

Parental Fear of setting expectations: "I don't want trouble": Many parents feared doing the very thing that enhances adolescent development—making maturity demands on their son or daughter (Baumrind, 1991). Parents felt that improvement in their relationship with their teenager would not be worth the necessary emotional pain and struggle. Many parents assumed that they could do nothing to influence their son or daughter and they simply had to wait until their child moved out or was arrested. In fact, many of these parents were intimidated by their adolescents (Dakof et al., 1998). Addressing parental expectations and negativity has been found to be an important aspect of family-based therapies (Patterson & Chamberlain, 1994; Schmidt et al., 1996; Stoolmiller, Duncan, Bank, & Patterson, 1993).

Ther: Are you happy with how things are going?

Mom: Of course not. But it is better than before. We don't fight as much, but we don't talk anymore either. We pass in the hallway and don't even say hello.

Adol: I say hello, but you just start yelling at me. So I don't say it any more.

Ther: So you just ignore each other.

Mom: Basically. It keeps the peace.

Parental Abdication: "I give up": Abdication shows up when a parent actively communicates his or her disinterest in continuing to exercise parental influence. Abdication is the last stop on a journey that ends in out-of-home placement. The parents' efforts to influence their adolescent's behavior have failed. They attribute this defeat to either their inability or lack of fortitude, or to their child's personality characteristics. Feelings of failure accompany the parents' sense of inadequacy. Together, these feelings accentuate further hostility and abdication.

Dad: I'll tell you Terry [therapist], our hopes and dreams have faded. He could move out and do fine; but at this point, I actually don't give a damn. We cannot communicate with him no matter how hard we try, and I don't think things are ever going to change. It's just the way he is. So I think the emancipation may be our only hope.

Adolescent Entitlement: "You can't tell me what to do": Many adolescents were unwilling or unable to negotiate for autonomy with their parents. With parents who generally had given up monitoring or structuring, these adolescents were accustomed to considerable independence, far greater than nonclinical adolescents. Many adolescents felt entitled to their independence, and not accountable to their parents' inconsistent rules.

Adol: She tells me to stay home and that's BS. I'm not going to stay home on a weekend night. I stay home on weeknights because I have to go to school. I don't go to school on Saturday, so I want to go out on Friday, and I am going to go out. You can't treat me like a child now, because you didn't when I was twelve.

Adolescent Rejection of parental authority and hierarchy: "We are all equal": These adolescents strongly resisted the therapist's attempts to increase parental control. They scorned parental authority, viewed their parents as peers, and expected equal power in the relationship with their parents. Our sample of parents showed an authoritarian (vs. authoritative) parenting style (Schmidt et al., 1996), yet they felt powerless and were ineffective. The adolescents resented this mix-

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ture of authoritarianism and incompetence, and they often exploited this weakness.

Mom: Yes. It's like she won't let me be the mother.

Adol: You can be the mother. I don't care.

Mom: I can't. Because if I tell you "no," you don't like it.

Adol: Well you don't trust me.

Mom: I don't. In the first place, I don't have to give you a reason for everything.

Adol: It would be nice to let me know . . . then why should I have to give you a reason? We are both equal and are both human beings!

Mom: We are not equal!

Adol: Yes we are. We are all equal, excuse me. [to therapist] Aren't mothers and daughters equal? We're all human!

Adolescent Hopelessness: "Things will never get better": Parallel to what the parents articulated, the adolescents expressed their own despair (Grilo, Walker, Becker, et al., 1997) and rebuffed the therapists' attempts to rekindle hope. They maintained strong pessimism about family relationships improving (Newcomb & Harlow, 1986). Continual hostility and disagreement had led to repeated disappointment. These adolescents seemed to lower their expectations for parental love, protection, and guidance—perhaps in order to protect themselves from the disappointment of further caregiver failures.

Adol: I think we should just call it off and go home. We're never going to get anywhere. She [mom] is stubborn and I am stubborn. And I'm sick of it. We're at that point. We won't be able to get along never, never, never, never. If it has not worked yet, it won't work now.

Adolescent Negative Perceptions: "I can never get a break": Adolescents often felt that they were trying to cooperate, but their parents refused to recognize their efforts. They complained that parents were too restrictive in their attempts to reestablish control, or that their parents' negative set toward them would never change. The adolescents' perception of their parents' rigidity matched the parents' identical belief about their teenager.

Adol: I told her I was going to the movies yesterday. I told her I'd be late. I came back an hour and fifteen minutes after curfew. It wasn't like I was out on the streets running around, doing something stupid. There ain't nothing I can do right.

Adolescent development is characterized by the transformation of the adolescent-parent relationship. Over time, parents and adolescents usually negotiate the balance of autonomy and connectedness. But for the families in this study, and in parallel clinical samples (Papini & Roggman, 1992; Rosenstein & Horowitz, 1996; Volk et al., 1989), the attachment relationship was in severe disrepair. The adolescents no longer feared losing their parents' love and respect, and showed little motivation to cooperate or be civil. Both the parents and adolescents felt hopeless about improving their relationship, and each complained of feeling disrespected. The parents felt stripped of their authority while the adolescents felt entitled to their independence. Consequently, from discussions about topics such as daily routines, emerged parental hostility or rejection and adolescent retaliation. Under these conditions, day-to-day problem solving and dialogue in general came to a halt. Faced with this unproductive and sometimes destructive in-session process, the therapist attempted to shift the discussion from a focus on behavior management problems toward a discussion of relationship or attachment themes.

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Therapist Behaviors During the Shift

In the second half of this report, we focus on the therapist skills needed to facilitate the shift themes. Unfortunately, the specification of therapist interventions and their interaction with client performances has received minimal attention by task analytic investigators (G.S. Diamond & G.M. Diamond, in press). Conceptual models for describing this interaction have yet to be developed. Pinsof's (1986) Therapists Behavior Rating Scale and Hogue, Liddle, & Rowe's (1996) call for adherence process research may serve as starting points for development in this domain.

In the 1996 article (G.S. Diamond & Liddle), we articulated the successful and unsuccessful sequential interactions between the therapists' interventions and the patients' responses, from the beginning to the end of the change event. A brief example of this type of dialogue is presented below. In this report, we present information regarding the therapist skills needed to facilitate the shift theme. While the shift strategy provides the direction and goal of the intervention, these skills represent a microanalytic assessment of the moment-by-moment decision rules and strategies needed to orchestrate a complex family dialogue (that is, enactment). In the following Figure, we organize these skills according to stages of implementation. First we describe strategies for initiating the shift. Then we describe how therapists tracked and used feedback from the families and themselves to further develop the theme of the shift. In stage three, we depict techniques for coaching the family once the interaction/dialogue has begun. Finally, we briefly address how the process begins to move from a very directed sequence to a more open-ended exploration, once the resolution of the impasse (not necessarily the problem) has been achieved.

In brief, one version of a successful shift intervention might go as follows. Therapist initially circumvents the parents' hostility by pulling for feelings of regret: "Is it a disappointment that you and your son have grown apart?" Assuming the parent affirms this, the therapist may then turn to the adolescent and ask: "Did you know that your mother has these regrets?" Usually the adolescent would display disbelief. The therapist might then ask if the adolescent has any regrets about the lost relationship. If the adolescent denies this, the therapist may ask the parents why the adolescent is so angry that he or she no longer even cares about them. At this point, the conversation has clearly moved away from behavior management and onto the quality of the relationship. Parents are then encouraged to ask the adolescents what has happened that makes them so bitter. If an adolescent feels protected by the therapist and trusts that the parent really wants to hear these reasons, he or she may begin to describe long-standing problems (for example, neglect, abandonment, and abuse). The disclosure of these topics is considered the resolution of the impasse (and the beginning of interpersonal conflict resolution). However, the therapist must help the parents remain respectful, curious, and empathic, or the adolescent will perceive this as another failed problem-solving episode.

The above description is only a brief overview of the shift procedure (see G.S. Diamond & Liddle, 1996 for more details). The actual conversations are drawn out and complicated. Each therapists and patient statement may become the topic of an extended conversation. The actual success of each step will depend on the therapist's ability to facilitate, here and now, emotionally charged, multifaceted, complex conversations. The skills outlined below represent several portions of these

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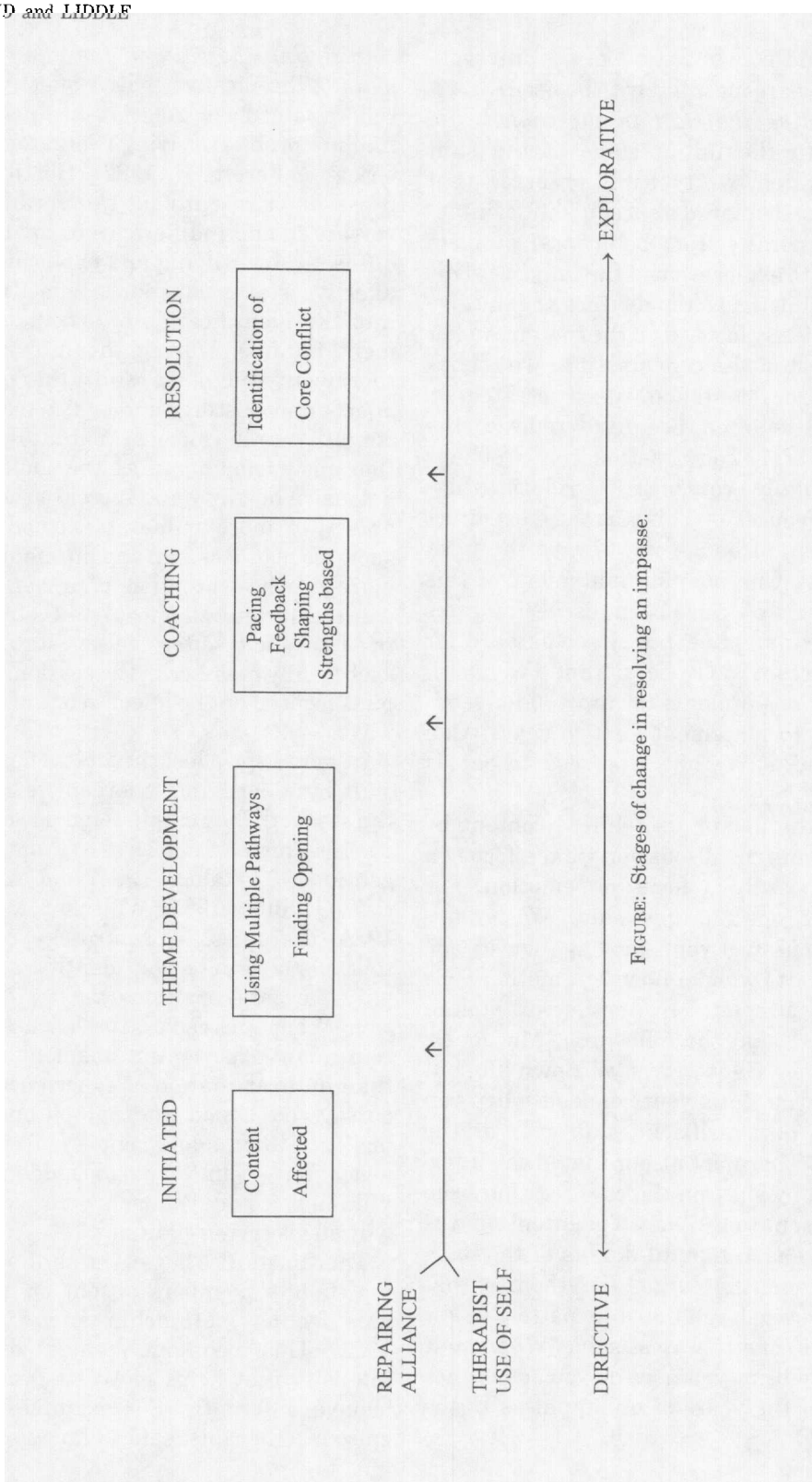

FIGURE: Stages of change in resolving an impasse.

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skills and at what stage of the intervention they are most likely to be used.

Initiating the shift in the content domain: In the initial stage of the shift intervention, we typically observed that therapist displayed a specific shift of intention, generally from behavioral problem solving to exploration of the impasse. This initial shift was often distinct and incisive and typically focused on the content and/or the affect of the conversation. We identified three content-focused strategies. Therapists often began to redirect the content of the conversation from problems about daily routines to relationship-focused concerns. This was the most direct approach, although not always the most effective. One opening statement of this type was: "We have been discussing rules for your daughter, but it seems hard for her to accept you as her parent. I wonder if she has resentments toward you for sending her to placement for two years? Can you find out what the resentment is about?"

The therapists also shifted content by redirecting the discussion from a focus on a behavior to a focus on emotion. For example, one therapist said, "We can finish discussing your moving out of the house, but I wonder how your mother feels about your plan." In another example a therapist said the following: "Mr. Jones, you have a right to live your own life, but how do you think your son feels when you have a new girlfriend stay over at the house?" Therapist also initiated the intervention by shifting the conversation from the present to the past. The intention was not to rehash hurtful details of the past, but to identify large, life themes that characterized relationship patterns. For example, one therapist said, "When your father yells at you now, do you sometimes think of the years of unhappiness in the family?"

Initiating the shift in the affective domain: A chronically negative affective tone, reflective of basic relationship problems, inhibits problem solving (Forgatch, 1989; Griest & Forehand, 1982). Hostility, depression, or resentment can derail a conversation, and indifference or apathy can diffuse it. Identifying and exploring these affective states can be an effective lead into the identification of specific attachment failures. During the intervention, therapists sought to shift the parents' affect from hostility and/or frustration to empathy and concern. Simultaneously, therapists tried to reduce the adolescents' defensive hostility and increase the availability of more vulnerable mood states such as sadness, disappointment, or a more direct expression of anger/resentment. In general, most shift strategies tried to elicit softer feeling states from each family member in the session. Therapists focused on the affect in one of several ways.

In many episodes, therapists began the shift by identifying emergent feelings in the session. The goal-directed use of emergent feelings characterizes existential (Bugental, 1987; Yalom, 1989) and experiential (Gendlin, 1981; Whitaker & Keith, 1981) therapies. This strategy requires therapists to perceive, identify, and amplify patients' emotions *during* the session. When successful, the discussion becomes an experiential moment, rather than an examination of experiences from outside the session. For example one therapist said to an adolescent: "You've pulled away. You seem very sad suddenly. Ms. Williams, could you ask your daughter why she is crying right now?"

Therapists also began the shift by "lending" family members absent or unavailable feelings (Minuchin and Fishman, 1981). This technique creates emotional intensity that helps motivate families to behave differently. For example, in one episode a therapist said, "I know you were

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angry when your daughter didn't come home, but weren't you also afraid? My goodness! I would have been." In another episode a therapist said "What a tragedy! You two had been close for so long and now it seems you have lost each other."

Frequently, therapists did not need to activate new emotions in the room. Instead, they merely brought the covert feelings of resentment or disappointment more overtly or explicitly into the discussion. "Ray, I don't think you are being straight with your father. You seem very angry. Why don't you tell him directly how you feel rather than complaining about this petty stuff?" In general, the clear intentional shift in content and affect not only served as the pivotal point to the intervention, but clearly differentiated the successful and unsuccessful shift episodes.

Maintaining and repairing the alliance: Maintaining working alliances with the parents and adolescents throughout the change event was challenging. The therapists typically sided with the adolescents during the shift, and parents often felt blamed and became defensive. In successful episodes, the therapist frequently focused on repairing the threatened alliance with the parent. For example, in one episode, the therapist suddenly stopped the shift goal and focused on the parent's reluctance: "Ms. Roberts, I am not blaming you for your son's problems. Do you feel I am? . . . Would you tell me if you did? . . . . Good! Because I am suggesting that your son has some things on his mind, big things, that are fueling his anger and lack of cooperation. If we could hear him out, it may diffuse some of his resistance and mistrust. Don't feel like you have to defend yourself now. Let's just hear what he has to say."

When parents accepted this kind of rationale, they became more engaged in the task. When parents' reluctance could not be assuaged, therapists often punctuated their progress, consolidated their gains, and scaled back their goals. "Well, at least we agree that the problem of chores does not warrant the anger you two are expressing. I think more lies behind this, but we may not get to it today. Let's stop for now and bring it up next time." In unsuccessful episodes, therapists missed or ignored this feedback, trying to push their agenda forward in spite of the resistance. In successful shifts, the therapist often attended to the alliance even if for only a brief moment. This checking-in process helped the therapist keep in touch with the patient.

Therapists' use of self: Like the alliance, therapist use of self was a focal point of the interventions throughout the change event. During the shift, therapists asked families to focus on painful feelings or discuss long-avoided topics. Therapists encouraged family members to be direct, honest, and vulnerable with each other. This required tremendous trust and courage of all participants. Therefore, the therapists' personal investment in each therapeutic moment greatly affected its outcome. Personal investment refers to the therapists' willingness to enter intense, interpersonal conversations with the families. Therapists must bring to the task their own honesty, commitment, conviction, and vulnerability. This stance not only lends courage to families, but also mirrors the integrity that the therapists attempt to engender in each family member. In contrast, if a therapist expresses a hopelessness and pessimism about change, this "bad attitude" can permeate treatment and undermine the family's efforts. In this regard, therapist attitude is as vital a target of input in a therapeutic system as any family members' attitude (Liddle, Becker, & G.M. Diamond, 1997).

Developing and working a therapeutic theme: Once the shift had been initiated,

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therapists worked to develop and maintain a focus on the interpersonal themes that began to emerge. Themes help to create new "working realities" (Minuchin & Fishman, 1981) or reframe deleterious problem explanations into more productive ones (Watzlawick, Weakland, & Fisch, 1974). An effective theme captures a core conflict or an essential dynamic of the parent-adolescent relationship. The astute clinician then uses the theme to guide the focus of treatment. But these focus opportunities depend upon a therapist's perception. The therapist elicits the stories—the content that represents the family members' lives. These themes also become familiar as they repeat across families and the therapist begins to use them as templates for assessment as well as targets for intervention.

Themes are not easy to develop. In unsuccessful episodes, therapists articulated vague and inaccurate themes or discussed them too briefly. Rather than emerging naturally from the families' experiences, therapists too often imposed themes on the family. In contrast, in the successful episodes, themes were clear, to the point, and directly focused on families' core conflicts or attachment disruptions. Therapists also worked to keep the theme at the center of the conversation long enough to penetrate the families' resistance. For example, the shift frequently focused on the adolescent's sadness behind his or her anger. In the vignette presented at the beginning of this article, the therapist said, "Ms. Jones, I wonder if your daughter feels like you gave up being her mother when you sent her away, and now she resents that you expect everything to be back to normal." Although this may be an accurate interpretation of a core conflict, both the parent and adolescent might initially reject it. The mother might reject it out of pride or to protect her self-esteem, while the adolescent might reject it to conceal her hurt and disappointment. At this juncture, the therapist would begin using multiple pathways to gather ideas, emotions, body language, and interactions as evidence, either to modify the theme or to articulate it better. Articulation of an accurate therapeutic theme may not be curative in and of itself, but it is a critical step in the facilitation of the shift.

Multiple pathways: The difficulty of orchestrating a complex, clinically meaningful dialogue between conflictual, disengaged family members should not be underestimated. It requires attention to the details of within-session content and process, and the flexibility to respond to it. MDFT assumes that all intrapersonal (emotion, cognition, motivation), interpersonal, (family, peer), extrafamilial (relatives), and social (school, probation, community) aspects of a family's functioning are appropriate targets of intervention (Liddle, 1998). For the flexible therapist, these targets can serve as the openings and pathways toward desired therapeutic goals.

By flexibility, we refer to knowing how to focus on suitable content in a session, how long to focus on it, and how to shift to a more productive zone of work when needed. For example, in one unsuccessful episodes, the therapist emphasized only one aspect of a theme: "Eric, talk to your mother about why you are sad." The therapist failed to address the complex weave of personal and interpersonal memories, motivations, and behaviors that made up this core relationship failure. In contrast, in successful episodes, therapists used multiple pathways to facilitate the shift. Let us give an example of two types of pathways.

One pathway involved using one family member to motivate shifts in another. Emotional or attributional shifts in one person, when expressed, can be used to

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motivate or prompt changes in another person. For example, in the episode presented in an earlier vignette, the therapist said to Ms. Jones, "I know you felt justified in placing your daughter, but I bet you also missed her while she was away." (Mother agrees and a shift in expressed emotion occurs.) [Turns to daughter] "Did you know that your mother missed you? . . . . Besides being angry, did you ever miss her as well?" Using this sort of shuttle diplomacy (G.S. Diamond & Liddle, 1996), the therapist would establish a new content domain and emotional tone in the conversation.

A second pathway involved using multiple family members to frame and facilitate in-session action. When one family member resisted the shift theme, therapists turned to other family members for help. For instance, the therapist turned to the younger child of Ms. Jones and said, "Jim, your sister is having difficulty putting her sad feelings into words. Could you help her out? Do you think she missed her mother?" Assuming the brother was in agreement with the therapist's goal, and capable of responding empathetically, the sibling could introduce new information to support the shift, embellish or refine the theme, or lend courage to his sister to venture into the theme's emotional territory.

Perceiving and capitalizing on openings: Using multiple pathways requires the ability to see, hear, or create clinical moments or "openings" that support the direction of the shift. Using the theme as a guide, therapists judged which client statements, mood shifts, interactions, or behaviors would facilitate or inhibit the direction of the shift. For example, at one point a daughter said to her mother, "You didn't understand what I just said. You never listen to me." Focusing on the first statement could elicit a conversation about communication problems. The second part of the statement, however, contains complaints about neglect (content), a tone of disappointment and resentment (affect), and references to the past (history). Amplifying these aspects encourages a focus on the desired shift theme. The therapists continually made judgments about which material to focus on and which to avoid, based on the intent of the shift theme.

Pacing and obtaining feedback: Once a therapist had identified and developed a shift theme, and the family began to accept it, the therapists became less content-directive and focused more on coaching the process of the conversation. During this coaching stage, accurate pacing is essential. Pacing refers to moving a discussion forward without losing the family's investment in, or understanding of the task. In unsuccessful episodes, the therapists' goals or plans often blinded them from reading the family's feedback. For example, when therapists push a family member too hard, they threaten the alliance. In successful episodes, therapists perceive these ruptures and respond to them (that is, extreme reluctance = slow down). In one example, the therapist stopped his shift challenge, leaned forward and gently said, "Am I pushing you too hard? I know this can be difficult." When the family member confirmed the therapist's fear, repairing the alliance temporarily became the focus of conversation. If the family member disconfirmed the concern, the therapist resumed the shift strategy.

A therapist's speedy pace and failure to read the feedback was a common error in the unsuccessful episodes. For instance, therapists often presented too many ideas at one time, thereby either confusing the family or not getting their agreement and acceptance on themes. For example, in one unsuccessful shift a therapist said to an adolescent, "You seem very hurt by your mother. And you feel like she doesn't

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understand this. But she says she can't listen when you yell at her. Do you think you and I could talk about this together first? Then, later, we can discuss it with your mother?" Each of these sentences represents an important topic, worthy of an entire conversation. In addition, the meaning of each statement may only make sense if the adolescent agrees with the previous one. In successful episodes, the therapists explored each idea, one at a time, insuring that the adolescents understood and agreed with each before presenting the next. Again, this process of "checking in" with family members helps to keep the therapists on-track and the family on-board with the intervention. It also conveys a process that models effective problem solving: "We'll take each of these complex issues apart, and deal with them one piece at a time."

Shaping the conversation: Complex enactments such as the shift require the therapist to shape or sculpt the conversation. Therapists should be thinking to themselves: "A bit more of this, a little less of that. Now let's hear from mom but not on that topic. The content is not great but the tone is good. Is the emotional tone good?" For example, while an adolescent was expressing her disappointment, she regressed to complaints and anger. The therapist briefly entered the conversation to bring the adolescent back to the softened affective stance, the one aligned with a core relationship theme "Sally, you often tell your mother about your anger. But this time, let her know about your disappointment." The ability to quickly and tightly shape or coach the conversation increases the likelihood of its staying on-track. But, if the therapist remains in the conversation too long, the family dialogue could stop, and the therapist would become the center of attention.

Effective shaping is guided by three questions: a) Is this conversation accomplishing what I want? b) Should I say something and to whom? c) If I enter the conversation, how long should I stay in? The answers depend on the stage of the therapy, the quality of alliance, and the level of the adolescents' and parents' interpersonal skills. Early in treatment, or with a less functional family, therapists may re-enter the conversation frequently, continually reiterating the theme, and stay involved for longer periods. Higher functioning families or families farther along in treatment need less coaching from the therapist. Parsimony is the guiding principle, and successfully creating a meaningful conversation is the primary goal.

Strength-based interventions: In the successful episodes, the therapists used support and compliments as prompts to shape the conversation. For example, when one adolescent lapsed into accusation and criticism, the therapist entered quickly saying, "Come on, Jim, I have seen you do better than this. I know you can be more direct about how this affects you. Tell her now what's happening with you." Or, when a father moved off-focus and began blaming his son, the therapist said, "Mr. Edwards, right now I think Billy needs your understanding, that strong but supportive quality of yours that you showed last week." Embedding challenges in compliments reduces resistance and inspires compliance.

Resolution: knowing what to do when the shift worked: Finally, therapists had to identify when the shift had succeeded and what to do next. For coding purposes in this study, the resolution was defined as at least one family member identifying an interpersonal/attachment problem and expressing a less negative affective tone. However, in most episodes the therapists continued working the shift strategy until the other family members at least acknowledged the importance of the shift

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theme. The therapeutic skills involved in resolving the conflicts and resuscitating the attachment/caregiver relationship were characterized by two features. First, after the resolution, therapists became less directive and provocative, and more facilitating and encouraging. Second, the therapists became less goal-focused in one sense (for example, in identifying the relationship problems). Instead, the focus became more experiential (helping the family remain in a nondefensive, honest, sustained engagement [Friedlander et al., 1994]).

SUMMARY

"Up to now, the family therapy movement has done better in the area of how-to-change-it than of what-to-change. Descriptions of the creature that family therapists are out to get have been notoriously unsatisfactory. Clinicians know something is rustling about in the bushes, but nobody has done a good job of finding it and explaining what it is" (Hoffman, 1981, p. 176). Terms such as Minuchin's "enmeshment," Bowen's "undifferentiated family ego mass," or Wynne's "pseudomutuality" offer important theoretical frameworks (see Simon, Stierlin, & Wynne, 1985, p. 196), but they fail to illuminate in-session processes that could lead to specific symptom reduction and improved family functioning. In contrast, in this article, we have begun to identify a specific in-session deleterious process, an impasse, an intervention strategy to resolve it, the shift, and a detailed, descriptive account of possible pathways through which this may occur.

Impasse was defined as the unwillingness or inability of a parent and adolescent to have a constructive conversation regarding the parent's expectations about daily household routines. We proposed that unexpressed negative feelings about the quality and history of the attachment/caregiver relationship, may fuel expressions of anger and chronic disagreement in the behavioral domain. We described a shift intervention to resolve this impasse. The intervention shifts, multidimensionally, a family's conversation from a discussion of behavior management problems to the identification of core relationship conflicts. Helping family members identify unaddressed interpersonal conflicts reduced unproductive, negative affect, led to more potent therapeutic content, and engaged family members in the therapy (G.S. Diamond & Liddle, 1996). Although this study's sample consisted of adolescent substance abusers, findings regarding the impasse and the strategies for resolving it may also be generalizable to other clinical problems and populations. For example, this intervention framework is currently being applied to depressed adolescents (Diamond & Siqueland, 1995, 1998). Identifying and addressing damaged attachment relationships may be a potent intervention strategy for a variety of clinical situations (Doane & Diamond, 1994). Although this article exists in the tradition of contemporary treatment development (Kazdin, 1994), which is characterized by the empirical refinement of different aspects of treatments, the particular theme of this article—how to facilitate a healing, developmentally syntonic connection among family members—itself represents a core and indeed timeless theme in family therapy.

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ANNOUNCEMENT

The Division of Social and Transcultural Psychiatry of McGill University will hold the Fifth Annual Summer Program from May 3-28, 1999, in Montreal, Quebec, Canada. Courses and workshops include: Cultural Psychiatry; Psychiatric Epidemiology; Working with Culture – Strategies for Mental Health Practitioners; Evaluation Research in Social Psychiatry; and, Qualitative Research Methods, An Advanced Summer Study Institute on "The Politics of Trauma" will take place from May 31 to June 4, 1999. For more information, contact:

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