

Translating Parenting Research into Clinical Interventions for Families of Adolescents

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ABSTRACT

The contributions of parenting to the adolescent's psychosocial development have become the focus of increased attention by researchers and clinicians alike. Although parents face the difficult challenge of providing increasing levels of autonomy to the maturing adolescent while peers become more central to the adolescent's life, parents continue to exert significant influence throughout this developmental stage. Significant progress in this research specialty has been highlighted by researchers, assisting in the specification of developmentally sensitive interventions for problem adolescents. We review selective, clinically relevant research on parenting during the adolescent transition in order to demonstrate how interventions can be informed by basic developmental research. The clinical implications of parenting within the adolescent developmental research are emphasized throughout the review. A particular intervention module, a parental reconnection intervention, which has been used in the context of a family-based intervention, Multidimensional Family Therapy is described as a prototype of an empirically based treatment component.

KEYWORDS

adolescent development, adolescent substance abuse, clinical applications, family-based intervention, parenting research

CONTEMPORARY INTERVENTIONS for troubled adolescents are remarkably different than a decade ago. Today, outpatient, inpatient or residential treatment for a variety of disorders, is more likely to include the teenager's family, be targeted to the multiple impairments of the adolescent, including extra familial domains such as peer relations, and developmental theory and research specific to the second decade of life (Liddle, 1995; Tolan, Guerra, & Kendall, 1995). Research evidence suggests that adolescent disorders such as conduct disorder and drug abuse remain not only the most prevalent in treatment settings, but also among the most intractable of problems to change (Kazdin, 1994). At the same time, certain approaches, most notably family-based treatments with particular features, have demonstrated promising results in rigorous tests

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(G.S. Diamond, Serrano, Dickey, & Sonis, 1996; Lebow, & Gurman, 1995; Liddle, & Dakof, 1995a; Mann, & Borduin, 1991). While the efficacy results are encouraging, our understanding of the means by which treatments achieve their effects is at an early stage of development (Friedlander, Wildman, Heatherington, & Skowron, 1994; Henggeler, Borduin, & Mann, 1993). So, while we have some indications for how existing treatments can be altered to enhance their efficacy (Miller, & Prinz, 1990), we can consider process research as holding great promise for increasing our specification of interventions and their mechanisms of action. Gaston and Gagnon (1996) make the link between process research and treatment manual development. The present article contributes to these still evolving traditions – the specification of specialized treatments and manual development for adolescent treatments which are informed with developmental research. We are in need of prototypes for integrating developmental research into the understanding of psychopathology (e.g. developmental psychopathology), and using these formulations as the basis for empirically targeted interventions (del Carmen, & Huffman, 1996; Holmbeck, & Updegrave, 1995; Kendall, & Williams, 1986). This article illustrates how contemporary developmental research findings on parenting are translated into assessment and intervention ideas for clinicians who work with adolescents.

Families are instrumental in adolescent development (Grotevant, & Cooper, 1983; Hauser et al., 1984). Parent–child relationships and parenting practices with particular characteristics facilitate positive adolescent outcomes (Hauser et al., 1984; Hill, 1980; Montemayor, 1983, 1986). Major developmental challenges of adolescence, identity formation, cognitive and moral development, achievement, sexual maturation and autonomy development, are understood contextually and not as either intrapersonal or interpersonal events (Baumrind, 1991a; Erikson, 1968; Holmbeck, & Updegrave, 1995; Paikoff, & Brooks-Gunn, 1991; Petersen, 1988). Parents and adolescents together create the emotional environment necessary for the adolescent’s successful maturation and adaptation to the demands of young adulthood (Bronfenbrenner, 1979; Steinberg, 1987). Baumrind (1991a, p. 112) summarizes the basic challenge of adolescence as follows: ‘Successful stage-transition, resulting in a more differentiated and integrated level of adaptation in young adulthood can occur only through personal commitment to courses of thought and action that depart from early, more stable and secure patterns; and

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accommodation by parents and other significant adults to the changing status of the child.' Complex biological, cognitive, and emotional changes of adolescence are interdependent, and they evolve simultaneously within multiple contexts of development (Holmbeck, & Updegrave, 1995; Petersen, & Hamburg, 1986).

Parenting research

Identity formation, autonomy development and parenting

Erikson (1968, 1980) theorized that the major challenge of the adolescent period is the establishment of a stable, continuous ego identity in the face of enormous physical, social and emotional changes. This process is shaped by the adolescent's perceptions of how others value him and appraise his abilities, as well as the extent to which he has formed identifications with parents and others in his social world. Baumrind (1991a, p. 114) maintains the position that 'identity formation' is indeed the core developmental process during adolescence, and defines this process as 'the adolescent's ability to conserve a sense of continuity through the act of validating simultaneously the interest of personal emancipation and individuation, and the claims of other individuals and mutually shared norms.' Difficulties in identity formation have been associated with alienation (Baumrind, 1991a) and 'identity confusion' (Erikson, 1980), both of which are thought to influence the development of problems such as delinquency and drug abuse.

Individuation, the process of achieving 'psychological distance' from the family, involving 'the subtle but crucial phenomenological shifts by which persons come to see themselves as distinct within their relational context' (Sabatelli, & Mazor, 1985, p. 620), has been theorized to be a necessary step in the formation of identity. Researchers examining the process of identity development have tended to overlook the family's importance in this process (Sabatelli, & Mazor, 1985). Furthermore, in considering the family's role in the adolescent's identity development and individuation, there has been an overemphasis on rebellion and conflict as an essential and normative aspect of this transition (Steinberg, 1987). Recent work in this area has shown that intense conflict between parents and adolescents is not the norm, nor is such conflict a prerequisite for successful identity development. Conflict and estrangement in the parent-adolescent relationship is characteristic of clinical families and not community samples.

Adolescents clearly require increased independence as they develop greater capacity for decision-making, accept and are granted greater flexibility in social roles, and experience increased attachment to peers. Classic views of the adolescent developmental period emphasized the importance of separation from parents in order to successfully transition into adulthood (Blos, 1962; Freud, 1958). However, contemporary perspectives on normative development indicate that there is not a sudden, dramatic change in the relations between parents and their children during the period of adolescence (Baumrind, 1991a; Collins, 1990). The transition is a more subtle one in which parents and adolescents renegotiate changes in their relationship (Delaney, 1996). Although negotiation can be conflictual, at the same time adolescents frequently seek out their parents for support and guidance (Greenberg, Siegel, & Leitch, 1983) and parents continue to have considerable influence on their adolescents in many areas (Hill, 1987). Adolescents desire high levels of support from parents but also want parents to be adaptive and responsive to their changing needs (Noller, & Callan, 1986). Adolescent individuation is thus viewed as a process that pertains to changing the nature of one's connection with parents, and not a process which is primarily oriented toward separation (Gilligan, 1982).

Achieving autonomy while maintaining a positive relationship with parents is recognized as a critical task of adolescence and it is linked to numerous positive social

outcomes (Allen, Hauser, Eickholt, Bell, & O'Connor, 1994; Hill, & Holmbeck, 1986; Steinberg, 1990). Failure to develop autonomous functioning creates a major developmental risk factor for the adolescent and parent. For instance, Allen, Hauser, O'Connor, Bell and Eickholt (1996) demonstrated that young adolescents who are unable to engage in autonomous discussions with parents show higher levels of hostility and conflict with their parents 2 years later. These authors suggest that the adolescent who is unable or ill-prepared for the task of autonomy development may need to place hostile distance between himself and his parents later in adolescence in order to assert control. Repairing conflictual relations helps parents to promote the adolescent's autonomy. Attachment theory, as it has been re-conceptualized and researched for application in adolescent-parent relations, is enormously helpful as a framework for assessment and intervention (Allen, Hauser, O'Connor et al., 1996; Liddle, 1995).

Researchers have shown that failure to maintain relatedness results in externalizing behaviors at least as dangerous, if not more so, as the failure to establish autonomy (Allen, Hauser, O'Connor et al., 1996). In numerous studies externalizing problems have been linked to parental rejection and lack of parental involvement (Dadds, & McHugh, 1992; Loeber, & Dishion, 1983; Patterson, & Bank, 1989). Clinical samples show patterns of disconnection between parents and adolescents (Schmidt, Liddle, & Dakof, 1996; Volk, Edwards, Lewis, & Sprenkle, 1989). Allen et al. (1994) hypothesize that adolescents may be less motivated to please their parents when they feel disengaged, which lessens the impact of a critical regulating influence within the family. Results such as these suggest that one of the primary goals of family-based interventions with problem adolescents may in fact be the emotional reconnection of the parent and adolescent, crafted to fit the developmental needs of both parent and teenager.

Similarly, other research indicates that young adults who are more emotionally detached from their parents are at greater risk for developing internalizing problems, such as a negative self-image, than those who feel connected and close to parents (Ryan, & Lynch, 1989). Papini and Roggman (1992) found that adolescents with strong attachments to parents feel more competent and are less depressed and anxious than adolescents with weak parental attachments. Baumrind (1991a, p. 115) links alienation to lack of relatedness with parents, hypothesizing that 'early separation from family bonds of attachment in the interest of furthering their individuation may leave adolescents vulnerable to loneliness, despair, and uncritical dependence on peer group norms.' Furthermore, Delaney (1996) found that adolescents whose relationships with parents were characterized as 'detached' reported higher frequency of anxiety and depression symptoms and had lower self-esteem than adolescents whose relationships with parents were characterized as 'individuated.' Thus, parents' difficulties in providing flexible relational boundaries and helping the adolescent maintain connections present obstacles to adolescents' healthy psychosocial development.

Adolescence is a naturally stressful period for both the parent and adolescent, and an already difficult or tenuous relationship between parent and child is likely to become more strained during early adolescence (Steinberg, 1990). As an adolescent increasingly demands autonomy, the relationship with his or her parent must change, and this process presents an accommodation challenge for the parent. But success in this transitional period has positive benefits for the adolescent and parent alike (Hauser et al., 1984). In working clinically with adolescents and their parents, family therapists utilize interventions designed to repair strained relationships in order to facilitate accommodation by both the parent and adolescent to the demands of this developmental stage. The intervention's focus, as well as its implementation, depends on a thorough assessment of the clinical presentation of the adolescent's current problems, his history of emotional and

behavioral problems and difficulties with parents, and the parent–adolescent relationship. Therapist interventions designed to impact parent–child relatedness and improve parenting behaviors will be described in the last section of this article. Next, we review the literature on the nature and ingredients of effective parenting during the adolescent transition.

Parenting style

Parenting style has been conceptualized as a global contextual variable that influences the child's development by moderating the impact of specific parental behaviors on the child (Darling, & Steinberg, 1993). Parenting style is understood less as an aggregation of various parenting practices; and more as the emotional climate in which socialization occurs. Specific parenting behaviors may only be effective when they are joined with the provision of an appropriate emotional relationship context. Parenting style refers to the parent's attitudes about the child across a wide range of situations. This integrative model of parenting is particularly useful to the clinician because it distinguishes specific parenting techniques (parenting practices) from the emotional climate in which parenting occurs (parenting style). Understanding this distinction has important assessment and intervention implications.

Baumrind's (1967) highly influential tripartite model of parenting style distinguished three types of parental control: authoritarian, authoritative and permissive. Parenting style is best conceptualized across multiple domains, including responsiveness and demandingness (Maccoby, & Martin, 1983). Steinberg and colleagues added a third dimension to the typology of parenting, called psychological autonomy granting, which is defined as 'the extent to which parents use noncoercive, democratic discipline and encourage the adolescent to express individuality within the family' (Steinberg, Darling, & Fletcher, 1995, p. 432). Maccoby and Martin's (1983) parenting typology is widely recognized and accepted as capturing the essential elements of parenting. They differentiated permissive parents as being either indulgent or neglectful, depending on their level of responsiveness. Authoritarian–autocratic parents are characteristically demanding but lacking in responsiveness, authoritative–reciprocal parents are high on both dimensions, indulgent–permissive parents demand less from their children but tend to be responsive to their emotional needs, whereas indifferent–uninvolved parents are deficient in both domains. This typology has been influential because it has allowed the systematic study of the effects of varying levels of the linear constructs of demandingness and responsiveness on children and adolescents (Holmbeck, Paikoff, & Brooks-Gunn, 1995).

Authoritative parenting, which incorporates both warmth and control (high responsiveness as well as high demandingness), is associated with positive adjustment in many areas of functioning throughout development (Steinberg, Lamborn, Dornbusch, & Darling, 1992). Authoritative parents are consistent and firm in monitoring and disciplining their children but are also warm, responsive and high in psychological autonomy granting. In comparing over 20,000 high school students raised by parents of varying styles, Steinberg and his colleagues determined that 'adolescents raised in authoritative homes are better adjusted and more competent; they are confident about their abilities, competent in areas of achievement, and less likely than their peers to get in trouble' (Steinberg, Darling, & Fletcher, 1995, p. 436). Summarizing many years of work, Maccoby (1992) concurs with this conclusion in her review of the many conceptualizations of 'optimal parenting:'

However authoritative parenting is defined and whatever the age of the child, there appears to be a common core of meaning that defines the optimal cluster, and it

has to do with inducting the child into a system of reciprocity. An authoritative parent assumes a deep and lasting obligation to behave so as to promote the best interests of the child, even when this means setting aside certain self-interests. At the same time, the parent insists that the child shall progressively assume more responsibility for responding to the needs of other family members and promoting their interests as well as his or her own within the limits of a child's capabilities. (p. 1013)

Authoritative parenting has been shown to be positively correlated with a variety of adolescent attitudes and behaviors including school performance and engagement (Steinberg et al., 1992). Because of the nature of their longitudinal study, Steinberg and colleagues are confident in their conclusion that authoritative parenting *leads* to school success, even among older adolescents. These authors were also able to show that the effects of authoritative parenting on positive school performance and engagement can be explained largely by the involvement of these parents in their adolescents' academic activities (attending school functions, discussing curriculum, monitoring progress, etc.). However, this involvement is most effective in the context of authoritative parenting, and not necessarily linked to positive outcomes with nonauthoritative parenting. While supporting the important role of parent participation in the adolescent's school activities, they also highlight the impact of parents' more general style of interacting.

Authoritative parenting has been related to positive outcomes for children across developmental stages, and the nature of parenting demands changes during the adolescent transition. Optimal parenting during this transitional period involves less emphasis on power and control than during the childhood years (Holmbeck et al., 1995; Pardeck, & Pardeck, 1990). Also critical is responsiveness to the adolescent's increasing needs for independent decision-making, identity exploration and peer involvement. 'The central issue for normal development may not be whether adolescents can establish autonomy at any costs, but whether they can establish autonomy *within* a positive adolescent-parent relationship or only by undermining or withdrawing from the relationship' (Allen, Hauser, & Borman-Spurrell, 1996, p. 438). Gavazzi, Goettler, Solomon and McKenry (1994) conclude that high individuality tolerance along with a general capacity for intimacy creates the optimal atmosphere for the adolescent's development. Family therapists can err on either side by providing incomplete interventions. Inattention to either process creates an imbalance in which adolescent differentiation cannot be fostered.

Steinberg et al. (1995) provide evidence for the role of parenting factors in different types of deficits during adolescence. Adolescents with authoritarian parents generally demonstrate obedience and conformity in the home environment and at school but lack self-confidence and self-reliance. Adolescents who describe their parents as characteristically indulgent are more likely to demonstrate problem behaviors such as drug use and school disengagement than their peers raised by authoritative and authoritarian parents. However, they do not show a pattern of serious delinquency, nor do they demonstrate deficiencies in self-concept or social competence. Neglectful parents, who lack both responsiveness and demandingness, tend to have children who exhibit problems on many indexes of functioning, including self-concept, distress, problem behaviors and competence.

Interesting cultural variations have been reported linking parenting practices and parent-child relations to different outcomes among high-risk urban youth (Florsheim, Tolan, & Gorman-Smith, 1996). These authors found that early adolescent African-American boys were more asserting and separating in interactions with parents than

Hispanic boys, who exhibited more submissive and deferential behaviors with parents. In addition, Hispanic parents evidenced more control over their sons and offered fewer opportunities for autonomous functioning than African-American parents. Overall, greater levels of hostility were observed among families of high-risk boys than families of low-risk boys. Family patterns, including parenting strengths and deficits, appear to be exhibited in different ways within these ethnic groups. On the one hand, autonomous behavior appears to be more normative and more strongly encouraged in concert with trusting and relying behaviors among African-American families. On the other hand, Hispanic families show a pattern of actively discouraging autonomous behaviors through high levels of control. Understanding cultural differences in parents' expectations, familial patterns of interaction, and parenting strengths and weaknesses can provide assessment and intervention clues. Case formulation generally, and assessment of parenting strengths and weaknesses in particular, are most effectively conducted with careful consideration of cultural norms.

This discussion of parenting style underscores the importance of the emotional climate of parenting behaviors in determining the impact of specific parenting practices on adolescent functioning. Changing the emotional climate of parenting, or the level of warmth, support and acceptance displayed by parents toward the adolescent, may be the vehicle by which the family therapist can motivate parents to be receptive to reviewing existing practices and adopting new parenting behaviors.

Parenting practices

Darling and Steinberg (1993) differentiate *parenting practices* ('specific, goal-directed behaviors through which parents perform their parental duties') from *parenting styles* ['non-goal-directed parental behaviors such as gestures, changes in tone of voice, or the spontaneous expression of emotion' (p. 488)]. Parenting practices are specific parenting behaviors intended to shape the child's responses and actions in various realms of functioning. They are understood to be domain-specific, operating in circumscribed areas such as academic and social competence, and are defined in terms of the parent's particular goals for the child's socialization. Darling and Steinberg (1993) maintain that the emotional climate, or parenting style, determines the impact of parenting practices. In addition, parents characterized by the same type of parenting style probably vary significantly in the specific practices they use.

Children's behaviors and characteristics appear to be directly influenced by parenting practices (Darling, & Steinberg, 1993), and many stressors, such as poverty and single parenting, may negatively impact upon children by disrupting parenting behaviors (Long, 1996). Effective parenting practices include developmentally appropriate limits and consistent discipline and rules. In concert with positive parenting goals, values and styles, these practices are associated with positive social outcomes for children. Ineffective parenting practices, however, have been related to a variety of emotional and behavioral problems in adolescents, including aggressive behavior (Loeber, & Stouthamer-Loeber, 1986; Patterson, 1982, 1986), and adolescent substance abuse (Block, Block, & Keyes, 1988; Steinberg, Fletcher, & Darling, 1994). Parental attitudes can also predict developmental outcomes. Parental permissiveness toward alcohol and drug use is related to adolescent drug taking (McDermott, 1984).

A broad category, parenting practices includes such diverse parent behaviors as setting clear standards for a child's behavior, enforcing rules and regulations, providing consistent discipline, permitting give-and-take, monitoring the child's whereabouts, providing information and encouraging differentiation from the family (Holmbeck et al., 1995). The range of parenting practices can be organized into categories of monitoring and

supervision; control, strictness and consistency of discipline; and support and communication.

Monitoring and supervision Parental monitoring is conceptualized as one aspect of a constellation of interrelated parenting practices that involves both structuring and tracking the adolescent's behaviors (Dishion, & McMahon, in press). One of the most robust findings in the adolescent development literature is that parental monitoring and supervision are related to positive adolescent outcomes. Parents are most effective when they are involved in their adolescent's life and monitor daily activities without being over-protective (Holmbeck et al., 1995). However, poor supervision and limited paternal involvement, as early as fourth grade, place boys at risk for poor adjustment (Capaldi, & Patterson, 1991) and may set the stage for later antisocial behavior, early substance use and involvement with deviant peers (Dishion, & McMahon, in press). Disruptions in family management practices, including poor parental monitoring, inconsistent discipline and ineffective problem solving are related to problem behavior among early adolescents (Loeber, & Dishion, 1983; McCord, 1979; Patterson, & Stouthamer-Loeber, 1984) that can progress to more serious difficulties in later adolescence and young adulthood (Farrington, 1995; Moffitt, 1993; Newcomb, & Bentler, 1988).

Given increasing autonomy and independence demands, the task of adequately monitoring and supervising adolescent behavior becomes simultaneously more difficult and more important for parents. A high proportion of treatment families show deficiencies in parental functioning in these areas (Patterson, & Chamberlain, 1994). In these families, by the time adolescents manifest serious emotional or behavioral problems, there is often a history of coercive family functioning and parents feel that they have lost control over their child. Family therapy provides a context for exploration of these past 'failures' and examination of why parents' efforts have been ineffective with the adolescent. Because the foundation of effective parental monitoring is a positive parent-child relationship and negative emotions toward the adolescent can decrease a parent's motivation to remain involved in the adolescent's life (Dishion, & McMahon, in press), therapists must address parents' feelings of hopelessness and frustration. The therapist uses these stories of defeat to build and encourage the practice of new parenting skills, taking advantage of opportunities to show parents that they can, in fact, have a positive impact on the adolescent, and that they can be more effective in using certain parenting tools.

Dishion and McMahon (in press) propose that the process of helping parents to improve their monitoring practices involves increasing parents' motivation to monitor, teaching the skills necessary to monitor effectively, and changing the ecology of the family so that effective monitoring can take place. Methods for increasing parents' motivation to monitor the adolescent include providing feedback from assessments of parenting skills and family strengths and weaknesses, balancing the power in the marital relationship so that both partners share the burden of monitoring and can work as a team, and presenting information concerning the importance of monitoring for the adolescent's adjustment. Teaching developmentally appropriate monitoring skills is a continual process throughout therapy. Finally, life stressors that make monitoring difficult for parents, such as limited financial resources, physical and mental health problems, and overwhelming work responsibilities, can be reduced by helping parents identify and mobilize resources within the family, the adolescent's school and the community (Long, 1996; McLoyd, 1990). These high strength, comprehensive interventions (Kazdin, 1994) are implemented today within multisystemic and multidimensional family-based models (Tolan et al., 1995).

Control, strictness and consistency of discipline Control, strictness and consistency of discipline are related to the extent to which parents set limits and enforce rules. Parents who set clear standards for their adolescent's behavior, enforce rules and regulations with sanctions that are not overly punitive or coercive, and provide consistent discipline that establishes stability for the adolescent (Holmbeck et al., 1995). These practices provide structure but must be instituted with enough flexibility to respond to the adolescent's changing needs. As with other parenting practices, parents may err by providing either too little or too much control and negative developmental outcomes have been documented in each situation. Too much control or the use of control techniques that are manipulative and intended to induce feelings of guilt or worthlessness may be related to poor developmental outcomes for adolescents. Ferrari and Olivette (1993), for example, found that daughters who perceived both their parents as highly authoritarian were more likely to have tendencies toward indecision than were daughters of less authoritarian parents. Grusec and Goodnow (1994) have studied the possible mechanisms by which parental discipline practices may influence adolescent's internalization of values and beliefs. These authors find that when adolescents perceive that their parents' actions are appropriate, they are motivated to accept their parents' position and understand that these beliefs have been self-generated rather than imposed, they are then more likely to accept their parents' messages.

Baumrind (1991a) examined adolescent outcomes in relation to three distinct types of parental control: restrictive control, assertive control and rational control. Restrictive parents, those who demand conventional values and behaviors, tend to have adolescents who are less likely to engage in problem behaviors such as drug abuse, but who also lack self-esteem, social assertiveness and close relations with parents. Rational control, an approach characterized by open negotiation and reasoning with the adolescent, is associated with positive social behaviors, respect and close relations with parents, and high self-esteem, but does not appear to deter drug use among adolescent boys. Adolescents of assertive parents, who both confront and monitor, are even less likely than adolescents of restrictive parents to engage in externalizing behaviors; furthermore, they show secure attachments to parents, high achievement orientation, social responsibility and agency, and an internal locus of control. These results suggest that parental control that involves both confrontation and close monitoring of the adolescent's behaviors is the optimal parenting approach. Therapists' careful assessment of parenting skills and deficits in these areas is critical in helping parents expand their repertoire of effective practices.

Barber, Olsen and Shagle (1994) examined the impact of psychological and behavioral control, two independent processes occurring within the family, on the developing child's psychological health. They found that excess psychological control, defined as 'patterns of family interaction that intrude upon or impede the child's individuation process' (p. 1121), by stunting autonomy development in the adolescent, was associated with internalizing symptoms. A lack of behavioral control, defined as 'family interaction that is disengaged and provides insufficient parental regulation of the child's behavior' (p. 1121), was related to externalizing problems among adolescents. As noted before, stunted autonomy development may be associated with difficulties in relationships with parents during late adolescence and may prolong the process of identity formation.

Clinical work with problem adolescents and their parents involves careful attention to parents' methods of exerting control and the ways in which the adolescent responds to parents' efforts at control. These parenting practices cannot be changed without understanding of the emotional and relational issues about control in the parent-adolescent relationship. Substantive exploration into patterns of family dynamics is often necessary

to illuminate the emotional forces creating control and discipline problems between the parent and adolescent. Once uncovered, therapists can help family members articulate their needs and negotiate a compromise with each other. In order for therapists to help families determine appropriate levels of control, choose methods of discipline and establish consistency, they must be aware of the developmental processes of adolescence and help parents respond to their child's evolving needs.

Support and communication The adolescent's socioemotional growth is facilitated by open communication within the family, when parents explain their assertions, permit give-and-take in family discussions, provide information and permit differentiation within a connected environment (Holmbeck et al., 1995). These parenting practices involve the parent's responsiveness to the adolescent's needs and feelings. Given adolescents' increasingly sophisticated cognitive skills, they need to experience the consideration of their views and opinions and practice their new communication skills as they near adulthood themselves. These discussions are facilitated in conversations between the therapist and adolescent as well as during interactions between the adolescent and parent within therapy sessions.

Support and communication are important to family decision-making processes. Joint decision-making and encouragement of achievement have been shown to be positively related to adolescents' grade point average, drug use and self-reliance (Brown, Mounts, Lamborn, & Steinberg, 1993). Democratic decision-making within the family facilitates a genuine feeling of involvement, and participation helps adolescents remain connected to their parents in ways which respect their increasing ability and maturity. Parents need to adjust their communication styles and accommodate the adolescent's needs for greater involvement in family decision-making processes and increased opportunities to make independent decisions.

Family therapy provides an ideal environment for the development of improved communication skills between the parent and adolescent. Family interventions specifically designed to improve family members' capabilities to listen, communicate thoughts and feelings, negotiate effectively, and solve problems have been shown to reduce family conflict and adolescent problems (Mann, & Borduin, 1991; Schmidt et al., 1996). Our approach asserts that communication skills, and more fundamentally, parental motivation, are best facilitated by preparing the adolescent and parent in individual sessions, and then bringing them together to address an issue, particularly when the topic is emotionally charged (Liddle, Dakof, & Diamond, 1991). One of our process studies supports this assertion (G.S. Diamond, & Liddle, 1996). The therapist may explore with the adolescent why it is difficult to talk with his parents and to share his feelings with them. Parents are encouraged to hear not only what the adolescent is saying but also to pay attention to the emotions she experiences as she shares her experiences (Liddle, 1995). Communication between family members improves when the affective components of each member's side of the story is utilized, elaborated and ultimately, accepted (Liddle, 1994).

Parenting factors and adolescent drug abuse

Advances in the adolescent substance abuse and problem behavior research specialty, particularly the identification of familial and peer factors involved in the initiation and maintenance of problems, have significantly informed the development of the multi-dimensional family therapy model (Liddle et al., 1991). The next section illustrates the connection of particular research findings to our clinical interventions.

Studies by many researchers have identified problems in the parent-adolescent

relationship as a crucial determinant of adolescent drug use (Block et al., 1988; Brook, Whiteman, Nomura, Gordon, & Cohen, 1988; Hawkins, Catalano, & Miller, 1992; Shedler, & Block, 1990), and there appears to be 'a near unanimous conclusion that a positive relationship between the child and his or her parents can serve as a deterrent to the use of drugs' (Glynn, & Haenlein, 1988, p. 44). Aspects of the parent-child relationship which have been found to be associated with adolescent drug use include lack of parental involvement and warmth (Brook et al., 1988; Stoker, & Swadi, 1990; Williams, & Smith, 1993; Shedler, & Block, 1990), poor communication of needs and feelings (Glynn, & Haenlein, 1988; Stoker, & Swadi, 1990), lack of parental support, encouragement and responsiveness (Rhodes, & Jason, 1990; Wills, Vaccaro, & McNamara, 1992), and parental rejection (Simons, & Robertson, 1989).

Children of authoritative parents are less likely to use drugs than children whose parents are unresponsive and emotionally unavailable (Baumrind, 1991b; Baumrind, & Moselle, 1985; Fletcher, Darling, Steinberg, & Dornbusch, 1995; Maccoby, & Martin, 1983). Comparing adolescent drug-users and abstainers, Coombs and Landsverk (1988) conclude that nonusers' parents are more likely to provide praise and encouragement, set down guidelines and rules about the adolescent's activities, and play an active role in the teenager's life than users' parents, who are seen by the adolescent as emotionally distant, less helpful and less likely to establish limits. The nonuser's parent enforces rules and maintains control through respectful but firm limit-setting and positive reinforcement of the adolescent's appropriate choices. Children who do not use drugs perceive that their parents provide more praise and encouragement, are more trusting and helpful, and set clear and consistent limits (Coombs, & Paulson, 1988; Dembo, Farrow, Des Jarlais, Burgos, & Schmeidler, 1981). In comparison, middle schoolers who do use drugs describe their parents as having unclear or inconsistent rules, responding only to negative behaviors and unavailable to discuss important problems (Coombs, & Paulson, 1988). An authoritative parenting style can effectively deter drug use even in parental absence (due to death or divorce) cases (Baumrind, 1991b; Coombs, & Paulson, 1988; Dembo et al., 1981), or in situations in which drug experimentation has already begun (Steinberg et al., 1994).

Conflict with parents has been identified as an important predictor of delinquency (McCord, 1979) as well as drug use (Hawkins et al., 1992). Baumrind and Moselle (1985) hypothesize that family conflict creates risk for adolescent drug use and abuse because it helps the adolescent to feel alienated from his parents. Furthermore, coercive family processes (Patterson, 1982) and high levels of family stress (Needle, Lavee, Su, Brown, & Doherty, 1988) characterize the families of drug-using and problem adolescents. Unlike the families of addicts, which are typically characterized by an enmeshed family structure (Stanton, & Todd, 1979), the families of drug-abusing adolescents are more likely to be disengaged (Liddle, & Dakof, 1995a; Volk et al., 1989). When attachment relations are strained or have been badly damaged, attachment bonds must be repaired or rebuilt before families can consider behavior change (Wynne, 1984).

Family environment effects on the adolescent are cumulative. When family relationships falter or when they remain poor over time, an adolescent's psychosocial growth deviates from normative parameters (Baumrind, 1985; Brook et al., 1988; Kellam, Brown, Rubin, & Ensminger, 1983; Shedler, & Block, 1990). Research indicates that, even in early childhood, the quality of the mother-child relationship predicts later development of adolescent substance abuse. Adolescents characterized as 'frequent users' had mothers who were critical and unresponsive when they were as young as 5 years old (Shedler, & Block, 1990). Baumrind's (1991b) results show that mothers of adolescents characterized as 'heavy users' were less demanding and confronting, offered

less structure, and were more often absent from the home than mothers of nonusing adolescents when their children were as young as 4 years old. So, interventions must be complex. They should target ineffective parenting practices, certainly, but the relationship context in which these ineffective practices occur must also be addressed. This relationship context is often characterized by longstanding relational disruptions between the parent and adolescent.

Parenting factors and peer influences on adolescent developmental outcomes

Authoritative parenting has been linked to positive peer relations and less involvement with deviant and drug using friends (Fuligni, & Eccles, 1993; Steinberg et al., 1994). The pattern that emerges implicates negative parenting behaviors in the establishment of aggressive or deviant child behaviors, which in turn lead to involvement with similarly rejected or antisocial friends during early adolescence (Dishion, Patterson, Stoolmiller, & Skinner, 1991). Parents are thought to shape their adolescents' attitudes and behaviors (both prosocial and antisocial), which subsequently determine the kinds of friends they seek out and are accepted by (Brown et al., 1993). Authoritative parents instill in their adolescents an orientation toward achievement and a positive self-concept, which promote involvement with peers who are invested in school and other prosocial activities.

Specific parenting behaviors, especially monitoring and limit-setting, are crucial to adolescent development due to the increasing importance of peer relationships during this developmental stage. Children spend the majority of their time in school and as they enter adolescence, spend more of their time with peers than with their parents (Brown, 1990; Larson, & Richards, 1994). Adolescents tend to become more concerned with being socially accepted and positively regarded by their peers than they were as children. They value their relationships with their friends more than at younger ages and turn to their peers for advice and support (Fuligni, & Eccles, 1993).

Adolescents naturally strive to become independent from their parents and establish their own identity by seeking a greater amount of control over their lives and personal decision-making. Often this growth toward independence is mistaken by parents as rebellion. The adolescent begins to question the parent's values and challenge their opinions. At the same time, peers may fill the void and be treated as though they are primary in the adolescent's life. These are essential aspects of the adolescent transition, processes that can be successfully negotiated within a supportive and structured parent-adolescent relationship. It is in the absence of warmth, encouragement, and sufficient limit setting and monitoring that adolescents have difficulty making the transition from primary reliance on parents to greater independence and increased focus on peers.

Studies show that adolescent substance use is best explained by the synergistic influences of parent and peer factors (Dishion, & Loeber, 1985; Steinberg et al., 1994). Poor problem solving and lack of monitoring within the family have both direct and indirect influences on the development of adolescent antisocial behavior and drug use (Patterson, 1982, 1986; Paterson, & Dishion, 1985). These family management problems actually train children to use coercive, antisocial behaviors in many situations and may in fact encourage the child to socialize with other deviant youngsters. Distant relations, poor monitoring and inadequate supervision precede and have effects on adolescent peer group affiliations (Brown et al., 1993; Dishion, Reid, & Patterson, 1988; Dishion et al., 1991). 'If parents model deviant behavior or fail to maintain close relationships with their teenager, the child is more likely to drift into deviant peer crowds and, as a consequence, be more involved in drug use or delinquency' (Brown et al., 1993, p. 469). This

perspective suggests adolescents are not so much pulled away from adults by antisocial peers as pushed toward this group by family environments with particular characteristics (e.g. overabundance of conflict, interpersonal disconnection) generally, and parents' ineffective childrearing practices (Patterson, & Dishion, 1985) in particular.

It should be reemphasized that parental monitoring not only discourages adolescents from beginning to use drugs, but it also has intervention effects as well. Steinberg et al. (1994) found parental monitoring to be associated with the amelioration of drug use among adolescents who have initiated use. These authors emphasize the importance of positive peer influences and parental monitoring, particularly during the critical phase of initiation into drug use. Especially for boys, once the adolescent has established himself in a peer group of heavy users, his substance use is likely to escalate regardless of the monitoring of parents. Parents' knowledge and supervision of the adolescent's activities deters the adolescent's drug use and involvement with drug-using peers. Contemporary research findings suggest that a full understanding of the relative role of parents and peers must include appreciation of the sequence of behavior that potentiates movement from one stage of behavior acquisition to another (i.e. disengagement from the parent/family potentiates affiliation with deviant peers).

Poor parent-adolescent relationships have ramifications in a wider social context as well because families serve as buffering mechanisms to protect against the influence of deviant peer and societal influences (e.g. Burke, & Weir, 1979; Steinberg, & Silverberg, 1986). Absent from a positive environment or foundation in which adolescents can successfully explore new relationships, interests, and identities, teenagers are more likely to turn to peers for guidance. Fuligni and Eccles (1993) found that early adolescents who reported few opportunities to participate in decision-making and perceived their parents as failing to accommodate to their autonomy needs were more likely to be oriented toward maintaining relationships with peers and seeking advice from friends rather than parents. Thus, parents who have difficulty adapting to their children's need for independence and fail to become more flexible, unfortunately contribute to the familial alienation that is a key step in the process of antisocial peer group affiliation.

Finally, the emotional component of the adolescent's family environment has also been investigated in relation to peer influences. Emotional support from one's family has a protective or buffering effect against substance abuse (Burke, & Weir, 1979; Greenberg et al., 1983). Contrary to much of popular lore about factors influencing a teenager's behavior, the perceived quality of the affective relationship with parents is a significantly stronger predictor of adolescent's self-esteem and general well-being than the perceived quality of the adolescent's peer relationships (Greenberg et al., 1983). Similarly, Wills and Vaughn (1989) found that under circumstances when there is a high level of substance abuse in the peer network, family- but not peer support had protective effects. Taken together, these findings support the salubrious effects of positive parent-adolescent relationships and parenting behaviors in directly reducing the adolescent's deviance involvement as well as regulating the influence of and the adolescent's access to antisocial peers.

Changing parenting behaviors

Problematic parenting practices and techniques have been targeted in several approaches, most notably parent training, which evolved from the behavior modification models of the 1950s. Parent training is a collaborative approach to treating problem children in which parents are taught to interact differently with their child via more consistent and positive discipline and communication practices (Webster-Stratton, & Herbert, 1993).

The parent training model, which was developed mainly for clinical work with parents of school-aged children (Forehand, & McMahon, 1981; Webster-Stratton, & Herbert, 1993), has been modified for interventions with adolescents (Dishion, & Andrews, 1995; Patterson, & Chamberlain, 1994). These methods are based on the general view that behavior problems are learned over extended periods in the context of social interaction, particularly within the family; and it is that these interactions, having well-defined features, which promote aggressive and discourage prosocial behavior (Patterson, 1982). These problem behaviors have a definable course (Loeber, 1988; Patterson, & Bank, 1989); they are repetitive, become automatic, and in their advanced forms, highly stable and difficult to change (Loeber, 1982). Identified as the most well-investigated technique in child psychotherapy research (Kazdin, 1994), parent training has been shown to be effective in treating childhood emotional and behavioral problems, particularly conduct disorder (Graziano, & Damient, 1992; Kazdin, 1994).

In practice, parent management training has been found to be a critical component in the prevention and amelioration of adolescent behavior problems (Dishion, & Andrews, 1995; Dishion et al., 1988; Schmidt et al., 1996). Alexander and Parsons (1973) have demonstrated the efficacy of functional family therapy, which integrates a family systems and parent training-like behavioral approach in treating delinquent adolescents and their families. Chamberlain (1990) found that foster parents of extremely antisocial adolescents could be trained to change their behavior and thus affect their adolescent's behavior. Dishion and Andrews (1995) present evidence for the efficacy of a parent-focused family management training prevention program in reducing behavior problems among high-risk young adolescents. This program targeted four key family management skills: monitoring, positive reinforcement, limit setting and problem solving. Families who received the parent-focused intervention demonstrated decreases in coercive interactions and reported less conflict in the family following treatment. Young adolescents in these families demonstrated decreased behavior problems in school as reported by teachers. In a statement that could be said to apply to the child and adolescent behavior problem specialty generally, Dishion and Andrews (1995) conclude that intervention with parents around issues of family management is a critical ingredient in interventions designed to prevent later behavior problems.

Although pessimism for changing negative parenting practices can be found in the clinical and research literatures, parenting behaviors, even with advanced clinical samples, can change. For example, in one of our studies with families of drug-abusing adolescents we found that the majority of parents (69%) demonstrated increases in positive parenting behaviors and decreases in negative parenting behaviors during the course of a developmentally oriented family intervention (Schmidt et al., 1996). Specifically, parents significantly improved on dimensions which are related to both positive and negative developmental outcomes – including discipline, communication, monitoring, limit setting, positive affect and commitment. And for the majority of families, improvements in parenting were associated with decreased acting out and substance use in adolescents. That is, most of the time, in this referred, clinical sample, when parenting practices improved, adolescent behavior problems and drug use decreased (Schmidt et al., 1996).

Intervening in precise ways which provide the opportunity to learn new parenting and relationship alternatives is basic to reestablishing a developmental course that excludes the adolescent's drug use and other problems (Steinberg et al., 1994). In fact, certain parenting practices, such as cross-generational coalitions, negative affect, resistance and parent-adolescent conflicts are empirically established examples of dysfunction-related processes that are easily targeted in treatment (Alexander, Holtzworth-Munroe, &

Jameson, 1994; G.S. Diamond, & Liddle, in press; Mann, Borduin, Henggeler, & Blaske, 1990; Patterson, & Chamberlain, 1994). However, predicting intervention impact is difficult since the manner in which risk and protective mechanisms exert their effects varies according to the developmental periods in which they occur and the social context in which they interact (Loeber, 1990). These complexities are still being articulated and rules for intervening according to these principles are presently the subject of focused discussion in this specialty (Center for Substance Abuse Treatment, 1998).

Supporting the premise that parents are a critical focus of intervention with young adolescents, Rohrbach et al. (1994) found that parental participation in a multicomponent prevention program contributed to a decrease in adolescents' use of alcohol and cigarettes. Similarly, in a prevention program for at-risk children of alcoholic fathers, Maguin, Zucker and Fitzgerald (1994) found that the participation of both parents in an intervention involving both parent training and marital issues counseling had a significantly better effect on the development of adolescent prosocial behaviors than the participation of the mother alone. In light of the importance of parental monitoring and limit-setting to adolescent development, these results call for a strong focus on the parent-adolescent relationship as a prime means of influencing a positive trajectory for adolescent development.

Clinical application of parenting research: parent reconnection interventions (PRI)

Our manualized family intervention model is comprised of a series of sequentially applied modules, devised in response to individualized assessments. These assessments are multidimensional and they include the parent and individual adolescent as subsystems, the interactional patterns of the parent and adolescent, and the family members' relational patterns with extrafamilial sources of influence on the adolescent and parent (Liddle, 1995). We use empirically established theory from basic research – adolescent development and developmental psychopathology literatures mainly – to define assessment and intervention domains. PRI facilitate the derailed developmental tasks of the parent and adolescent which become overshadowed by problem behavior (Kandel, Kessler, & Margulies, 1978). In essence, this task involves the renegotiation, or in some cases, healing, and then, recalibration of the parent-adolescent relationship. Ideally, this is accomplished in a way that enables increased adolescent autonomy while encouraging this increase in autonomy in a context of continued but changed connectedness or relatedness (Allen et al., 1994; Grotevant, & Cooper, 1985). Additionally, this relationship repair often takes into account the historical events of the relationship, which frequently includes misdeeds of the parent, including drug abuse, alcoholism, or physical abuse or neglect. Parental behavior within this intervention is defined as the capacity to become and remain emotionally invested, interested and supportive of their adolescent's independence-seeking attempts. The PRI is designed to bridge the emotional distance between the parent(s) and their adolescent. In our epigenetic, developmental model, it is the estranged emotional connection that requires attention first, not attempts at behavioral influence (Wynne, 1984). The challenge is multifaceted and has non-normative and normative aspects – emotions can run high, there is much negative history and hurt to overcome, motivation of parent and adolescent may be quite low, other family members or other circumstances may be demanding the attention of the parent and the teenager. Most fundamentally, however, this task is challenging given the changed developmental realities within which a new attachment must be forged. The nature of this normative challenge is articulated by Gilligan (1982), who discusses how

adolescence signals not only a change in the balance of power but also changes in the experience and meaning of connection.

So we now know that clinical families are doubly disadvantaged. They must negotiate the normative crisis – a new way of relating that takes into account changed developmental circumstances. This process is difficult for all parents and teenagers. At the same time, however, clinical families must make these efforts in the context of their own relationship history – a history which is, as we well know, filled with pain, disappointment and estrangement. In Patterson and Chamberlain's (1994) terms, these are families who appear after they are well on their way to writing their own 'history of 10,000 defeats.'

Research indicates that unlike families of addicts, which have been characterized as having a more enmeshed family structure (Stanton, & Todd, 1979), families of drug-abusing adolescents are more likely to be disengaged (Liddle, & Dakof, 1995b; Volk et al., 1989). PRI assume that a renewed connection and decrease in emotional distance are the central mediators through which new parental skill acquisition occurs. Just as we are beginning to understand the sequential aspects of therapeutic relationship formation with the teenager (G.M. Diamond, & Liddle, in press), we now articulate parental change in stages as well. While the ultimate aim of PRI is to have the parent reconnect on an affective level with the adolescent, and hence recommit to try to help him/her (i.e. reclaim their parenting role and functions), proximal goals generally have to do with the therapist and parent discussing the barriers to relationship repair and reconnection. Most basically, these individual sessions between the parent and therapist initially involve attending and accepting the parent's many feelings – helplessness, anger, despair and hurt – about what has happened with their son or daughter. In communicating about this zone of work to the therapists, we use a 'hitting bottom' metaphor. We urge the therapist to travel with the mother or father to the 'parental hell' in which they now feel that they reside. Paradoxically perhaps, from this position of acceptance and tolerance of strong negative feelings, a dialectical process of change occurs – and the parent then can make beginning overtures of wanting to change (or fundamentally, of discovering, again, some renewed hope for their son or daughter). These processes, often referred to as the dialectics of change, have again become popular in psychotherapy theories applied to a variety of populations and presenting problems (Hayes, Strosahl, & Wilson, in press; Liddle, 1984; Linehan, 1993; Jacobson, & Christensen, 1997).

Underlying assumptions of PRI include an epigenetic theory of development and its application to the clinical area (e.g. Allen, Aber, & Leadbeater, 1990; Liddle, & Saba, 1983; Wynne, 1984). When attachment relations are strained or have been badly damaged, these attachment bonds must be addressed first before behavior change (e.g. problem solving) can be considered by those experiencing the strained or damaged attachment relations. Research has demonstrated areas in which parents transform their relations in the area of attachment and furthermore, we have established that such affective reconnection processes can be achieved (Schmidt et al., 1996), that these processes relate to the adolescent development and adolescent developmental psychopathology literature (Liddle, & Schmidt, 1994), and that particular therapist techniques are related to these attachment targeted relationship shifts (G.S. Diamond, & Liddle, 1996). Our therapy development work has identified and manualized the therapist techniques that target affective reconnection within the parenting behaviors realm (Liddle, 1994, 1995). The following methods are core aspects of PRI.

Enhancing feelings of parental commitment and love

These interventions include therapist behaviors that actualize a parent's experience and feelings of love, caring and commitment toward the adolescent. To achieve acquisition of

these emotions and experiences, therapists might help the parent recall past feelings of love, joy, aspiration and pride between the parent and adolescent. This includes focused recollections of rewarding parenting experiences from earlier developmental periods, and small pleasures that occurred in the recent past.

Validating parents' past efforts

In clinical samples, although parenting deficits outweigh strengths, if we look, parenting strengths and areas of competence can also be found (Schmidt et al., 1996). Minuchin (1974) warned of clinicians becoming psychopathological sleuths – we took this admonition very seriously. It is vitally important to search and to confirm examples of successful parenting behaviors and to validate abilities where they exist. A deep knowledge of the range of parental socialization practices is indispensable in helping a therapist know where to search for strengths.

Our approach to change relies on successive approximations. We look for small, underdeveloped and hidden areas of competence and strength, and seize upon them with enthusiasm and a high degree of focus. From here we amplify and search for other areas of strength, using the initial island of strength or competence that, at first, may appear quite modest, or from certain perspectives, might not be visible at all.

Acknowledging parents' stress and burden

The therapist acknowledges the difficult past and present circumstances that impede parenting and family management practices and acknowledges that the parent has individual problems, disappointments, desires, hopes and dreams as an adult. The parent is provided validation that she/he has a life as an adult woman (or man) that is separate from the parent role. Just as our process research has established that it is important to empower the adolescent as an individual apart from his role as a family member (a son or daughter), the same intentions hold for work with the parent. And, this focus is much more than an engagement strategy. Using knowledge about how an adult's functioning apart from the parent role affects their parenting behaviors (Dix, 1991), we now recognize the importance of a parent's functioning as an individual in her or his own right. A parent's current relationship problems or other extrafamilial difficulties, recollections about the parenting they received, economic hardship, social isolation and stress, nonsupportive extended family, or problems with other children are some of the more common areas that are not outside of the purview of our approach which has as its central objective, the changing of the primary family relationship. The road to this change, however, often takes curious and devious routes. Although we have a map of the overall territory in which we want the conversations of therapy to operate, we realize that there are many different routes that can be travelled to achieve our preferred destinations. Our process research is presently charting the variations of these maps and the many routes that can lead to similar positive proximal in session outcomes (e.g. G.S. Diamond & Liddle, 1996).

Generating hope: parental influence

Most clinical families are hopeless about change. The majority of families who enter our treatment research studies have not received satisfactory therapy in previous outpatient treatment attempts. Research has helped us to understand how issues such as perceived barriers to treatment help to keep families thinking pessimistically about getting help through therapy. One of the most prevalent feeling states that parents present is hopelessness. Taking many forms, sometimes the feeling pertains to the parent's inability to see that anything could change their son or daughter, so dire is their child's situation or

so extreme their behavior. Another manifestation of hopelessness is the parent's strongly held set of beliefs, often presented as a pair – that not only can no one else influence their child's behavior but they, the parents, are not able to exert such influence either. In Wills' (1990, p. 91) terms, 'Many parents believe they are powerless in the face of peer pressures toward adolescent deviance.' Wills and other researchers have demonstrated how parents, through the support they provide to their teenagers (in part by remaining available and genuinely interested in their child's day to day life – beyond a 'tell me your problems' focus), can have considerable favorable influence.

The outset of treatment includes planned and focused discussions about the degree to which a parent believes he/she can influence their adolescent's life for the better, including therapist statements combating the parent's belief that the adolescent is not in need of or is beyond parental influence. The therapist's stance here is unequivocal in stating the need for the parent to stand by their teenager. The more severe the symptoms of the adolescent, the more the therapist paints a picture of need – a portrait in which the most important person to reconnect and stick with the teenager is the parent. The therapist acknowledges the lack of belief a parent may have about the possibility of their softening and reasserting a commitment to reconnect and help their son or daughter. At the same time, the therapist continually acknowledges the gravity and urgency of the clinical situation, the real possibilities of extremely negative or fatal outcomes for the youth, and the urgency of taking action. The therapist joins with the parent to reach out at least one more time, since the stakes are high and the parent is the best person for the job. With the focus, encouragement, guidance and support of the therapist (who also commits to helping the teenager to change in needed ways vis à vis the parent), the parent is literally walked through the crucible of parental hell.

Generating hope – therapist as an ally

These interventions describe therapist statements indicating that she/he is willing to work with and for the parent. The therapist indicates a willingness to stand by the parent and presents herself as an ally who will support the parent in his/her attempts to influence the adolescent. This is a critical additional ingredient to addressing the fundamental dilemma of hopelessness about change. The therapist, as we do with the teenager (G.S. Diamond, & Liddle, in press), presents himself as a personal collaborator, someone who will walk together with the parent to and through the depths of parental despair – the parental hell – that clinical families find themselves in.

Summary

There are more demands on clinicians than ever before. Although knowledge about adolescent development and problem behaviors has increased exponentially, efforts to systematically and actively incorporate this research into intervention models has been lacking. Given the difficulty of the therapist's task these days, and all that is at stake in any treatment episode, it is the premise of this article that attempts to organize and incorporate the vast research knowledge base into working models of empirically established interventions are efforts well spent.

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