TOWARD A DEVELOPMENTAL FAMILY THERAPY: THE CLINICAL UTILITY OF RESEARCH ON ADOLESCENCE

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Tremendous advances have been made in our understanding of the intrapersonal, interpersonal, familial, and contextual characteristics and processes that contribute to adaptive as well as maladaptive developmental outcomes with high-risk and clinically referred adolescents. This empirical knowledge base offers clinically rich opportunities for systematic treatment development. An important step in this process is distinguishing which research findings in basic science areas such as developmental psychology and developmental psychopathology might have clinical relevance. Toward this goal, we review relevant but selective research in areas that are central to clinical work with adolescents (parent-adolescent relationship, biological aspects, and affect and cognition), and we offer examples of how basic research in these areas can inform treatment.

INTRODUCTION

Family therapy's slow progress in enacting a progressive, clinically useful interaction between its research and clinical constituencies has been a topic of concern for some time. Although problem articulations have been plentiful, successful solutions have been more difficult to achieve (Liddle, 1991; Shields, Wynne, McDaniel, & Gawinski, 1994). But the disconnect between research and clinical practice is changing. One area of progress is in the development and testing of interventions that use research-based knowledge to inform, guide, and evaluate interventions (Cicchetti & Toth, 1992; Shirk & Saiz, 1992). Developmentalists are sensitive to the clinical implications of their findings (Baumrind & Moselle, 1985; Holmbeck, 1998; Sroufe & Rutter, 1984; Windle, 2000), and research has challenged long-held misperceptions about the second decade of life (Feldman & Elliott, 1990). Contemporary treatments have mined these research-based advances, constructing treatments that have a close reliance on the developmental particulars of the client population (excellent models include Kendall, 1984; Selman & Schultz, 1990; Shirk, 1988; Spivak, Platt, & Shure, 1974). Treatments that use the empirically derived knowledge bases of developmental psychology and developmental psychopathology exist, and many of these interventions continue to evolve in the context of ongoing research programs (Henggeler, Melton, & Smith, 1992; Liddle & Hogue, in press; Liddle et al., in press; Patterson, Reid, & Dishion, 1992; Tolan 1996). Given the well-documented difficulty of treating adolescents (Gould, Shaffer, & Kaplan, 1985), the increasingly complex nature of the clinical phenomena pertaining to adolescent problems (Costello & Angold, 1995), and adolescents' declining mental health status (Prosser & McArdle, 1996), the need for effective interventions is acute. Systematic study and application of developmental knowledge can create a new generation of research-informed therapies that can provide the best possible care for adolescents and families in need.

RATIONALE

Developmental sensibilities have informed family therapy theory and practice in earlier historical periods of the field (e.g., Haley, 1973; McGoldrick & Carter, 1982; Minuchin, 1985; Terkelsen, 1980). Given the rapid growth of and advances in adolescent development research, and the acknowledged clinical potential of this literature (Cicchetti & Toth, 1992; Dishion, French, & Patterson, 1995), a renewed commitment to exploring how research-based developmental knowledge can inform our efforts to develop and refine treatment is warranted.

Developmental knowledge offers several things to the clinical field:

1. Specific, factual, detailed information about the kinds and natures of processes and circumstances that create and perpetuate dysfunction as well as adaptive coping and development.
2. A conceptual map for clinical assessment.
3. A conceptual map that details intervention target areas.
4. Implicit and explicit guidelines about the nature and timing of interventions, as well as the evaluation criteria used to evaluate them.
5. Criteria to help us understand why interventions succeed or fail and how they might be recalibrated to maximize therapeutic impact.
6. Developmental theories and frameworks, by definition, are theories and frameworks about change; hence, developmental knowledge offers insights not only about the change process but also about the limits of change as well.

In this article, we discuss how developmental, nontreatment research informs our clinical approach for adolescent problems—multidimensional family therapy (MDFT; see Liddle, 2000; Liddle et al., in press). We use the MDFT approach as a reference point to illustrate how basic research can influence clinical practice. While previous work addressed how the parenting-research literature informed our treatment development (Liddle, Rowe, Dakof, & Lyke, 1998) and mechanisms of change research (Schmidt, Liddle, & Dakof, 1996), this article covers some clinically important topic areas in the adolescent development research area—adolescent-parent relationships, biological maturation, and cognitive and emotional development.

Attachment

The quality of the adolescent-parent relationship is strongly associated with a teenager's psychological well-being (Reimer, Overton, Steidl, Rosenstein, & Horowitz, 1996). Adolescents who feel that their parents are emotionally and physically available, that they can communicate with their parents, and that their parents will respond to them in times of need, tend to feel competent and secure. Conversely, adolescents who are emotionally detached from their parents are at greater risk for developing a variety of problems, including clinical-level internalizing and externalizing symptoms (Papini & Roggman, 1992). In families of emotionally healthy adolescents, teenagers frequently seek out their parents for support and guidance. Therapists can help family members negotiate adolescent psychological autonomy and behavioral independence in the context of supportive interactions with parents (Hill, 1987).

Disrupted adolescent-parent attachment relations are common in clinically referred families (Allen, Hauser, O'Connor, Bell, & Eickholt, 1996). These content themes reveal processes that frequently have been in existence for many years. These processes are fundamental to the development and continuation of problems for adolescents and their parents. Just as a clinical approach is phasic (Howard, Krause, & Lyons, 1993; Liddle, 2000), the clinical operations used to address these processes are sequenced—the therapeutic techniques proceed in logical steps. First, we elicit the distress and the emotional experience of the parent and teen in individual sessions, supporting each individual and exploring issues in a way that is careful not to assign blame. At the same time, accessing existing reservoirs of hope that may be small but, nonetheless, existent, we elicit family members' coexisting longings for closer, more harmonious relations with their parents or teens. Expressing feelings and beliefs about rejection, fear, and abandonment can be an important first step in reestablishing attachment relationships (Diamond & Liddle, 1999). Gradually we introduce behavior change possibilities into the description of these problem and negative-emotion sequences. The aim is to reweave the fabric of the adolescent-parent attachment relation. The rationale for the sequencing of this aspect of the work comes from epigenetic theory in developmental psychology. Achieving higher levels of functioning depends upon the successful completion of tasks and competencies at earlier developmental stages (Cicchetti, 1984). Failure at one stage or difficulty in developing competency makes it difficult or impossible to develop more advanced, higher-level skills (Cicchetti, Rogosh, & Toth, 1997) or relationships (Wynne, 1984).

Research and clinical experience suggest that emotional disconnection between parents and clinically referred adolescents is both common and developmentally deleterious to the well-being of the parent and the teen. The clinical picture of parent-adolescent disconnection shows considerable variation. Sometimes it is the adolescents (particularly depressed teens) who experience and express a longing for an increased emotional connection with their parents.

> *Therapist:* You sound like a pretty independent young lady. You get up by yourself, get dressed, go to school, come home, and sometimes put yourself to bed.
> *Adolescent:* Yeah . . .
> *Therapist:* Do you sometimes miss seeing mom—you wish she was there?
> *Adolescent:* I guess so . . . (begins to tear up)
> *Therapist:* You are sad.
> *Adolescent:* You know, she doesn't even know what I'm wearing—what I look like when I go to school in the morning.
> *Therapist:* Does it sometimes feel like she doesn't have time for you or that she doesn't care what is happening with you?
> *Adolescent:* She worries more about meeting her boyfriend at the bar than spending time with me.
> *Therapist:* It sounds like you would like to be closer to her. (Adolescent nods.) I think that might be something that can happen in here. I think that's something important that I can help you and your mom with.

With adolescents evidencing externalizing problems, parent-adolescent disengagement is frequently manifested in resentment, anger, and blame.

Mother: He goes to school in the morning and I don't see him until 11:00 at night. Up until a year ago, he would talk to me about school and his friends. He felt comfortable coming to me if something was bothering him. Now, I have no idea what he does, how he feels, or who he hangs out with. He's like a stranger to me . . . and what's worse, he doesn't seem to care.

While a first step is to help family members to articulate feelings of family disconnectedness in conversations alone with the therapist, the critical next step involves facilitating expression of these feelings with other family members. The therapist tries to go beyond the anger to uncover more vulnerable feelings related to the pain and disappointment. Disclosing and discussing core relationship events and the accompanying emotions such as fear, hurt, or loneliness facilitates reconnection among estranged family members.

Therapist: Does he know how much you miss him? How worried you are about him?
Parent: I tell him, if he wants to make it in this world, he needs to come home at a reasonable time, stay away from the punks in the street, keep his eye on his goals.
Therapist: So, you have given him some good advice. That's important in the right dose. I guess I just wonder if he knows how scared you are for him. Have you ever told him how much you miss being a part of his life?
Parent: No. I guess I never said it quite like that.
Therapist: I want to help you talk to him in a different way—to tell him how important he is to you. He tunes out when he thinks you're preaching to him. Can I help you talk to him in a way that he'll hear you—so he'll understand, really understand how concerned you are.

Conflict

Over time, severe and chronic conflict damages the developmentally instrumental parent-adolescent relationship. Although traditional views of adolescence created the expectations for emotional conflict and rebellion (e.g., Freud, 1958), contemporary research shows that most parent-adolescent conflict is not extreme, and in most instances, conflict does not jeopardize an otherwise healthy parent-child relationship (see reviews by Holmbeck, Paikoff, & Brooks-Gunn, 1995; Steinberg, 1990). For most parents and their teenagers, this conflict takes the form of quarrels over relatively minor issues such as curfew, chores, and appearance, with parents and their adolescents reporting significant agreement on basic values. Research also suggests that moderate conflict between adolescents and their parents can have an adaptive developmental function (Cooper, 1988). When teens are able to negotiate solutions to minor conflicts within a mainly supportive parent-child relationship, they practice and hone their reasoning skills, test out new ideas and express their developing sense of self, including feelings of self-competence, self-assertion, and autonomy.

Using this knowledge base clinically, we work the reparation of disconnected or strained parent-adolescent relations in developmentally appropriate ways. Disconnection between adolescents and their parents is not the norm, and we know that with clinical samples adolescent-parent relationship turmoil reflects the cumulative impact of many past disappointments, hurts, and conflicts (Diamond & Liddle, 1999). While the content of these parent-adolescent conflicts revolves around seemingly mundane transgressions or disagreements, the emotional valence of these arguments reflects the strongly experienced, underlying feelings of intense hurt. Therapists try to concretize and address these core relationship issues and conflicts, which have been characterized by blame and negative emotion. Moving beyond blame and experiences of negativity, a focus on core parent-adolescent relationship themes can create intrapersonal and interpersonal experiences of great impact that begin to facilitate a new way of being together as a family (Diamond & Liddle, 1996).

Parent: He hit me yesterday. I told him to take the trash out and he just walked away, telling me to —
— off. I've had it. He's not going to talk to me like that. I'm his father. So, I let him have it—I really lost it—I just started screaming. That's when he turned around and hit me.
Therapist (to Adolescent): What happened to you that you lost it like that?
Adolescent: I'm sick of his ——. Ten million times he's telling me to do the same thing. Over and over again. What the —— does he think, that I didn't hear him the first time? Who does he think did everything when he was out drinking all night?! Now he wants to come in and be Mr. Dad, and tell me what to do. No way.
Therapist: You are still furious at him for not being there for you during those years when he was

drinking.

Adolescent: You're damn right, I'm mad. (To Father) You let me go to school in ratty jeans while you were out drinking my ⸺ social security money. Do you know how that felt? Do you have any idea how it was for me to get harassed everyday for wearing the same clothes?

Here the therapist uses an opening to explore the adolescent's shame and disappointment, which are less obvious than the overt conflict. By helping the teenager to articulate these feelings in his father's presence and then asking the father to respond nondefensively and present his own perspective, the therapist helps dad and son face the unaddressed. These are initial steps in reweaving the emotional fabric of hurt relationships.

BIOLOGICAL MATURATION

Biologically based explanations are often invoked to explain adolescent development and behavior. Biological determinism is revealed in statements such as "it's those hormones again," "he was born difficult and that's how he is," and "this happens to all teenagers." These statements refer to changing biological features that accompany the pubertal period, constitutionally fixed features, such as temperament, or biological universals that cut across individual and group differences. Considerable research has occurred in all three of these areas in recent years, and these new findings have clinical relevance.

For an individual teenager and for others, an adolescent's physical changes often create confusion or concern. Puberty is a series of events with differences both between and within individuals in sequence, onset, rate, duration, and offset of various bodily and physiological changes (Brooks-Gunn, 1988). Puberty's observable manifestations signal impending changes in the adolescent's potential for greater responsibility, autonomy, adult reproductive capacity, and sexuality to parents and others in the teenager's social world. Although sometimes conceived of as a singular causative factor, research reveals that biological changes during puberty have little direct effect on behavior, feelings, attitudes, and adolescent-parent relations (Savin-Williams & Small, 1986). This research reinforces notions regarding the continued salience of interpersonal, affective, and behavioral targets during therapy with adolescents. In fact, the combined effects and interactions of pubertal changes, environmental and life events, social factors, norms, and expectations are far more powerful determinants of change during adolescence than is the influence of puberty's hormonal and physical changes.

An individual teen's adaptation to sexuality and physical changes is understood contextually. Research suggests that adolescents' experience of their own physical development during puberty relates to the quality of family interactions, and parents' ability to respond to the teen's changes appropriately. For instance, adolescent girls tend to have improved self-esteem immediately after menarche, but this association is mediated by the quality of the mother-daughter relationship and certain negative behaviors (e.g., punitiveness) of the father (Lackovic-Grgin, Dekovic, & Opacic, 1994). In addition, menarche is earlier among girls whose parents experience high conflict and divorce (Belsky, Steinberg, & Draper, 1991; Wierson, Long, & Forehand, 1993). An adolescent girl experiences puberty more negatively when she feels unprepared and confused about her physical changes, and adjustment is more difficult for a girl who physically matures earlier (Greif & Ulman, 1982). A developmental family therapy uses this information in treatment. Therapists normalize the acknowledgement and discussion of these issues, sponsoring difficult but important conversations between teens and their parents. These goal-focused talks frequently address the teen's sexual attitudes and experiences, a topic described in the next section.

Sexuality

Sexuality is a difficult issue for adolescents to address openly with parents, other adults, and even close friends. The serious implications of risky or irresponsible sexual behavior can create such anxiety for parents that they avoid the subject altogether (Katchadourian, 1990). An adolescent's social milieu can contribute to his or her confusion about sexuality, particularly when contradictory messages about sexuality and its expression are offered. For example, parents, churches, and school systems generally advocate abstinence, while peers, popular culture, and media encourage sexual expression at an early age. Research on the

development of "sexual styles" indicates that adolescents differ substantially in their attitudes, beliefs, and sexual risk-taking behaviors (Buzwell & Rosenthal, 1996). Thus, the messages received within the adolescent's own peer group may be contradictory and confusing.

Although parents may rarely speak directly to their adolescents about sexuality, they play an important role in shaping teens' sexual attitudes and behaviors (Rodgers, 1999). Parents influence their adolescent's sexual development through the messages and attitudes they convey about sexuality and contraception (Miller, Norton, Fan, & Christopherson, 1998). Recent research on adolescents' communication with parents about sex-based topics indicates that it is not simply what parents say to them about sex but how they say it that influences adolescents' sexual behaviors (DiIorio, Kelley, & Hockenberry-Eaton, 1999). Parents who talk to their adolescents about sexual risk and the importance of condom use have teenagers who report more condom use and more conversations with their partners about condom use, but only if parents are comfortable and skilled in these conversations (Whitaker, Miller, May, & Levin, 1999). As is true of adolescent drug abuse, parents may enhance or restrict opportunities for sexual activity by their presence, absence, and extent of the monitoring and supervision they provide, as well as the way they communicate about high risk behaviors (Rodgers, 1999). The etiology and expression of adolescent sexuality and its consequences involve individual, interpersonal, and broader contextual factors. A systemic understanding of sexuality is critical. Teens who drink or use drugs are more likely to have sex, initiate it at younger ages—as early as 12 years old—and have multiple partners, placing them at higher risk for sexually transmitted diseases, AIDS, and unplanned pregnancies (Center on Addiction and Substance Abuse, 1999). Given these realities, family therapists use their systemic perspective to help family members understand and deal with each other sensitively about the complex, secret world of adolescent sexuality.

Therapists are direct in discussing sex with adolescents, showing interest and respect in this important aspect of a teen's life. We avoid a judgmental tone and actions that disempower or disrupt the adolescent's own decision-making process. From the foundation of having and giving accurate information, therapists help teenagers to clarify how and why they make their own decisions about sexual behavior. Adolescents' sexual behavior and contraceptive use are intimately linked to their feelings about themselves and their cognitive skills such as decision making (Holmbeck, Crossman, Wandrei, & Gasiewski, 1994). Accordingly, therapists understand their role as facilitating a teen's process of making healthy lifestyle choices, and thus, they inquire about and discuss sexual behavior as inextricably linked to personal decision making (DiIorio et al., 1999).

Therapist: So you're thinking you might be pregnant.
Adolescent: I don't know . . . we didn't use anything. It was stupid . . .
Therapist: Was it just poor planning—something on the spur of the moment?
Adolescent (begins to cry): I didn't really want to have sex. He was kissing me and it felt okay at first, but I didn't want to have sex. I don't even know if I love him. I just thought that if I didn't, he would move on to someone who would (crying harder).
Therapist: It sounds like a lot of pressure to be under. That's a tough place to be.
Adolescent: Every single girl in my class has had sex.
Therapist: So if you had said no, you think he would have moved on. How would you have felt then?
Adolescent: Probably like ——. Like I wasn't worth anything—like he didn't care at all.
Therapist: Worse than you feel now?

Key to this process is the attempt to focus the teen on the sexual event and its multidimensional consequences. These conversations can generate strong emotions—discomfort, embarrassment, and shame are not uncommon. Up-to-date and sound information, sensitivity, and respect for the perspectives of and issues involved for each of the generations and a direct clinical style that is manifest in individual (parent and adolescent) and joint sessions are the ingredients of effectiveness in addressing sexuality with parents and teens.

Temperament

Teenagers are as diverse in personality and temperament as any other age group. Differences in personality styles or traits are evident from infancy, and most children show stability in temperamental style

(Kagan, 1989). In fact, the influence of genetic factors on an individual's development actually increases from infancy to adolescence as the adolescent seeks out experiences, situations, and people that fit with a person's unique genetic makeup (Scarr & McCartney, 1983). The impact of genetic factors on the nature of the parent-adolescent relationship also has been shown to increase over time (Elkins, McGue, & Iacono, 1997). As infants, individuals' environments and experiences are almost entirely shaped by parents' characteristics and choices, yet adolescents have much greater ability to seek out environments that fit with their own characteristics. During adolescence, the individual is able to make many autonomous decisions about friends, activities, academics, and employment opportunities—decisions that shape the teen's identity. Assuming that these life choices are part of a complex formula that includes genetic influences, parents can be helped to recognize, acknowledge, and ultimately accept their children's unique temperament and encourage their adolescent to make decisions according to their own interests, talents, and characteristics.

Not only do genetic factors determine to a large extent the types of experiences one seeks out but, throughout development, individuals evoke responses from others based on their temperamental style (Scarr & McCartney, 1983). For instance, "difficult" children, whose behavior is rated by objective observers as socially unresponsive and inappropriate, tend to evoke more negative responses from their mothers and unrelated adults than children with easier temperamental styles (Bugental, Blue, & Lewis, 1990).

However, these same children evoke more negativity from adults who attribute difficulties in caregiving to low parental control and high control in children. An optimal attributional set for parents appears to be a belief that both parents and children are high in personal control. Mothers who attribute high control to themselves and to children communicate most effectively with, and foster assertiveness and socially appropriate responses from children who are either characteristically responsive or unresponsive (Bugental & Shennum, 1984). The clinical implications of these findings are twofold. First, parents can be helped to recognize and accept the idea that some behaviors have more to do with their adolescent's personal style than interpersonal factors. Misinterpretation or personalization ("he is doing this to me") of another family member's behaviors can precipitate and escalate negative emotions and disengagement. Second, therapists who are able to foster parental beliefs about their own control and their children's personal control may transform negative interactions and minimize negativity between the parent and adolescent.

Research also suggests that negative aspects of the family environment can exacerbate genetic vulnerabilities. For instance, family stress, such as conflict or illness, has been shown to activate temperamental vulnerabilities for withdrawal and inhibition (Kagan, 1989). Interventions aimed at reducing family conflict and negativity may minimize the impact of negative temperamental tendencies. Taken together, developmental theory and research findings suggest that the temperamental "fit" of a child with his or her parents appears to have a significant impact on the quality of the relationship, and clinicians can help families to better estimate the degree to which they can and cannot shape each other's personalities and behavior. Parents can be helped to encourage their adolescents' expression of their own unique personality and to recognize that they have less control over their adolescents' interests and skills than they might like to have. The field's recent interest in acceptance-based strategies has relevance here (Cordova, Jacobson, & Christensen, 1998). At the same time, therapists can help parents to recognize their own parenting strengths while accepting and fostering their adolescent's personal control—aspects of the teen's behavior that are developmentally important and normative.

COGNITIVE DEVELOPMENT

An adolescent's cognitive development is another area of expanding capacity for the teenager and an intervention opportunity for clinicians. Information-processing research has transformed our understanding of mental skill development. Teenagers show an increased capacity for storing content, as well as for faster, more automatic, and more efficient processing of information. Teens also show changes in earlier established "concrete" skills such as classification, as well as in practical intelligence (Keating, 1990). Information-processing and problem-solving skills affect an adolescent's everyday practical problem-solving and decision-making abilities.

Research inspired by Piaget (1991) has revealed qualitative changes in cognitive structures of

adolescents. It has also helped us to understand the complex interactions of adolescents within their many developmental environments. During adolescence, the potential for a qualitative structural shift from concrete to formal operational thinking is evidenced by the emergence of sophisticated scientific and logical reasoning. Many adolescents develop the capacity to think in terms of possibilities and new ideas, think through hypotheses, anticipate future events, and plan and think about the relations among different sets of ideas (Keating, 1990). Often, the new thinking patterns draw the adolescent into the world of theories about self and life, about the world as it is and as it might be, and the nature of cause and effect relationships. Cognitive developments are accompanied by improved abilities to take on the perspective of others and to engage in positive social interactions (Offer & Sabshin, 1984). These developmental changes present opportunities for individual work with teenagers and for work with parents that can refer back to and use the new (or hoped for) developmental changes in the teen (i.e., talking with parents about a teenager's developing perspective-taking capacity).

Cognitive development, like the other developmental domains, has intrapersonal and interpersonal aspects. Family relationships serve as one of several critical contexts for the adolescent's cognitive development (Wozniak, 1993). For instance, parental responsiveness to their teenager is related to an adolescent's attainment of formal operational thought (Reimer et al., 1996). Parent-adolescent conversations can be understood according to the different ways in which parents and their teens understand and define family rules, events, and regulations. Smetana (1988) explains that adolescents are more likely to view issues of contention between themselves and parents as matters of difference in personal choice. Facilitative developmental environments provide opportunity to voice these differences of opinion and discuss alternatives. Therapists make every effort to help teens "stretch" their ability to think analytically. Careful not to lecture or ask closed-ended questions, we adopt a Socratic strategy that challenges adolescents to think and articulate mature, prosocial rationales for their positions and behaviors.

Adolescent: I don't care what anybody says. She (the teacher) was wrong to make me feel stupid like that and tomorrow, I'm going to tell her to —— off in class—right in front of everybody. Nobody can stop me.
Therapist: You are absolutely right, no one can stop you.
Adolescent: That's right!
Therapist: Just one thing, how do you think she is going to respond?
Adolescent: I don't give a ——. She had no right to talk to me like that.
Therapist: It does sound humiliating. I agree, she could have handled it much better. You're a smart guy, though. You must have some idea how she'll react?
Adolescent: She'll probably call right down to the principal's office. I'll probably get suspended again.
Therapist: How long a suspension do you think you'll be facing?
Adolescent: Probably a week.
Therapist: What will that mean for your finals? I thought you said the grades you make this term will determine if you graduate.
Adolescent: (after a few moments of silence): I hadn't really been thinking about my finals. I guess it won't really help very much if I'm suspended during finals.
Therapist: So are you really getting back at her by cussing her out in front of the class? Would it be worth not graduating and spending another year maybe even in her class? This is important. I think this is something we ought to think through together.

Through probing yet nonevaluative questioning, therapists help adolescents think about their experiences and decisions, facilitating perspective taking and adoption of a future orientation. In the case described above, the therapist continues to discuss the teen's priorities and the advantages of graduating. The therapist challenges and helps the teen to conceptualize his actions not as isolated events but as decisions that have important and potentially costly personal future implications.

Cognitive development can be a mediator and an outcome of psychotherapy (Shirk, 1988). Cognitive development is an outcome of therapy when the adolescent shows increased self understanding, expanded capacity to comprehend complex causality, or more objective and refined interpersonal perceptions over the therapy process. According to Shirk (1988), children at different ages bring markedly different cognitive repertoires and information-processing capacities to the therapeutic process, affecting their ability to communicate in and extract meaning from psychotherapy. Thus, individual differences in the cognitive

domain potentiate different in-therapy processes and can organize or affect a therapist's interventions and responses (Kendall, 1984) to individual family members, for better or worse. The content and form of interpretations are adjusted to fit the cognitive level of clients (Shirk, 1988). Family members of different ages and cognitive levels cannot all find the same meaning in a given communication sequence, content area, interpretation, or reframe. Therapists are sensitive to how different family members may have particular difficulty deriving meaning from the process and tasks of therapy.

Rapid changes in cognitive ability and functioning during adolescence yield increasing opportunities for therapeutic discussions about the adolescent's ideas about herself, her family, her social world, and her goals for her future. Family members may need help in realizing and adjusting to the adolescent's advancing cognitive abilities, and therapists can offer parents a fresh perspective. Consider this example.

> *Parent:* She just doesn't know what she's doing. It's not even worth trying to talk to her about these things, because she's not even able to think rationally about anything since she started with that guy. It's up to me to make these decisions for her because she's ruining her life and she can't even see it. What does she know about raising a child?
>
> *Therapist:* Yes, I hear that you're afraid for her. Also, I think it's good that you are so involved in helping her to make the right decisions for herself. I wonder, though, if you're underestimating her. I think Julie has thought a lot about what she wants for herself and I think it is critical that you try to talk with her about she wants to do. She's 17 now, and she will be graduating next month. Even though it doesn't seem like she's making good decisions right now, Julie really is capable of thinking about her future and making decisions for herself. The best thing you and I can do for your daughter is to recognize that. Can you help her think through this very important decision? When Julie comes back in let's talk through this together. Can you hear her in a different way—as a young woman—not as a little girl?

EMOTIONAL EXPERIENCE AND EXPRESSION

Emotional development is fundamental to the focus and work of therapy. Emotion is a primary communication system that influences behavior. It is an organizer of perceptions, actions, and personality and a guide to and target of therapeutic change. The emotional expression of one person influences the emotional experience and expression of others. In positive relational sequences, these transactions are satisfying, yet in many clinical families, consistently negative emotional sequences have serious deleterious effects (Patterson et al., 1992). Although negativity in families can change in therapy, these processes are powerful, they can intimidate therapists and family members alike, and they pose unique clinical challenges. Understanding how the experience and expression of emotion develops throughout adolescence can increase clinicians' facility in shaping positive emotion-focused, in-session sequences (Robbins, Alexander, Newell, & Turner, 1996). Emotions not only help therapists to understand core relationship issues but they can also provide an important clinical focus and a modus operandi for relationship healing (Liddle, 1994).

Emotional Experience and Expression

Affect and emotions can be elusive terms (Collins & Gunnar, 1990), and clinicians must be conscious of and attentive to the differences between emotional experience and emotional expression. Emotional experience is defined as the subjective interpretation of events or interactions that is associated with a positive or negative emotional state (Lewis & Michalson, 1983). For example, a mother and her teenage daughter may have different emotional experiences of an interchange that occurs during a therapy discussion about curfew. The mother leaves the session feeling positive, happy, and satisfied. She and her daughter were able to establish what mom believed to be a mutually acceptable curfew. But the daughter, who agreed to certain terms to avoid conflict in the session, leaves the session feeling upset, angry, and overlooked. She believes that her feelings and input were disregarded by her mother and that the therapist sided too much with her mom. In contrast, emotional expression is the affective state that is assigned based on observations of an individual's response to a particular event or situation (Flannery, Torquati, & Lindemeier, 1994). In the example, the teen's emotional expression in the session did not reflect her experience or her real reactions to the discussion and agreement. Although this was unfortunately not the case here, therapists should be sensitive to and actively elicit these feelings, checking in on a teen's emotional agreement to matters that pertain to them. Direct questioning

("How do you feel when you hear your mother say that?") and "lending" feelings to prompt an interchange ("I think I would have felt pretty awful if someone had said that to me") are two common methods in this regard (Liddle, Dakof, & Diamond, 1991).

Emotional Development in Context

Understanding emotional development is enhanced when we include the mediating influence of other factors. Cognitive changes enable the adolescent to interpret events and express feelings about those events at a more sensitive and complex level than was possible at earlier developmental stages (Larson & Ham, 1993). In contrast to younger children, preadolescents can understand that emotions are internal events and that multiple feelings about the same event are possible (Nannis, 1998). Teenagers can recognize that they have some control over their emotional expression. The attainment of formal operational thought helps adolescents perceive the interdependence between external events and emotions. In order to explain emotions, adolescents apply universal rules about emotional experiences. They are thus more capable of understanding the emotional states of other people than are preadolescents and children. Formal operational thought also permits the adolescent to attribute emotional states to events occurring across a broad temporal spectrum (past, present, future), as opposed to attributing emotions to immediate events (Larson & Asmussen, 1991).

A vital aspect of the teen's affective process is the adolescent's subjective understanding of interpersonal events (Powers, Welsh, & Wright, 1994). As the social network changes from childhood to adolescence and the adolescent's interpersonal needs develop, the contexts for affective expression and experience also change (Flannery et al., 1994). Children tend to ascribe their affective states to family relationships, while adolescents tend to associate emotional experiences with peer relationships (Haviland, Davidson, Ruetsch, Gebelt, & Lancelot, 1994). Therapists help the adolescent to explore feelings associated with new relationships, which are sometimes very intense. A therapist might suggest, "You got quiet after we talked about your ex-boyfriend. You seem sad right now. Can you say how you're feeling? I think there's a lot more going on inside of you than you usually let on. These feelings you're having about Mike are important."

Although peers are increasingly central during adolescence, a teen's development is influenced considerably by the emotional climate of the family environment. Adolescents' global and immediate emotional states tend to reflect those of their parents (Larson & Richards, 1994). The open expression of nonhostile emotion in the family promotes healthy adjustment during the early adolescent transition, including prosocial behavior for boys and high self-esteem for girls (Bronstein, Fitzgerald, Briones, Pieniadz, & D'Ari, 1993). Not surprisingly, hostility during family discussions tends to interfere with problem solving (Forgatch, 1991). Expression of both positive and neutral emotions not only facilitates problem solving but is also related to high self-esteem in adolescent boys and strong parent-son relationships (Capaldi, Forgatch, & Crosby, 1994). A therapist might approach the discussion of family tensions by saying, "One of the things that we try to do in here is that, even when you disagree, it will be important to slow things down a little bit so you can express what's important to you in way that others can hear you. Then each person is in a better position to respond to what others are saying."

As discussed earlier, serious conflict is addressed through a sequence of therapist actions, the first of which involves accessing emotions such as hurt, resentment, and disappointment that are foundational to a family member's hostility (Liddle et al., 1998). Appreciation of how the adolescent's experience and expression of emotions differs from that of younger children, as well as the interaction of emotional development with other critical changes in the biological and cognitive domains, informs interventions with all family members. Conversations about past events take on new meaning as the adolescent develops increased capacity to reflect and identify experiences at earlier stages of development. Furthermore, increases in a teen's knowledge of emotions potentiates new opportunities for perspective taking and empathic understanding and expression of other family members' feelings (Sessa & Steinberg, 1991).

CONCLUSION

Research-based knowledge of the contributors to determinants of dysfunction as well as the ingredients and processes that promote health are valuable informers of what therapy can be and where it needs to go. Developmental knowledge helps us to understand the complexity inherent in adolescents and their social worlds. Taking developmental trajectories and levels into account provides an empirical and clinically rich intervention foundation (e.g., Kendall, Lerner, & Craighead, 1984).

It is important to note that the findings discussed in this article represent only a small sample of the clinically relevant research available on adolescents. Furthermore, many of these findings are based on studies of white, middle-class adolescents and may not generalize to all populations, ethnicities, or family types (see Burton, Allison, & Obeidallah, 1995, Burton, Obeidallah, & Allison 1996 [culturally specific basic family research]; and Boyd-Franklin, 1993; Jackson-Gilfort & Liddle, in press [culturally specific clinical work]). Similarly, incorporation of the full scope of gender socialization research was beyond the scope of this article. Eating disorders have been carefully considered from a gender-informed and developmental perspective (Surrey, 1991). In addition, the clinical insights of Pipher (1996) and the seminal work by Gilligan and colleagues (Gilligan, Lyons, & Hanmer, 1989) are powerful reminders of core gender-based issues in the second decade of life. As is the case in other areas of adolescent research, these advances in research-based knowledge have direct and clinically useful impact in the clinical arena (Dakof, 2000). The clinical implications of this article's empirical findings may be specific to certain groups, and as in all clinical work, they must be applied with careful attention to the idiosyncratic context of the adolescent's and family's life.

A golden era for therapeutic approaches and policy changes favorable for teenagers and their parents (Lerner & Galambos, 1998) may lie just ahead. Because of two sets of developments—research advances in our understanding of normative and dysfunctional developmental processes (Holmbeck & Updegrove, 1995; Petersen & Hamburg, 1986; Zucker, Fitzgerald, & Moses, 1995) and strides in therapy development (Kazdin, 1994)—contemporary interventions with adolescents can be formulated and enacted according to the teen's unique developmental issues, challenges, and needs (e.g., Diamond, Liddle, Hogue, & Dakof, 2000; Shirk & Saiz, 1992). However, a fully articulated and effective family therapy will not be simple to achieve. There is considerable variation within developmental stages and within the developmental tasks and processes of adolescence (Kendall, 1984). And, just as theory development can move at what seems to be a snail's pace, the rigorous testing of treatments is both difficult and too infrequent, despite an increase in family-based treatment studies with difficult adolescent problems such as drug abuse and delinquency (Ozechowski & Liddle, in press). But as more examples are created that illustrate how research advances can inform and enhance interventions, tomorrow's treatments will increasingly be based in developmental research (Vernberg, Routh, & Koocher, 1992). The achievement of critical developmental tasks and the adoption of new behaviors and attitudes that propel adolescents on a healthy trajectory are key goals of the therapy process. Although systematic efforts have been made to integrate adolescent developmental research findings into model development, and some of this integration activity has resulted in outcome research findings that are very encouraging, we are still at an early stage of this process.

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