
The Therapist-Parent Alliance in Family-Based Therapy for Adolescents



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This article describes procedures for developing a therapeutic alliance with a parent within the context of family therapy for adolescents. After an overview of the general clinical model, specific themes and interventions are described that provide a map to facilitate this process. Following Bordin's (1979) model, alliance is conceptualized in three parts: bonds, goals, and tasks. The bond phase consists of the therapist showing empathy and understanding toward the parent and the parent developing empathy toward their own life struggles. The goal phase consists of defining parent-child relationship building as a primary focus of treatment. The task phase consists of preparing parents to better communicate with their adolescent. These phases can occur sequentially within a single session with a parent alone. The alliance building session sets the foundation for parent-adolescent conflict resolution leading to reattachment in future sessions. © 2000 John Wiley & Sons, Inc. *J Clin Psychol/In Session* 56: 1037-1050, 2000.

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Therapist-Parent Alliance

In the 1950s, family systems therapies redefined the meaning of relationship-based therapy. The innovation was not only in bringing family members together in one room but also in clarifying how we understand psychopathology and change. Pathology was no longer seen as driven solely by intrapsychic forces but also by interpersonal functioning. The focus of treatment shifted from internal representations to real relationships. Change was no longer thought to occur via the transference relationship but through improving communication or behavior between family members. Unfortunately, in their revolutionary fervor, radical constructivist family systems theorists went too far in ignoring individuals' cognitive and emotional functioning. However, contemporary, integrative, family-based treatments have succeeded in finding a balance between the individual and interpersonal factors implicated in the etiology and amelioration of psychopathology. These treatments address multiple domains including individual's cognitive and emotional functioning, family relationships, and extrafamilial relations (Liddle, 1999).

This article describes the complex interaction between individual and interpersonal factors in contemporary family-based treatments for adolescents. Specifically, we explore how parents' personal history, emotional experience, attributions, and behavioral patterns influence the parent-therapist alliance-building process, and how this alliance can facilitate subsequent conjoint conflict-resolution episodes between adolescents and their parents. Commonly defined as the strength of the bond between client and therapist, and the degree to which they agree on the goals and tasks of therapy (Bordin, 1979), the therapeutic alliance has been positively associated with a broad range of outcomes across a variety of psychotherapy approaches (Horvath & Greenberg, 1994). Much less, however, has been written on the step-by-step process of developing a therapeutic alliance and the mechanism through which it brings about change. This article presents a model for building an alliance with parents in a family-based treatment for clinically depressed adolescents and articulates the role of the therapist-parent alliance in creating change.

Family Therapy for Depressed Adolescents

Family Therapy for Depressed Adolescents (Diamond & Siqueland, 1995, 1998) is a multimodal, empirically based family treatment for clinically depressed adolescents that has its origins in Multidimensional Family Therapy (Liddle, Dakof, & Diamond, 1991), Structural Family Therapy (Minuchin, 1974), Emotionally Focused Experiential Therapy (Johnson & Greenberg, 1992), and adolescent attachment theory (Kobak, Duemmler, Burland, & Youngstrom, 1998). Modeled after Multidimensional Family Therapy, a developmental-ecological, multisystems, multidimensional, family-based treatment for adolescent substance abusers, Family Therapy for Depressed Adolescents recognizes that people function simultaneously in numerous, interconnected domains (e.g., affective, cognitive, behavioral) and within multiple interconnected contexts (e.g., individual, dyadic, familial, and extrafamilial). For example, research shows that individual factors (i.e., biology, cognitive attributions), parenting factors (i.e., abusive behavior, lack of parental monitoring), interpersonal family factors (i.e., disengaged or hostile parent-adolescent relationships), and extrafamilial factors (i.e., negative peer group, poor school functioning) are all associated with adolescents' symptomatic behaviors such as depression and drug abuse (Downey & Coyne, 1990; Hawkins, Catalano, & Miller, 1992). Consequently, each of these areas (e.g., adolescent, parents, parent-adolescent relationship, and extrafamilial contexts) are important foci of treatment (Liddle, 1998).

Family Therapy for Depressed Adolescents places particular emphasis on the interpersonal risk factors and processes associated with depression, specifically the quality of

the adolescent-parent attachment. Healthy adolescent development is thought to be partially dependent on at least one parent (caregiver) remaining a reliable attachment figure. In the context of this secure base, adolescents explore their own autonomy and competency as well as freely express negative emotions (e.g., fear, anger, distress) with the expectation of acceptance and comfort. Thus, secure attachment leads to more direct communication, which fosters perspective taking, problem-solving skills, and support (Koback et al., 1998). On the other hand, a caretaker's unavailability and unresponsiveness, particularly at critical moments, leads to insecure attachment. In such instances, rather than serving as a source of safety and support, caretakers become a potential source of emotional injury. Consequently, negative or vulnerable emotions (e.g., pain, anger, hurt, rejection, abandonment) remain unexpressed or become indirectly expressed in a destructive manner (e.g., conflict, depression, self-injurious behavior).

Families of clinically depressed adolescents frequently have suffered severe breaches of attachment due to parental psychopathology (i.e., depression, substance abuse), environmental factors (i.e., divorce, poverty), or trauma (i.e., parental death). Whether insecure attachment is a causal factor, a risk factor, a correlate, or a consequence of depression is not fully understood. In addition, the degree to which the attachment bond can be repaired and whether that reduces depression, prevents relapse, or both is also unknown. However, results from a nearly complete, randomized clinical trial conducted at the University of Pennsylvania by the second author suggest that parent-adolescent attachment can be improved and that such improvement is correlated to reductions in depression.

Although repairing attachment (Diamond & Siqueland, 1995) or reconnecting parents and adolescents (Liddle, Rowe, Dakof, & Lyke, 1998) is the initial goal of this treatment, the therapy subsequently turns its focus to promoting the adolescent's competence in day-to-day activities (e.g., school, peer relations). We address these two overarching goals (reattachment and competence) via five specific, sequenced treatment tasks. Each task represents a distinct, in-session episode during which a specific problem state (i.e., poor attachment) is focused on using specific intervention strategies in a coherent and sustained fashion.

The first task, the relational reframe, is designed to shift the goal of therapy from "fixing" the patient to improving family relationships. Relationships are promoted as the cure (although not necessarily the cause) of the problem.

The second task, alliance building with the adolescent (done in an individual session), focuses on building a bond with the adolescent, identifying what has damaged trust in the parent-adolescent relationship, and contracting to help the adolescent discuss these issues with his parents.

The third task, alliance building with the parent (done alone with the parent), involves empathetically exploring the personal challenges that parents face (e.g., depression, marital conflict, poverty, and so on) that impact on their parenting and on the adolescent. Increased attachment is presented as a potential ameliorator of the adolescent's depression, and parents are again asked to adopt relationship building as the initial goal of treatment.

The fourth task, reattachment, focuses on helping parents and adolescents discuss important feelings, thoughts, and memories, identified in previous sessions, that impede trust and communication in their relationship. In many instances, these conversations focus on the adolescents' experience of betrayal, abandonment, or abuse. Ideally, during such conversations parents apologize for their transgressions, adolescents forgive their parent(s), and there is a mutual sense of responsibility for past problems and future solutions.

As the family tension diminishes, therapists begin the fifth task—promoting competency. This task involves helping parents to help their adolescent rebuild his or her life at

school with peers and in other extrafamilial pro-social contexts. Although the first four treatment tasks are often accomplished in the first five sessions, helping parents to become and remain appropriately involved in the many aspects of their adolescent's life is the primary focus of the rest of the treatment. The prototypes of these tasks were developed in Multidimensional Family Therapy with substance-abusing adolescents and have been modified here specifically for use with depressed adolescents.

Role of the Therapist-Parent Alliance

Building an alliance with parents is crucial for at least two reasons. First, a strong therapist-parent alliance increases the likelihood that the family will consistently attend and participate in treatment. In most cases it is the parent, not the adolescent, who initiates treatment and is responsible for physically bringing the family to the clinic. Second, the success of the subsequent reattachment task depends largely on the strength of the therapist-parent alliance. Successful reattachment episodes require, among other things, that parents respond to their adolescent's expressions of pain, hurt, and anger with interest, empathy, and support. Parents are more likely to adopt such a stance if they feel supported and understood by the therapist, agree with the treatment goal of reattachment, and are willing to try new ways of interacting with their child.

Obviously, for a relationship to improve both sides must make an effort. Regardless of how willing and skillfully a parent reaches out to the adolescent, if the teenager remains recalcitrant or withdrawn reattachment does not occur. In such instances, a strong therapist-adolescent alliance can provide leverage for challenging the adolescent to engage in the relationship-building process. Thus, the therapist-parent alliance is only one of many pieces in the relational puzzle. In this approach, however, it is a critical piece. We expect parents to initiate the reattachment process. We ask them to reach out to their adolescents in ways that they have not tried before. Accomplishing this goal requires an especially strong therapist-parent alliance. For that reason, we have chosen to focus specifically on the process of building alliances with parents in this article.

A three-phase model is presented. Based on Bordin's (1979) tripartite definition of the therapeutic alliance, the three phases of the alliance building process are (a) establishing a bond, (b) identifying meaningful treatment goals, and (c) agreeing on how to achieve these goals. For each of these phases or tasks, the therapist has specific foci and desired outcomes. The bond phase, for example, has three goals: identify parents' strengths and resources, understand the stressors in their life, and help them to articulate and empathize with the attachment violations they have suffered in their own families of origin. This last goal is essential. Many parents of depressed adolescents have suffered from inadequate parental care, neglect, or abuse. Getting them to acknowledge and sympathize with their own losses, disappointments, and pain prepares them to be more empathetic toward their adolescent's current experience.

In the second phase, goal formation, the therapist works to strengthen the parents' commitment to relationship building as a worthwhile treatment goal. The logic of this phase is as follows. Once parents acknowledge and sympathize with the loss, disappointment, fear, and pain they experienced during moments when their own parents were emotionally unavailable, the discussion turns to how current or past stressors in the parents' own lives may impact on their ability to be emotionally available for their child. The intent here is not to blame the parent but to express empathy for how difficult it is to parent a needy (depressed) adolescent when one is overwhelmed, depressed, or has never experienced adequate parenting. Once parents acknowledge their own limitations, the therapist introduces the idea that the adolescent may have experienced relational failures

similar to what the parent experienced growing up. The therapist suggests that, in fact, maybe it is the adolescent's strong feelings about these relational failures that keeps him or her from trusting or talking more with the parent. Typically, the therapist has already met with the adolescent for a similar alliance-building session and knows what content areas are most meaningful. If parents are receptive to this line of reasoning, the therapist then suggests that helping the teen get these feelings off of his or her chest (regardless of their accuracy) may serve to diffuse some of the tension between them and their adolescent. When this phase is executed successfully, parents express a willingness to listen to their adolescent's grievances and offer support.

The third phase of the session, task formation, involves teaching parents skills that will help them to facilitate their adolescent's disclosure of heretofore unspoken yet potent thoughts and feelings. Such skills include listening nonjudgmentally to their adolescent's story, displaying sincere curiosity and respect, and resisting the desire to defend themselves. The excerpts presented below, taken from a single session, demonstrate the three phases of the alliance-building process.

Case Presentation

Presenting Problem/History

Michael, a 15-year-old, white male, was referred to our depression clinic by his school counselor after failing the 10th grade for the second time despite having an IQ in the superior range. Based on the Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADDS; Puig-Antich & Chambers, 1988) interview completed at intake, Michael qualified for a diagnosis of major depressive disorder. He scored a 19 on the Hamilton Depression Rating scale and a 26 on the Beck Depression Inventory, suggesting that he suffered from moderate-to-severe depressive symptoms.

The oldest of three brothers, Michael was 10 years old when his parents, Carl and Stephanie, divorced. He and his two brothers live with their mother. Their father lives with his new wife and children approximately one hour away. Because Stephanie works extended hours and rotating shifts as a nurse, Michael spends many evenings at home alone caring for his younger siblings, aged 13 and 10. During the initial interview, he expressed feeling sad, lonely, and scared during those evenings when Stephanie was not home. Furthermore, Michael complained that even when his mother was home, she spent little time with him and was "more interested in her boyfriend."

Despite an engaging sense of humor, Michael has very few friends. He is socially awkward and spends most of his free time reading or playing computer games. In school, he is teased mercilessly about his severe acne condition and academic failure. His father teases him about the same things during their biweekly visits. Michael asked his mother to stop these visits but she has not done so for fear of being accused of coming between Michael and his father.

His mother, Stephanie, reports a personal history of drug use and depression. She also was emotionally involved with several men who were both psychologically and physically abusive toward her and the children. Stephanie reports that she feels tremendous guilt for having exposed her sons to this abuse, though she and the boys have never discussed these events. For the past year, she has been in individual therapy and on antidepressant medication.

In the first session, Stephanie presented as a caring mother, worried about her son's depression, acne, school failure, and past abuse. Despite her stated concern, however, she had not as yet substantially helped Michael to address these problems. For example, she

never made an appointment with a dermatologist for his skin condition. Although she did express concern about him staying home alone at night, she maintained that it was an unfortunate yet necessary consequence of her work schedule and had not attempted to explore alternative plans for supervision. Furthermore, Stephanie found it hard to talk with Michael about his failure in school and in social contexts or about the abuse that he suffered in the past.

Case Formulation

Rather than label Stephanie as "uncaring," we attributed her inattention to Michael's needs as a consequence of her depression, preoccupation with work, and difficulty tolerating the pain and guilt associated with her lapses in parenting. At the content level, our greatest concern was the repeated humiliation, abuse, and abandonment that Michael experienced at the hands of his father and subsequent male caregivers. We assumed that Michael was furious at these men and disappointed in his mother for not providing more protection. We felt that these attachment violations left Michael with deep feelings of distrust toward his mother, which in part made it difficult for him to use her for support and problem solving when feeling depressed or suicidal. A primary goal of the therapy would be to help Michael and Stephanie discuss their feelings about the abuse, first with the therapist alone (during the individual alliance sessions) and then together (during the subsequent reattachment task). Such a conversation would ideally (a) help Stephanie take charge as a parent, (b) communicate to Michael that his mother is ready and willing to listen to his pain, (c) help Michael practice articulating his emotions, (d) show that Stephanie is willing to take responsibility for her part in the abuse and, (e) recast Stephanie as someone who can offer support rather than as someone who is uncaring, overwhelmed, and fragile.

Course of Treatment

Phase 1: Building a Bond. After an initial family session and then a session alone with the adolescent, the alliance-building meeting alone with the parent took place during the third session of treatment. During the first phase of the session, bond building, the therapist explored various strengths and weaknesses in the parent's life, independent of problems with the adolescent. The therapist gathered information in a manner that conveyed admiration, empathy, acceptance, and support. Although a variety of topics were discussed, four common content areas were covered: work, romantic relationships, family of origin, and individual functioning. Again, the goals here were to (a) get to know the world of the parent; (b) convey support and understanding, (c) empathize with breaches of attachment experienced by parent, (d) identify stressors in the parent's life, and (e) use parents' empathy toward themselves to generate empathy and appreciation for their adolescent's experience.

The major clinical challenge in this phase is deciding how long to focus on each aspect of the parent's personal life. If a therapist remains focused on a given aspect too long, parents begin to feel blamed or too much the focus of treatment. Furthermore, overfocusing on one area yields too narrow an understanding of the parent's life circumstances. On the other hand, if the therapist does not remain focused on a particular aspect long enough, parents perceive him or her as being insincere or superficial. The goal is to remain focused on each aspect of parents' lives long enough to understand how it impacts their ability to care for their adolescent. The therapist usually begins the bond phase by looking for strengths. For example:

THERAPIST: So today I would like to spend some time learning about you, separate from the problems you are having with your son. I always find it helpful to know a bit more about parents so I can put things into perspective. Let's start with your work! You said you are now a charge nurse?

STEPHANIE: I started out as a charge nurse, doing hands-on care, medications, documentation, running the unit.

THERAPIST: What kind of unit is it?

STEPHANIE: The Skilled Care unit. We have the more critically ill people, with the IVs, the tube feeds, and the tracheotomies. Now we have a ventilator unit. A few months ago I became the supervisor—sometimes I am responsible for overseeing 300 residents!

THERAPIST: Wow!!! That's a lot of responsibility and authority? Do you enjoy that?

STEPHANIE: Well I used to feel completely inadequate, like I was an imposter. But I have gotten used to the position and I do a good job.

THERAPIST: I can imagine this job creates a lot of stress as well.

STEPHANIE: Yeah (*nodding her head in agreement*), it does. And some nights I have a lot of headaches. I've come home occasionally after having a really bad night and let them [the kids] know I really have a headache. That I'm in a bad mood, and that I really need some time. And . . . sometimes it works and they leave me alone, a lot of times it doesn't (*laughs*).

THERAPIST: This must be very hard on you.

This topic continues for a short time with the therapist inquiring about the details of Stephanie's work, her experience of leadership and competency, and the stress of her position. Stephanie's job situation reflects many of the contradictions in her life, the most obvious one being the contrast between the authority and responsibility she displays at work versus her minimal level of functioning at home. However, in this phase of the session, the therapist was mostly interested in highlighting Stephanie's competencies. Acknowledging resilience and accomplishments validates parents who often arrive for therapy feeling embarrassed or incompetent. Even when Stephanie herself made a connection between the stress at work and her parenting, the therapist responded with empathy and support rather than by exploring the point further. Exploring the connection between the parent's personal life and the role as parent will come later. Ideally, during this first stage, the therapist simply punctuates such comments by saying "That is really important and I want to return to it. But for now, tell me more about your life."

In the next segment, the therapist moved on to explore Stephanie's general level of functioning and coping skills. Stephanie mentioned that she has suffered from serious bouts of depression.

THERAPIST: Tell me a little bit about your depression. How bad has it been?

STEPHANIE: It was tough. It was like looking in the mirror and seeing nothing. It's hard for me to talk about it. I still get weepy (*begins to cry*). I never want to feel that way again. It was horrible . . . to have to wake up and look in the mirror and feel nothing, and see nothing, and then still have to go to work. . . . I just want the world to go away. I don't want to go outside for anything. It might be that I don't even take a shower. I'll just lay there. I get very introverted and I don't want to do anything.

Taking the time to understand and empathize with the parent is crucial to establishing a bond. To accomplish this, the therapist uses traditional supportive and explorative techniques found in any individual therapy session. Simultaneously, the therapist is careful to note the themes or stories that will be introduced later in the session during the goals and

tasks phases. The therapist here assumed that Stephanie's depression periodically rendered her emotionally and physically unavailable for her sons. Such breaches in attachment will be explored later in the goal phase of the session and will provide the rationale and motivation for working toward the goal of increased attachment.

An important, and always informative, area of work is the exploration of intergenerational themes and patterns. Many parents either repeat the relationship patterns they experienced in their youth or strive to do the opposite! Common remarks from parents include "My mother was too strict so I give them more slack." or "My father was emotionally unavailable; I suppose I do the same." Work in this domain serves several purposes. First, many parents are unaware of these intergenerational influences on their parenting. Second, many parents have never understood or come to terms with their own childhood experiences of abandonment, neglect, or abuse. If they cannot empathize with and console themselves, how can we expect them to do this for their children? When therapists help parents access and empathize with their own experiences of attachment failures, parents become emotionally primed to empathize with their adolescent's experience of abandonment and neglect.

As this session continued, the therapist explored Stephanie's relationship with her parents. He found out that Stephanie's father was emotionally very distant, which made communication and problem solving in the family difficult. In the following segment, the therapist learned that Stephanie's mother was even less emotionally available than her father. Her mother suffered from an affective disorder, which burdened the family and created a cloud of secrecy, anxiety, fear, and unpredictability.

THERAPIST: What was your mother suffering from?

STEPHANIE: I think that she was manic-depressive. She had been hospitalized once, because she just broke down. She was running outside naked, screaming.

THERAPIST: Sounds like things were out of control (*nodding empathetically*).

STEPHANIE: Yeah! I remember the day my father told us. He was very uncomfortable. And we had to go visit her in the hospital. It was horrible.

THERAPIST: You must have been scared.

STEPHANIE: I was. It was very scary. Especially going to see her. You just never knew when she was going to flip out or what was going to set her off. Even after she came home, this went on for years.

THERAPIST: Given Dad's style, I bet the family never talked about this?

STEPHANIE: Oh, no!!! We could not discuss this. It would have been disrespectful to her. Both mom and dad got upset easily.

THERAPIST: That is a big burden for a little girl. . . . You must have constantly been on the look out to monitor their moods?

STEPHANIE: You always had to be careful not to upset her. I mean, you didn't want to make her mad. Because if you did, everybody suffered!!

Here, we clearly see an intergenerational repetition of family dynamics. Both Stephanie and Michael have parents with a severe psychiatric disorder and both felt burdened and scared by their parents' behavior. Furthermore, both families were unable to openly discuss the meaning and experience of these behaviors. When children witness a parent suffering from a mental disorder and have no framework in which to discuss and understand it, they are liable to develop catastrophic thoughts, personalize their parent's behavior, and become hypervigilant. Like Stephanie, Michael has been alone with these concerns. In phase two of this session, the therapist will encourage Stephanie to share with Michael enough information to assuage his unbased fears and fantasies.

Next, the therapist moves on to explore the parent's relationships with friends and romantic partners. Hopefully, the parent has an intact support system that can serve as a resource during periods of stress. Unfortunately, depressed parents are often socially isolated and have a history of abusive relationships. These abusive relationships can harm the parent, negatively impact on their parenting, and directly impact upon the children.

THERAPIST: I spoke with Carol [Stephanie's individual therapist] by phone and she mentioned that you have been through a lot with spouses and partners.

STEPHANIE: Yeah. A lot of verbal abuse and we are working on that now ... it's gotten better over the years. I'll never go through what I went through with their father. But then . . . I did get into a relationship with someone named Fred. He was verbally abusive at times, and I see that now, but I got out of that relationship a lot sooner.

THERAPIST: This was your most recent relationship?

STEPHANIE: No, this was the one before. At the time I thought that he really was encouraging me but there were times when it was just pretty much verbal abuse. Finally, when I saw him doing it to my kids, I told him that he had to get out of our lives. But, there were things that the boys didn't tell me that had occurred even before.

THERAPIST: Like what?

STEPHANIE: Well, he used to baby sit them when I went to work. And I felt safe . . . (sighs) . . . until Jerry [youngest son] told me that he [Fred] came in and turned off all of the hot water while he [Jerry] was in the shower. It was like a form of torture. I mean, there was no reason to do that. At other times, he would humiliate Michael about his acne. The boys started to avoid him. When he would come to baby sit, they would leave. Finally I thought, "this is *their* house!, not his!" I felt like I had to fight for them, if nothing else. It was hard for me to do this, but something had to happen . . . I didn't do it for myself, I did it for *them*.

In this segment, the therapist learned important information about Stephanie and her past relationships. Although Stephanie's ability to eventually stand up for her children is admirable, the embarrassment, pain, and guilt she likely feels for not having protected them better remains unspoken. We also know from our individual session with Michael that he bears anger and resentment toward his mom for allowing the abuse to occur. A primary treatment goal will be to facilitate Michael's sharing of his thoughts and feelings about the abuse and encourage his mother to share her feelings of regret and sorrow.

Phase II: Goal Formation. By this point in the session, Stephanie's affect, responsiveness, and willingness to disclose important, vulnerable information suggested that an initial therapeutic bond was formed. Furthermore, the therapist gathered quite a bit of information about Stephanie, the family, and the events and themes that contributed to the emotional rift between her and the children. With this foundation, the therapist proceeded to initiate the second stage of the alliance building process—goal formation.

In the goal-formation phase, the therapist aims to establish relationship building as the initial objective of treatment. This phase begins with the therapist shifting the focus of the session from the parent's own life experience to the quality of the parent-adolescent relationship. Typically, the therapist makes a statement like "How much do you think these events/experiences that we have just talked about have impacted upon your parenting and/or your relationship with your son/daughter?" This question should not carry a tone of blame but rather convey empathy and acknowledge the difficult task of parenting, particularly when under stress.

In some cases, parents resist exploring the connection between their own life experience and their parenting. Such resistance can be due to feelings of guilt and remorse or anger and entitlement, and may take the form of denial, minimization, and/or blame. In such cases, the therapist must reevaluate the strategy and approach the transition from another angle. In most cases, however, parents are willing to examine the impact their own life experience has on their parenting. In such cases, the therapist becomes increasingly more direct and explicit (e.g., "Do you think that when you were very depressed, your daughter was afraid that you couldn't take care of her?"). Many parents already have thoughtful, well-articulated theories about how their own functioning negatively impacted upon their relationships with their adolescent. In the segment below, Stephanie makes the connection between the abuse she suffered, her depression, her diminished capacity to parent, and how her children have suffered.

STEPHANIE: It breaks my heart. Because at the time, you think you are making the best decision and then you look back and say, "Wow, I put them in a situation that wasn't good." So that, now, it's hard for me to let somebody watch them, even at night. When I feel like I'm not a good mother, I get real depressed.

THERAPIST: Do you have many regrets?

STEPHANIE: I'm always beating myself up that I'm not a good Mom, and Michael is having all of these problems because I wasn't there emotionally for him, especially when he was little. I was so young. (*Tearful*) I wasn't ready, emotionally, to have children. I met their physical needs but I didn't meet their emotional needs . . . I was being abused and . . . I wasn't able to be there.

Stephanie's remorse paved the way for introducing a relational goal for the therapy. At such junctures, the therapist should present treatment as a second chance. The therapist is likely to say "It is not too late to change things! You can be there for your son now." In most instances, parents respond enthusiastically. Most have a strong desire to become closer to their teenager but simply do not know how. It is the therapist's role to help them cross this bridge. One path is through more candid and emotionally vulnerable conversations about the pain, fear, and disappointment associated with past relational failures. The therapist will frequently begin this phase by asking the parent if he or she *knows* how the adolescent feels about the themes or events discussed earlier. If parents say "yes," the therapist should inquire as to whether what they "know" is by conjecture or because their adolescent actually shared thoughts or feelings with them. If the latter is true, the therapist highlights the importance of such conversations and offers to help the family continue and elaborate upon them in therapy. However, in most cases, there has been little real sharing between parents and their teenager around these themes. It is the therapist's job to generate or amplify the parents' desire to know more about their adolescent's life. In an effort to pull for sentimental and softer feelings, the therapist asks questions such as "Would you like to talk with him more? What do you miss most about talking with him? Did you think the two of you would ever be this distant? Why do you think he doesn't come to you to talk about these things?"

THERAPIST: I get the feeling that you rarely talk about these events with your children.

STEPHANIE: Well, it hasn't really been brought up for a while.

THERAPIST: Why doesn't he talk to you about these things?

STEPHANIE: I usually start crying and Michael gets upset. I try to explain that I am not upset at him for bringing these things up it, but that I feel so guilty that I wasn't there

for him. When I feel like this I get defensive and then, instead of letting him talk, I start making excuses.

TERAPIST: When this happens, what does Michael do?

STEPHANIE: He shuts down. For example, on the ride back from his father's, he started telling me different things that were going on between him and his father and I could feel myself getting teary. He looked at me and said, "Are you O.K. Mom? You look as if you are getting ready to cry." And then I had to bring myself back because I could feel myself getting angry. I knew he needed to talk, but I could just not do it.

TERAPIST: So, when you get defensive he shuts down and when you get real emotional he shuts down.

STEPHANIE: 'Cause he doesn't want to hurt me. I think that he hides his feelings. He knows I have a lot of things to worry about. But this really upsets me. I want to know what's going on in his life.

These last statements represent the overall objective of the goal formation stage: to get parents on record as wanting to be closer to their child, and as wanting to understand the relational dynamics that have kept them apart.

Phase III: Defining the Task Ahead. The goal of the final stage of the alliance-building session, the task phase, is to prepare parents to reach out to their adolescent. The idea is that by first preparing parents and the adolescent individually, it is possible to increase disclosure, the sharing of vulnerable emotions, and mutual support during later conjoint conversations about difficult, relational themes. In order to prepare the parents, the therapist first helps them to identify the specific behaviors or approaches that have facilitated conversation between them and their adolescent in the past, and those that have pushed their teenager away or shut them down. This information is then used to help parents develop strategies for conducting future reattachment conversations and avoid pitfalls.

Typically, past attempts to discuss emotionally laden relational themes were cut short by blame, self-justification, and minimization. Generally, the therapist's role is to prepare parents to listen without getting defensive, ask questions rather than argue or attack, and express empathy rather than criticism and hostility. In this particular case, the therapist also focused on helping Stephanie contain her own feelings of guilt in order not to overwhelm, burden, and shut down Michael and in order to focus on Michael's story rather than her own.

STEPHANIE: When Michael brings up the bad stuff that happened between him and his father, I usually just say, "you know, Daddy really loves you and misses you." It's a little like I want to smooth it over. Though he probably wanted to talk more about it.

TERAPIST: I think that what is most important at this point is, not so much making everything seem all right, but to help him find a way to talk about what his experience of the situation was.

STEPHANIE: That's what we started doing in parenting class . . . how to get kids to talk.

TERAPIST: Right, exactly . . . this is about you being there for Michael.

Later in the session . . .

TERAPIST: Earlier, you said Michael was protective of your feelings and that your strong emotions shut him down. How might that shut him down during your conversation with him today?

STEPHANIE: Well, probably his trying to read my reaction and me trying not to be too emotional. I'm going to try to just listen to him and not feel too guilty about the things I've done. . . .

THERAPIST: What could you do to encourage him, to let him know that you're O.K.?

STEPHANIE: Sometimes I make eye contact with him or I'll go and give him a hug that says, "it's O.K., you can tell me this. It's O.K. if I cry."

THERAPIST: It's healthy to show some emotions and some crying is O.K. It probably would be pretty upsetting for him, however, if you became overwhelmed, you know, I could see that shutting him down.

STEPHANIE: Right.

THERAPIST: Maybe even before you start the conversation, it might be worth setting the stage by saying that, although you are an emotional person, you still want to talk about those things. By assuring him that you are strong enough to do it.

STEPHANIE: O.K. Like I said, I can tell when he's getting uncomfortable. Michael gets into a mood, just sort of doesn't look at anybody.

THERAPIST: When he gets uncomfortable, discuss that with him. You can say, "I think that you were doing a great job talking. What happened? Did you feel like I was getting too upset?" This is exactly what you need to bring up.

As can be seen in the segment above, the therapist's coaching is not limited to process statements (i.e., ". . . help him find a way to talk about his experience"). This phase of the session involves offering the parent specific, applied suggestions for what she or he might say (i.e., "Tell him you are an emotional person but still want to hear what he has to say.") and when to say it. The objective of this phase is to equip parents with the tools to be emotionally present for their adolescent.

Among families in which adolescents have suffered severe abuse, neglect, or other transgressions, the teenager may be so furious that he or she chooses not to respond to parents' overtures. In such families, forgiveness may be a prerequisite for any other relational work to take place. Consequently, the therapist must prepare the parents to apologize for instances in which they have failed or hurt their children. This is not an easy task. Asking for forgiveness is painful and puts one in a vulnerable position. However, a sincere apology followed by the parent's expressed and genuine interest in hearing about the adolescent's experience of an event or theme in question often triggers emotional, meaningful, and positive parent-adolescent interactions.

Outcome

When alliance building with parents goes well, we expect to see parents reach out to their adolescents in a manner not evident before. In Stephanie's case, we hoped that she would initiate conversation about difficult issues such as her depression and the past abuse and that she would prevent her emotionality from derailing such conversation. In the following segment taken from session four, Stephanie reassures Michael of her emotional resilience and willingness to broach difficult subjects. This is critical in order for Michael to feel safe enough to share vulnerable emotions without fear of hurting his mother.

STEPHANIE: I wanted to tell you . . . you know how when we used to go to therapy, and Mom used to get teary eyed?

MICHAEL: Yes.

STEPHANIE: And that sort of upset you and you didn't want to talk anymore?

MICHAEL: Yes.

STEPHANIE: I really need you to keep talking when we're here. Because even if I'm sad, I still need and want to hear what you have to say and what you feel.

MICHAEL: O.K.

THERAPIST: [to Michael] Do you believe that Mom is strong enough to have conversations about difficult things?

MICHAEL: Yes.

Later in the same session, Stephanie perseveres in helping Michael to talk about his experience of her depression. Stephanie successfully employs some of the strategies that she and the therapist discussed in the task stage of the alliance-building process. As a result, Michael shares important and heretofore unspoken information about his fears and anxieties.

STEPHANIE: How does it make you feel when you see me lying on the sofa?

MICHAEL: I think I have been sad when you are sad.

STEPHANIE: How can you tell that I'm sad?

MICHAEL: You sleep more and you just sag in the love seat and watch T.V.

STEPHANIE: And do I not pay attention to you?

MICHAEL: Yeah!

STEPHANIE: Do you feel bad when I don't pay attention to you?

MICHAEL: No, because you are depressed and you got all these problems. . . .

STEPHANIE: What problems do you think I have?

MICHAEL: I don't know. I wasn't really paying attention.

STEPHANIE: Did you just want to go away and not bother me. Did you think I didn't have time for anything for you?

MICHAEL: No.

STEPHANIE: But it made you feel bad when I got like that?

MICHAEL: Yes.

STEPHANIE: Because I don't spend time with you?

MICHAEL: Yes.

STEPHANIE: I'm trying to understand how it makes you feel when I get like that.

MICHAEL: Sad and worried.

This segment is exemplary. Stephanie does a superb job of keeping the focus on eliciting Michael's thoughts and feelings regarding her depression. She remains nondefensive, inquisitive, and undistracted by Michael's attempts to avoid or change the subject. Although Michael's responses are brief, it is the first time he directly disclosed his fear and pain to his mother. Stephanie's performance generates Michael's faith in her ability to conduct and withstand emotionally charged conversations.

As treatment progressed, Stephanie introduced other loaded themes such as the abuse, her availability around the house, and Michael's relationship with his father. Michael became increasingly more participatory and eventually began to initiate conversations about relational themes himself. Although invited to participate in the therapy, Michael's father declined. Not surprisingly, as Stephanie became more emotionally available to Michael, Michael's depression improved. By the end of treatment, Michael no longer met criteria for MDD and his scores on the BDI (2) and Hamilton (2) had dropped dramatically. At six months follow-up, Michael remained depression free. His score on the Hamilton Rating Scale dropped to 0 and his score on the BDI was 5. He also reported that his social relationships improved and that he now had a number of friends.

Conclusion

A growing body of research testifies to the potency of the therapeutic alliance. However, the means by which the alliance leads to change and the steps by which one develops an alliance are less clear. In *Family Therapy for Depressed Adolescents*, a primary goal of treatment is to help parents reach into the abyss of their child's depression and provide emotional support for their teenager. This is accomplished by reconnecting parents with their adolescent. When parents feel supported and respected by the therapist, agree on relationship building as a goal for therapy, and agree to engage in the often scary and painful task of exploring and repairing parent-adolescent relational failures, the reconnection process can begin.

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