Engaging reluctant adolescents in family therapy: an exploratory change process study

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Engaging Reluctant Adolescents in Family Therapy:

An Exploratory Change Process Study

by

Jane Higham

A Dissertation in Counseling Psychology

Submitted to the Graduate Faculty
Of the University at Albany, State University of New York
In Partial Fulfillment of
the Requirements for the Degree of
Doctor of Philosophy

2010

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Dedicated to

Mom and Dad, whose support, encouragement, and faith have provided me with a sense of purpose and determination to reach for my dreams, and without whom I would not be the person I am today.

Andrew and Timothy, you are the light of my life. You have enthusiastically endured late night runs to the computer lab, many potluck gatherings, and my angst when preparing a paper or studying for exams, just so that I could fulfill my dreams. Please remember that my efforts have always been to enrich our lives and inspire you to live out your own dreams.
Acknowledgements

I would like to thank Micki Friedlander for her unwavering support, guidance, and encouragement throughout my entire graduate career. You have been a listening ear when needed, a teacher, a muse, and a mentor not only in my academic pursuits but in my multiple roles as mother, and breadwinner for my family. The past few years have met numerous personal challenges and you have been a guiding force through it all. You taught me to have confidence in my self and to keep my eye on the goal.

To Valentin Escudero and Gary Diamond, I am extremely grateful for your willingness to take part in an intercontinental dissertation committee. This has been a unique and incredibly rewarding experience, which could only be made better if we could use webcams during Skype conferencing. Valen, I look forward to the opportunity to see you again, and, Gary, I hope to have the opportunity to meet you in person someday. Thank you for helping to make this experience so rewarding.

To Wendy and Kristyn, thank you for your time and willingness to participate in this study. I know that the lives of interns can be quite hectic, and it means a great deal to me that you could dedicate some of your precious time to help me complete the project.

To all previous Family Hope research assistants who have helped to collect and input the data used in this project. Without your effort, I would not have been able to perform this study.
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Abstract

Engagement in family therapy is considered to be a challenging task with adolescent members who resist the therapy process, and this task begins from the first moment of interaction (Liddle, 1995; Rubenstein, 2005). The term *engagement in family therapy* refers to a client’s observable or self-reported experience of therapy as meaningful, a sense of involvement, and active negotiation of the goals and tasks of therapy with the therapist and with other family members (Friedlander, Escudero, & Heatherington, 2006). There is, however, little empirical research on how to do so, and exactly how therapists can create a shift from disengagement to engagement has yet to be studied.

The present discovery-oriented exploratory study was the initial stage in a task analysis of critical shifts in adolescent engagement that occur early in conjoint family therapy. The goal was to elucidate mechanisms of change by intensively analyzing four conjoint family therapy sessions in which a shift in adolescent engagement either did or did not occur. Results of the qualitative comparisons suggested that five therapist elements (structuring therapeutic interactions, fostering autonomy, building awareness of systemic issues, rolling with resistance, and understanding the adolescent’s subjective experience) and one parent element (support) seem to be critical to a successful shift in adolescent engagement. Notably, verbal support from the parent (fostering a safe therapeutic environment and explicitly encouraging the adolescent to participate) was evident only in the two successful shift events.
The qualitative results were triangulated with quantitative data, specifically the adolescent’s self-reported target complaints pre-treatment, session evaluations immediately following the session of interest, and total satisfaction scores at the end of therapy. Satisfaction scores reported by the adolescents in the two positive engagement events were notably higher than those reported by the adolescents in the unsuccessful events. Session evaluation scores for Smoothness were also somewhat higher for the two more engaged adolescents. Implications for practice are provided, along with a discussion of the study’s strengths and weakness. Recommendations for future research are offered, related to (a) therapist and parent behaviors that facilitate adolescent engagement in conjoint therapy and (b) choosing intervention strategies based on the apparent reason for the adolescent’s reluctance to engage.
Chapter I

Statement of the Problem and Review of Literature

Research on the effectiveness of psychotherapy (Smith, Glass, & Miller, 1980; Wampold, 2001) has shown few differences across various therapy approaches in terms of demonstrable benefits and outcomes. One explanation for this finding is that common factors operate across the various treatment modalities, one of which is a therapeutic relationship, the mechanism through which the important work of therapy takes place (Wampold, 2001). The therapeutic alliance has been demonstrated to be one of the critical factors in producing positive psychotherapeutic outcomes (Horvath, 1994). The role of the alliance in family therapy, in particular, has received increased attention over the past two decades (e.g. Friedlander, Escudero, & Heatherington, 2006a; Pinsof, 1994; Rait, 1998; Sprenkle & Blow, 2004).

One challenging component of the alliance in family therapy is the simultaneous engagement of multiple clients so that positive outcomes can be achieved. The term engagement in family therapy refers to a client’s observable or self-reported experience of therapy as meaningful, a sense of involvement, and active negotiation of the goals and tasks of therapy with the therapist (Friedlander et al., 2006a). When a family member indicates that therapy is not useful, implies that the process is blocked, or shows indifference to what is being discussed, these negative alliance-related behaviors can have a detrimental effect on the therapy. Indeed, it is well known that client resistance to the therapeutic process must be resolved in order to achieve positive outcomes.

The present study focused on the engagement of adolescents, who are most often brought to treatment by their parents and tend to resist the therapeutic process if they feel
blamed for the family’s difficulties. Indeed, authors have noted that engagement with adolescents early in the treatment process is one of the most critical tasks of family therapy (e.g., Liddle, 1995; Rubenstein, 2005). Supporting this claim, Rubenstein (2005) suggested that effective psychotherapy with adolescents begins from the first moment of interaction, when the alliance is being constructed. However, the exact mechanism of change, i.e., how therapists can create a shift from resistance or disengagement to engagement, has yet to be studied.

There is some relevant research on shifting family members from disengagement with each other to sustained family engagement in problem solving (Friedlander, Heatherington, Johnson, & Skowron, 1994; Heatherington, & Friedlander, 1990). One study in particular (Diamond, Liddle, Hogue, & Dakof, 1999) found that overcoming an impasse with adolescents in family therapy involved establishing a safe atmosphere, attending to the adolescent’s experience, helping the teen to formulate personally meaningful goals, and presenting oneself as the adolescent’s ally.

Horvath and colleagues (e.g. Horvath, 2006; Horvath & Bedi, 2002; Horvath & Luborsky, 1993) called for research aimed at understanding how therapist actions facilitate alliance development and how changes in the alliance occur throughout therapy in order to influence outcomes. In line with this recommendation, the present exploratory study involved the initial stage in a task analysis of critical shifts in adolescent engagement in conjoint family therapy. The purpose of this mixed methods (qualitative/quantitative) discovery-oriented study was to elucidate mechanisms of change by analyzing a small sample of sessions during which resistant adolescents either
did or did not shift from disengagement to positive engagement in the therapeutic process.

**Therapeutic Alliance**

For the past three decades, the role of therapeutic alliance in effecting positive outcomes in psychotherapy process has proliferated in the literature (e.g. Bordin, 1979; Castoneguay, Constantino, & Holtforth, 2006; Horvath, 1994, 2006; Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Luborsky, 1994). Bordin (1979) described three key dimensions of the therapeutic alliance in individual psychotherapy: client-therapist agreement on (a) goals, (b) tasks, and (c) an emotional bond. Specifically, goals refer to the extent to which therapist and client negotiate and concur on the goals or potential outcomes of the therapy. Tasks are the major activities that therapist and client engage in during therapy and are influenced by the degree to which the client is willing to follow the therapist’s lead. The therapist strives to understand the client’s goals, suggests individual or family goals, and works to balance these goals throughout the therapy process. The bond refers to the affective relationship between client and therapist, which involves mutual trust, respect, and caring.

Luborsky (1994) described two distinct qualities of the therapist-client relationship that predicted positive outcomes at different points in individual therapy. In the early phase of therapy, the client experiences the therapist as helpful and supportive, conveying a belief in the value of the treatment process. In the latter part of therapy, the therapeutic relationship reflects a joint effort, i.e., client and therapist working together on a shared goal and the client’s increased capacity to cooperate with the therapist.
In a meta-analysis of 24 studies on the therapeutic alliance and therapy outcomes, Horvath and Symonds (1991) reported a moderate effect size (.26) for the relationship between the working alliance and therapy processes and outcomes. Patterns emerging from outcome evaluations across therapist, client, and observer reporters suggest that the working alliance is mutual and collaborative, and likely to vary with aspects that are “equally accessible to observers and participants.” (p. 147). Specifically, observable behavior reflecting the client’s forming a positive relationship with the therapist, engaging in the therapeutic tasks, and collaborating in setting goals was evidence for success within the therapeutic context.

Castonguay, Constantino, and Holtsforth (2006) discussed the clinical implications of past alliance research and suggested directions for future efforts. Based on their review of alliance research, the authors surmised that although the alliance is linked with treatment outcomes, the causal direction of the relationship has yet to be clearly established. These authors also pointed out that although evidence supports the claim that good alliances likely result in successful treatment, how the therapeutic alliance develops is less clear. Thus, researchers need to examine how expert therapists establish a good alliance, how the alliance is transformed over the course of therapy, how ruptures in the alliance are repaired, and how a balance is achieved between therapeutic technique and support.

Similarly, reflecting on the status of alliance research, Horvath (2006) speculated that past efforts to study the alliance have failed to generate a “consensual definition” of the construct and resulted in limited understanding of the specific components and the active processes that characterize the alliance (p. 261). To address this failure, Horvath
suggested that research on the relationship take place on a “micro- rather than macro-
level,” through examination of “small-scale interpersonal events anchored within therapy
tasks” (p. 261). This recommendation echoed Horvath and Luborsky’s (1993) earlier call
for research aimed at understanding variations across different measures of the alliance
and alliance components; examining therapist actions that facilitate alliance development,
and repairs at different stages of therapy; exploring differences in therapists’ versus
clients’ assessment of the alliance; understanding therapists’ and clients’ relational
contributions to alliance development; and examining changes in the alliance throughout
therapy and how these changes influence outcomes.

Therapeutic Alliance in Family Therapy

In recent years, the development of therapeutic alliances in family therapy has
received increased attention in the literature (Friedlander, Lambert, & Muñiz de la Peña,
2008b; Friedlander et al., 2006a; Pinsof, 1994; Rait, 1998; Sprenkle & Blow, 2004). The
obvious challenge for family therapists is to develop an alliance by simultaneously
engaging multiple clients who are often in conflict with each other.

Pinsof (1994) pioneered an integrative and systemic model of the therapeutic
alliance, advancing the concept that alliances are not only formed between each
individual and the therapist, but also within the therapy system, and between and within
the therapist and client systems. The interpersonal system dimension of this model
accounts for (a) the individual subsystem (between each individual and the therapist), (b)
the interpersonal subsystem (between parental or sibling subsystem and the therapist), (c)
the whole system alliance (between family as a whole and the therapist), and (d) the
within system alliances (family members’ alliances with one another). The content
dimension of Pinsof’s model is derived from Bordin’s (1979) three key dimensions, i.e.,
tasks, goals, and bonds. The key assertion of the integrative systemic model is that the
therapeutic alliance consists of relationships between and within the therapist and client
systems that pertain to the family members’ capacity to mutually invest in and
collaborate on the tasks and goals of the therapy.

In response to a perceived lack of attention to common factors in couple and
family therapy (CFT), Sprenkle and Blow (2004) argued that not only do similar factors
play a role in family therapy, but also there are common factors that are unique to CFT,
including “relational conceptualization,” “the expanded direct treatment system,” and
“the expanded therapeutic alliance” (p. 124). That is, across various CFT orientations,
therapists must address complex interactions between and within different systems and
subsystems, while forming and balancing the relationships with each individual,
subsystem, and the family as a whole.

Although most studies on the therapeutic alliance support its role in fostering
positive outcomes in therapy, precisely how does the therapeutic alliance in family
therapy operate? Addressing this question was the basis for creating and testing an
observational rating system of couple and family alliances, the System for Observing
Family Therapy Alliances (SOFTA-o; Friedlander et al, 2006a). In one study using this
rating system, Friedlander et al. (2008b) examined two aspects of the alliance in family
therapy: observation of the parents’ level of safety in the therapeutic context and the
family’s shared sense of purpose (i.e., within-family collaboration). Results showed that
family members’ observable individual and interactional alliance-related behaviors in
session 1 contributed to parents’ ratings of therapeutic “improvement-so-far” after
session 3. These findings suggested that observable indicators of the alliance are, in fact, meaningful predictors of how well family therapy is proceeding.

**Therapists’ Contributions to the Alliance**

The therapist’s influence on the therapeutic alliance has been studied systematically by many authors in individual as well as family therapy (e.g. Foreman & Marmar, 1985; Friedlander, Lambert, Escudero, & Cragun, 2008a; Hill, 2005; Marmar, Weiss, & Gaston, 1989; Thomas, Werner-Wilson, & Murphy, 2005; Werner-Wilson, Michaels, Thomas, & Thiesen, 2003). The goal has been, generally, to identify “therapist facilitating behaviors” (Luborsky, 1994, p. 43) that result in improved alliances.

Hill (2005) explained how therapist techniques and client involvement interact to develop and deepen the therapeutic relationship across four stages of individual therapy. In the first stage (*initial impression formation*), the therapist administers supportive and informational techniques, with the goal of eliciting initial client involvement. In stages two and three (*beginning the therapy and the core work of therapy*, respectively), the therapist administers exploratory and theory-specific techniques, which lead to greater client involvement and engagement in the tasks of therapy, while simultaneously deepening the therapeutic relationship. Finally, in stage four (*termination*), the therapist uses specific techniques to foster the client’s processing of the relationship and future planning. According to Hill, at this point, the relationship becomes more “real” (p. 438).

Indeed, several studies demonstrate that therapists exert influence over the development of the therapeutic alliance. Friedlander et al. (2008a), for example, conducted an intensive comparative case analysis of one good outcome and one poor outcome family therapy case. Using the SOFTA-o, these authors found that in the good
outcome case, clients tended to respond positively to the therapist’s alliance-building interventions. Specifically, sequential analyses revealed that in the good outcome case, but not the poor outcome case, the therapist’s efforts to engage the clients were effective, as were the therapist’s efforts to connect emotionally with individual family members. Another family therapy study found that female therapists were better than male therapists at cultivating a therapeutic bond (Werner-Wilson, Michaels, Thomas, & Theisen, 2005), and in yet another investigation, family therapists who were able to reframe negative statements as challenges contributed positively to the therapeutic alliance (Thomas, Werner-Wilson, & Murphy, 2003). Finally, studies of individual therapy suggested that dealing with a client’s defenses, guilt, and feelings in relation to the therapist tended to improve the alliance (Foreman & Marmar, 1985), whereas confronting the client’s avoidance of important material, fostering a realistic view of the therapist, and targeting client transference were associated with higher levels of client hostility and reduced a client’s willingness to engage in the process of therapy (Marmar et al., 1989).

**Client Engagement in Family Therapy**

Bordin’s (1979) formulation of the therapeutic alliance emphasizes the importance of the client’s willingness to engage in the tasks of therapy, when there is perceived agreement with the therapist about the nature of what is to take place in therapy. In an extensive review of the process-outcome literature, Wampold (2001) agreed that active client involvement in the treatment process is a key factor in successful individual therapy. Differentiating between the general concept of alliance and the specific concept of engagement, Horvath (1994) asserted that the alliance can be
construed as a prerequisite to the client’s engagement in therapeutic tasks, in that the relationship fosters an atmosphere of trust and safety in which the client is willing to risk joining in the process of therapy, which in turn is directly responsible for change.

However, a notable challenge faced by family therapists is the simultaneous engagement of multiple clients so that positive outcomes can be achieved (Friedlander et al., 1994). According to Friedlander et al., (2006a), engagement in family therapy refers to a client’s observable or self-reported experience of therapy as meaningful, a sense of involvement, and active negotiation of the goals and tasks of therapy with the therapist and with other family members. Considered a fundamental dimension, easily observed in the SOFTA-o, engagement in the therapeutic process is represented by three behavioral aspects, which include:

“(a) client participation in defining therapeutic goals, that is, active collaboration and willingness to bring up problems for discussion, propose solutions, and articulate the anticipated outcomes of treatment;

(b) client participation in specific therapeutic tasks (e.g., enactments, expressing feelings, working out compromises, carrying out homework assignments, filling out questionnaires) and in setting the pace for therapy (e.g., the frequency of sessions and duration of treatment); and

(c) motivation for change, that is, the client’s expressed recognition of small improvements, of positive results from homework assignments, and of the efforts made by other family members” (Friedlander et al., 2006a, p. 75).

In this observational rating system, the therapists are observed to facilitate client engagement when they explain how therapy works, actively solicit client input in
defining therapy goals, explore clients’ willingness to try and practice new skills and behaviors, ask clients about their reactions to therapeutic events, engage everyone’s participation in the session, and acknowledge each small positive change as it occurs (Friedlander et al., 2006a). Although to date little research has been conducted with the therapist version of the SOFTA-o, there is some evidence to suggest that these kinds of observable therapist behaviors can prompt clients to become more involved in the therapy process (Friedlander, Lambert et al., 2008).

**Engaging Reluctant Adolescents**

Engagement in family therapy is arguably more difficult to accomplish with adolescents, especially if they perceive the therapy process as a threat. Often, children and adolescents are referred by a parent and enter therapy in a pre-contemplative stage of change (DiGuisepppe, Linscott, & Jilton, 1996). Thus, many adolescents approach therapy reluctantly (Taylor, Adelman, & Kaser-Boyd, 1985), and attrition rates tend to be high among adolescents who are not self-referred (Kazdin, 1990).

Several authors have posited that engaging adolescents early in the treatment process is one of the most critical therapeutic tasks of family therapy (Liddle, 1995; Rubenstein, 2005). Furthermore, engagement is a process that continues throughout therapy and often determines the intensity of therapeutic interventions (Liddle, 1995).

Rubenstein (2005) suggested that effective psychotherapy with adolescents begins from the first moment of interaction, when the alliance is being constructed. As the alliance develops, the therapist can facilitate engagement by encouraging an adolescent to identify and clarify therapy goals, share thoughts and feelings with parents, engage in enactments, and disclose vulnerabilities, reduce hostile parent-adolescent interactions,
and promote greater adolescent participation in the treatment process (Diamond & Liddle, 1996; Liddle & Diamond, 1991).

The psychotherapist’s nonjudgmental acceptance, respect, and validation for the adolescent’s perspective and experiences are said to be important for facilitating adolescent engagement in individual therapy (Rubenstein, 2005). Little has been written, however, about how therapists can behave to facilitate adolescent engagement in family therapy. The literature suggests that therapist flexibility and the capacity to meet the needs and goals of multiple family members are necessary features of effective therapeutic engagement (Diamond, Diamond, & Liddle, 2000; Garcia & Weisz, 2002; Liddle, 1995). Empathy, an empirically-supported relationship factor (Norcross, 2001), seems to be necessary for developing the therapeutic alliance (Greenberg, Elliott, Watson, & Bohart, 2001) with adolescent clients, but it is not sufficient. Arguably, many adolescents, like adults, need to believe that their therapist will understand them and be a source of support (Diamond et al., 1999).

Liddle (1995) emphasized the need for an ecological approach when treating adolescents. That is, engagement should not be discussed in general terms with the family. Rather, it is necessary for therapists to specify which family member or subsystem they are trying to engage (i.e. sibling, parental, parent-child, and extra-familial). Engaging the adolescent subsystem involves careful consideration and agreement on a theme, including goals and tasks generated by the adolescent, in order to make therapy acceptable and personally meaningful for each family member (Liddle, Dakof, & Diamond, 1991).
Stanton and Shadish (1997) asserted that the success of family interventions is in part the result of the therapist’s ability to engage and retain adolescents, parents, and other family members in treatment. It should not be assumed that therapeutic alliances with youth mirror those with adults (Creed & Kendall, 2005). For example, Safran, Muran, and Samstag (1994) found that techniques to repair ruptures in the alliance with adult clients, such as addressing negative feelings toward the therapist, were associated with improved alliances. Notably, when these techniques were used with adolescents, they were associated with relatively weaker alliances (DiGuisepppe et al., 1996). In fact, pushing the teen to talk predicted early as well as later negative ratings of the alliance by the adolescent.

Some studies explored the effectiveness of specific engagement interventions (Santisteban et al., 1996; Szapocznik et al., 1988). In these studies, engagement was conceptualized as a process rather than a behavior, and challenges to adolescent engagement were considered to be ongoing. Reluctance to engage in therapy can be understood as a benevolent process that is maintained by the personal and relationship challenges that arise in family therapy process (Szapocznik, Kurtines, Santisteban, & Rio, 1990). The process of initiating and maintaining engagement can be facilitated by developing joint goals for attending therapy, fostering a supportive working relationship, and handling disagreement about what therapy is or what it will address (Liddle, 1995). In other words, engagement was considered to be a specific treatment element that can be objectively defined and taught to therapists (Santisteban & Szapocznik, 1994).

Several researchers have explored the relationship between specific treatment modalities in family therapy in terms of fostering engagement with adolescents in family
therapy (Diamond, Diamond, & Liddle, 2000; Robbins et al., 2006; Robbins et al., 2008; Szapocznik, Perez-Vidal, Hervis, Brickman, & Kurtines, 1990; Szapocznik et al., 1990). For example, Diamond et al. established a connection between specific Multi-dimensional Family Therapy (MDFT) behaviors and increased engagement of therapy-reluctant teens. Robbins et al. (2008) reported a strong association between alliance and treatment retention in family therapy with drug-using Hispanic adolescents in Brief Strategic Family Therapy, an approach that uses specialized procedures for engaging and retaining adolescent and family members in treatment. Robbins et al. (2006) explored the link between adolescent and parent alliances and retention in MDFT. Results showed that alliances between therapists and both parent(s) and youth(s) declined over the first two therapy sessions in families that dropped out, but not among families that remained in treatment. Because it was unclear why some families responded disparately to MDFT, the researchers called for future research to examine the change process in family-based treatment in order to disentangle factors associated with variability in the alliance, therapist interventions, and retention.

Szapocznik et al. (1990) examined the challenge of resistant families and developed a procedure to engage drug abusers and their families in treatment. Strategic structural systems engagement is based on the premise that resistance to change within the family results from two system properties: the family as a homeostatic, self-regulating system and misdirected focus on presenting symptoms rather than the resistance to treatment itself. That is, resistance is defined as a symptom to be overcome, maintained by the family’s patterns of interactions.
To study engagement using the structural systems approach, Szapocznik et al. (1988) randomly assigned 108 Hispanic families to either a structural systems engagement condition or engagement-as-usual control condition. In the control condition, clients were approached in a manner typical for outpatient centers. In the experimental condition, techniques were used that the authors developed specifically for families that resist therapy. Over 57% of families in engagement-as-usual condition failed to engage in treatment. In contrast, only 7.15% of families in the structural systems engagement condition failed to engage. Retention rates also showed that 41% of engaged clients dropped out of the control condition, versus 17% of the cases in the experimental condition. One interesting finding was that the experimental engagement condition did not uniquely result in improvements in the adolescent’s problematic functioning. That is, both groups demonstrated significant improvements, but only the structural systems engagement condition seemed to influence retention and engagement.

In a qualitative study, Jackson-Gilfort, Liddle, Tejeda, and Dakof (2001) tested an adaptation of MDFT to different cultural groups to determine whether culturally-specific content themes could be identified and used in a systematic way to facilitate the treatment of African-American adolescents in family therapy. Specifically, the researchers examined the problem of low levels of therapy engagement and participation among African-American youth by examining whether and how therapist behavior and content focus influences adolescent engagement. Results indicated that discussing culturally-relevant content themes, especially concerning issues of anger or rage, alienation, respect, and the journey into manhood improved therapy engagement for Black male adolescent
clients. These results suggest that specific, culturally-sensitive interventions can be effective for African-American youth.

Despite extensive literature establishing a link between engagement in the process of therapy and outcomes, there is scant research on how, specifically, therapists can create a shift from disengagement to engagement with adolescents in family therapy. Previous studies on engagement interventions have focused either on therapist or client characteristics, therapist behaviors, or various treatment modality applications that lead to increased engagement and retention. However, microanalyses of in-session processes that facilitate adolescent engagement have yet to be conducted.

In an exploratory study conducted by Diamond et al. (1999), five cases in which the adolescent therapeutic alliance improved were compared with five cases in which the alliance did not improve from the first session of family therapy to the third session. Results yielded moderate to large main effects for addressing trust, honesty, and confidentiality in the therapeutic relationship, orienting the adolescent to the collaborative nature of therapy, attending to the adolescent’s experience, and presenting as the adolescent’s ally. In the improved versus the unimproved cases, therapists demonstrated significantly greater effort at attending to the teen’s experience, presenting as an ally, and formulating personally meaningful goals with the adolescent.

**Discovery-Oriented Research**

The present exploratory study was conducted to elucidate mechanisms of change in adolescent engagement during family therapy. Over the past 25 years, researchers have increasingly acknowledged the value of exploring common mechanisms of change, such as the alliance, at a micro-analytic level, using discovery-oriented methods that can
inform theory as well as practice (Horvath, 2006). Gurman, Kniskern, and Pinsof (1986) recommended the use of discovery-oriented strategies in the study of family therapy, including qualitative analysis, is uniquely poised to provide valuable information for practitioners. These kinds of studies answer the call for new research methodologies that can merge rigorous scientific inquiry with the reality of the complexities inherent in family therapy (Pinsof, 1989).

Qualitative research in particular aims to foster “holistic understanding” and discover meaning from naturally occurring, complex events, actions, interactions in context by intensively examining a small number of cases (Moon, Dillon, & Sprenkle, 1990, p. 358). Informed by theory, qualitative researchers are explicit about their inquiry, asking open-ended, exploratory questions (e.g., “What is going here and why?”).

**Change process research.** Traditional process research, which emphasizes the mechanisms of therapeutic change, (Greenberg & Pinsof, 1986) is defined as:

“… the study and interaction between patient and therapist systems. The goal of process research is to identify the change process in the interaction between these systems. Process research covers all of the behaviors and experiences of these systems, within and outside of the treatment sessions, which pertain to the process of change.” (p. 18)

In family therapy, general process research refers to a descriptive study of the interaction between therapist and family systems and subsystems.

*Change process research* (Greenberg, 1986), on the other hand, involves identifying, describing, explaining, and predicting the effects of specific events that bring about successful therapeutic change within a therapy session or over the course of
therapy. Safran, Greenberg, and Rice (1988) argued that intensive analysis “is a conceptually demanding, methodologically rigorous, and labor intensive process which should not be relegated to the status of ‘pilot work’ which takes place before the ‘real research’ begins” (p. 15). Thus, change process research has earned a rightful place among more traditional research methodologies.

**Task analysis.** In 1984, Rice and Greenberg proposed using task analysis as a research paradigm to study meaningful change events in psychotherapy. Task analysis, adapted from industrial-organizational psychology, refers to a method of investigation in which a specific, recurring task is resolved. It is an event-based strategy that illuminates the component steps or stages involved in the solution of a specific, interactional, and observable task (Greenberg, Heatherington, & Friedlander, 1996; Rice & Greenberg, 1984). As described earlier, the therapeutic process contains discrete identifiable events in which client and therapist engage in interactional sequences that predictably result in observable change (Rice & Greenberg, 1984). The aim of a task analysis is to conduct a microanalysis of what occurs during the event, beginning with the client’s exhibited behavior that marks the need for a specific change and ending with some indicator of successful resolution, i.e., that the change has been accomplished.

Change events (Rice & Greenberg, 1984) are defined as therapeutic episodes in which a specific therapeutic task is worked on. These episodes involve a series of interactional sequences between client(s) and therapist within a time period that has a beginning and an end, as well as a structure that distinguishes them from the surrounding behaviors in the ongoing psychotherapeutic process (Greenberg, 1984). Therapy tasks identified for this kind of analysis typically involve three elements: “a stimulus situation;
a reaction that may involve feelings or behavior, or both; and an indication that the client finds his or her own reaction problematic in some way” (Rice & Saperia, 1984, p. 34).

Change events tend to be complex and are composed of interconnected activities in a changing pattern, which occur within a continuous period of time and most often end within a single therapy session. According to Greenberg (1986), isolating change events provides a means for answering several critical questions about the therapeutic process, such as:

“1. What client in-therapy performances, or markers, suggest themselves as problem states requiring and ready for intervention?
2. What therapist operations are appropriate at these markers? What therapist operations will best facilitate a process of change at this marker?
3. What client performances following the markers lead to change? What are the aspects of the client performance that seem to carry the change process, and what does the final in-therapy performance or immediate outcome look like?” (Rice & Greenberg, 1984, p. 6).

Horvath (1994) proposed that task analytic studies permit an examination of client-therapist interactions that can lead to a greater understanding of the therapeutic alliance. These studies follow two distinct but complementary paths: the intensive micro-analytic exploration of events that influence the alliance and qualitative analyses of shifts in more and less successful treatments.

The task analysis research paradigm (Rice & Greenberg, 1984) has been applied to the study of various change events in couple and family therapy, including transformation of client constructions of the presenting problem (Coulehan, Friedlander,
& Heatherington, 1998); alliance-building interventions with adolescents (Diamond et al., 1999); committing to or sustaining family engagement on a problem-solving task (Friedlander et al., 1994; Heatherington & Friedlander, 1990); in-session change in couples’ conflict interactions (Greenberg, Ford, Alden, & Johnson, 1993); and facilitating blamer softening in couples therapy (Bradley & Furrow, 2004).

Heatherington and Friedlander (1990) argued that task analysis is well suited to study the process of change in family therapy and illustrated their application with a mixed methods (qualitative and quantitative) microanalysis of a change event that they termed commitment-to-engage. These authors’ analysis of two commitment-to-engage events in demonstration interviews by structural theorist and therapist Salvador Minuchin showed that, in each event, (a) Minuchin’s techniques were consistent with the theory of structural therapy, and (b) a shift in family members’ verbal behavior with one another could be observed.

Four studies were used to construct a preliminary model for the engagement shift event studied here. First, Heatherington and Friedlander (1990) illustrated the application of task analysis methodology to the study of important change events in structural therapy. These authors conducted a second, more extensive comparative analysis of four successful and four unsuccessful “sustaining engagement” events (Friedlander et al., 1994), which resulted in a refined model of interpersonal processes to overcome disengagement in family therapy. In this second study, Friedlander et al. compared four successful and four unsuccessful sustaining engagement events in which family members shifted (or failed to shift) from disengagement to sustained engagement with one another on a specific problem solving task. In a similar study, Coulehan et al. (1998) used task
analysis to explore the transformation of clients’ constructions in Sluzki’s (1992) narrative family therapy. Finally, Diamond et al. (1999) used a task analysis to study therapist alliance-building behaviors associated with improved therapist-adolescent alliances in family therapy.

Greenberg (1986) described a change event as consisting of four components: a client marker, a therapist operation, a client performance, and an in-session outcome. The marker is a series of statements or behaviors that suggest to the therapist that a particular problem exists and that a therapeutic intervention is needed (Heatherington & Friedlander, 1990). The marker must be operationally defined so that observers can reliably identify behaviors that signal the beginning of the event of interest. The second component is the task environment. This component involves therapist operations (i.e., interventions), and client performances (Greenberg, 1984). Heatherington and Friedlander (1990) argued that therapist operations and client performances are not distinct in family therapy and that family members and therapist work together toward a common goal of interpersonal change. The successful change event concludes with a resolution, an in-session outcome that signals that the clinical task has been successfully handled.

In their sustained engagement study, Friedlander et al. (1994) defined the marker as family members’ “resistance to engagement in problem solving on the designated topic in response to a minimum of three attempts by the therapist to facilitate discussion on the topic” (p. 441). In other words, the family members’ inability to sustain a conversation as directed by the therapist signaled the need for a series of interventions to overcome the interpersonal impasse.
Coulehan et al. (1998) identified the marker of a transformation event as a “problem description when the speaker (a) uses words like problem, difficulty, disagreement, or conflict; (b) responds to an inquiry about the problem, or (c) describes a negative emotional state or attitude, problematic reaction, diagnosis, condition, or impasse, implying the need for change” (p. 22). This change event involved transforming the parents’ views of the presenting problem from intrapersonal (i.e., focused on the child’s difficulties) to interpersonal (i.e., relational within the family). Results of this task analysis showed that parents’ constructions of the presenting problem could be modified in the first conjoint family therapy session.

Friedlander et al.’s (1994) results were a task environment of the successful sustaining engagement event that consisted of 5 steps. First, family members recognize their own contribution in the disengagement impasse. Therapist interventions such as clarifications, reflections, meta-communications, and self-disclosures helped foster the clients’ awareness of unexpressed thoughts and emotions related to their impasse. Next, family members were able to communicate their thoughts and feelings about the impasse to one another, coached by the therapist. In the third step, family members acknowledged one another’s thoughts and feelings about the impasse. Therapists modeled acceptance by validating and encouraging family members’ disclosures. Finally, the task environment ended when family members developed a new understanding about the impasse. At some point in the process, the motivation for sustained engagement was discussed. One successful case, for example, a wife was willing to communicate with her husband after she learned that he understood her pain and realized he was frustrated by her criticisms. Comparison of the four unsuccessful events to the four successful events showed that
these five steps were only present in the sessions in which family members were able to sustain a conversation on the designated topic for at least eight speaking turns, i.e., the operational definition of the resolution.

In Coulehan et al.’s (1998) transformation event study, the resolution was defined as the point at which one parent acknowledged hope or the possibility of change, and there was movement by the parent to become more nurturing and empathic. The successful transformation events involved three stages. In the first stage, individual family members shared their constructions of the problems, interpersonal aspects of the problem were highlighted, and exceptions to the problem were recognized. In the second stage, an affective shift in the tone of the session was accomplished when parents’ shared positive attributes of the problem child, contribution of family history and structure were recognized, and family strengths associated with change were identified. Finally, in the last stage, family members expressed hope for the possibility of change. As one example, a family’s interpretation of the oldest daughter’s oppositional behavior changed when they became aware that her behavior stemmed from the daughter’s difficulty adjusting to a new step-family situation, which had resulted in her feeling unloved and jealous of her younger sister. One interesting finding that emerged when comparing the successful events to the unsuccessful events was the absence of hope in all four of the unsuccessful sessions.

**Rational model.** In order to begin a task analysis, a hypothetical model of the change event is developed, i.e., the steps taken in the task environment that are likely to produce a successful resolution. This preliminary model is based on a comprehensive review of the research and theoretical literature and the investigator’s clinical expertise
(Greenberg, 1986). Once constructed, the rational model is then compared to a small number of actual change events (Rice & Saperia, 1984). Refinement of the rational model involves generating a set of descriptive labels for the observed behavior. These descriptive labels are then used to classify each segment of the client’s performance and the therapist’s operations. In other words, using the descriptive codes developed in the rational model requires close examination of each change event so as to produce an increasingly precise set of descriptors (Rice & Saperia, 1984). In this way, the clinical data are used to refine the original steps in the rational model and new behavioral categories are developed.

Subsequently, the final set of descriptors is a contrast between the steps that were successful in accomplishing the specific clinical task in the successful events with what occurred in the unsuccessful events. The outcome of this comparative analysis is a refined model of the change process that distinguishes a resolved from an unresolved clinical task (Rice & Saperia, 1984).

The comparative analysis of improved adolescent alliances by Diamond et al. (1999) exemplified the process of refining a rational model. In this study, a preliminary list of alliance-building behaviors was developed inductively. This list was used to organize subsequent observations of therapist behaviors that occurred in a small sample of family therapy cases with improved alliances. This preliminary list, which included developing a collaborative set, goal formation, and generating hope, was based upon MDFT theory, adolescent development research, and clinical experience with substance-abusing and delinquent adolescents.
Next, this list was used in a comparative analysis of five initially poor alliance cases that improved by the third session of treatment. This analysis resulted in refinement of the initial items to include six alliance-building therapeutic interventions (attend to adolescent’s experience, orient adolescent to the collaborative nature of therapy, formulate meaningful goals, present self as an ally, challenge control and contingency beliefs, and address issues of trust, honesty, and confidentiality in the therapeutic relationship) and two generic therapeutic behaviors (gather information and challenge cognitions and behaviors). The enhanced model was subsequently tested and improved through an empirical analysis.

This exploratory analysis of alliance-building interventions in family therapy is similar to task analysis. Diamond et al’s (1999) preliminary list of alliance-building interventions was essentially a rational model that was tested empirically. Next, an inductive analysis was conducted to refine the list of therapist alliance-building interventions, and included new classes of interventions and exemplars of the interventions. The last phase of the analysis involved applying the model to a new selected sample of improved versus unimproved alliance cases. Results showed that three of the six therapist alliance-building interventions were significantly correlated with improved alliances: attending to adolescent’s experience, formulating personally meaningful goals, and presenting as the adolescent’s ally.

**Summary and Rational Model of the Adolescent Engagement Event**

The present exploratory study featured the initial stages of a task analysis of critical shifts in adolescent engagement in conjoint family therapy. Specifically, in this mixed methods (qualitative/quantitative) discovery-oriented study, sessions drawn from
an archival data set were selected for intensive analysis. Client and therapist behaviors were identified by analyzing sessions in which a resistant adolescent either did or did not shift from disengagement to positive engagement in the therapeutic process. This study is based on Heatherington and Friedlander’s (1990) recommendations for studying clinically important change events in family therapy, Friedlander et al.’s (1994) comparative analysis of successful and unsuccessful sustaining engagement events, and Diamond et al.’s (1999) comparative analysis of improved and unimproved alliance cases.

Relevant theory and literature were used to generate a rational model of the successful engagement shift event (see Fig. 1). Based on Friedlander et al.’s (1994) sustaining engagement task analysis and Diamond et al.’s (1999) comparative analysis of alliance building with adolescents in family therapy, the engagement shift event was expected to include 5 recursive elements following the marker, which was defined as the adolescent expressing or otherwise demonstrating disengagement or resistance. In the task environment, (a) the adolescent communicates his or her thoughts and feelings about the problem, goals, or tasks of therapy, (b) the therapist validates the adolescent’s reluctance and encourages him or her to share these thoughts and feelings with other family members, (c) the adolescent recognizes some motivation for engagement, and (d) the adolescent receives information, clarification, or support from the therapist or from his or her parents in efforts to become more engaged in the process (see Fig. 1). The successfully resolved event was expected to be indicated by notably greater adolescent engagement signaled by, for example, introducing a problem for discussion, identifying a personal goal for therapy, asking for the therapists help, and so on. Some of these
behaviors may be those included in the Engagement dimension of the SOFTA-o (see Appendix A). The unsuccessful events were expected to have few or none of these positive elements of engagement. That is, the session would end with continued disengagement, reluctance, or resistance on the part of the adolescent.

It was reasoned that the successful engagement shift events might include the therapist reframing the parent’s blame of the adolescent. In a study of constructivist therapy, conversational analysis showed that therapists ignored, interrupted, or reframed blaming among family members (Friedlander, Heatherington, & Marrs, 2000). It also seemed likely that Diamond et al’s (1999) six therapist alliance-building interventions (i.e., attending to the adolescent’s experience, orienting the adolescent to the collaborative nature of therapy, formulating meaningful goals, presenting self as an ally, challenging control and contingency beliefs, and addressing issues of trust, honesty, and confidentiality) might emerge as important elements in the successful engagement shift sessions.

Figure 1 shows five potential steps toward a successful engagement shift. However, there was no basis for theorizing which elements would proceed or follow other elements, and it seemed likely that there would be some recursive movement between the elements. Indeed, earlier task analyses (Coulehan et al, 1998; Friedlander et al., 1994) resulted in refined models that showed a dynamic interplay among various elements within the task environment.
Figure 1: Rational Model of the Successful Engagement Shift Event

Marker
Adolescent demonstrates reluctance or resistance to the therapeutic process.

Task Environment

1. The adolescent communicates his or her thoughts or feelings about the problem, goals, or tasks of therapy

2. The therapist validates the adolescent’s reluctance and encourages him/her to share thoughts and feelings with other family members.

3. The adolescent recognizes some motivation for engagement

4. The therapist or parents offers information, support, or clarification.

5. Therapist intervenes to foster engagement

Resolution
Adolescent demonstrates more positive engagement
Significance of the Study

The present study was based on the initial, discovery-oriented stage of a task analysis. The purpose of this study was to develop and refine a conceptual model of the therapeutic process of engaging a reluctant adolescent in the process of family therapy. Furthermore, it was expected that an intensive microanalysis of a small sample of engagement shifts would result in a meaningful conceptual model that could be empirically tested in future research.

The present investigation was expected to contribute to the literature in several ways. First, it examined an important therapeutic process using both qualitative and quantitative analyses. Although the clinical literature offers examples of therapeutic techniques for eliciting engagement (Diamond et al., 1999; Friedlander et al., 2006a), there have been, to date, no empirical assessments of this process of change.

Furthermore, there have been few published studies of the process of change in family therapy and little evidence to suggest interventions that facilitate adolescent (or adult) engagement. Second, the present study was expected to advance theory on the therapeutic alliance by explicating how one aspect of the alliance (i.e., engagement in the process of therapy) may be fostered in conjoint family therapy with reluctant adolescent members. Finally, this study was expected to provide valuable information to practitioners about which therapist behaviors, adolescent characteristics, and parent-adolescent interactions are likely to result in effective adolescent engagement when there is obvious resistance on the part of the adolescent to the therapy process. Equipped with this knowledge, therapists will be better able to promote compliance with therapeutic
tasks, reduce the likelihood of dropout from therapy, and effect positive therapy outcomes with adolescents.
Chapter II

Method

Participants

Families. The data for this study were four sessions in which a reluctant adolescent either did or did not demonstrate a positive shift in behavior from disengagement to engagement (two positive shift sessions, two negative shift sessions). The sessions were selected from four cases in an archival data set of videotapes (Friedlander et al., 2008b).

In the original study, 29 low-income families with at-risk youth were seen free of charge at a not-for-profit community clinic in a small northeastern city. Families were recruited to participate in a study on “the effectiveness of family therapy.” After pre-screening, the families that met the inclusion criteria were offered 10 conjoint family sessions free of charge. During the course of treatment, the therapist and family members completed questionnaires about their perceptions of each session. Among the outcome measures was an individualized target complaints measure (Battle et al., 1967), which was completed pre- and post- therapy by all family members. Previous analysis showed that, on the whole, most family members reported satisfaction with their treatment, improvements in target complaints, and reduced symptoms (Friedlander et al., 2008).

Of the four families whose sessions were used in the final sample, three were White and one was Black. All were headed by single-parents (three mothers, one father) who were between the ages of 34 and 51 years; the adolescents who were the focus of this study were between the ages of 12 and 15 years (two girls, two boys). In two of the cases, a younger sibling was present in the session. Each family was referred for some
type of assistance with a family readjustment situation. For example, two families sought help after a recent parental separation, one family involved the recent death of the father, and one family involved a parent who recently assumed custody of the adolescent. Three of the families completed the full 10-weeks of family therapy; the family with the single father dropped out of treatment after 6 sessions.

**Therapists.** In the original study (Friedlander et al., 2008b), there were 10 therapists (8 women, 2 men) with varying levels of experience, ranging from master’s level counselors to Ph.D. psychologist. The treating therapists in the present sample were three women, all of whom were White, between the ages of 37 and 51 years. Two therapists each saw one case, and the other therapist saw two cases (one successful, one unsuccessful).

One therapist had a master’s degree, one was a master’s level counselor who was pursuing a Ph.D., and the third therapist had a Ph.D. in counseling psychology. All of the therapists had experience working with families (approximate range = 5 - 23 years). Their self-identified theoretical orientations included systems, solution-focused, structural, and eclectic.

**Design**

The present study was the intial, discovery-oriented stage of a task analysis. As described earlier, task analysis is a change process methodology that involves identifying, describing, explaining, and eventually predicting specific in-session processes that bring about demonstrable therapeutic change (Greenberg, 1986). In this study, the therapist’s "task" was to successfully shift a reluctant or resistant adolescent toward greater engagement in the therapeutic process.
In the first stage of a task analysis, a rational model of the specific change event was proposed (described in Chapter 1) based on a review of relevant literature. In this study, the model was assessed and refined through the intensive comparative analysis of a small sample of successful and unsuccessful adolescent engagement shifts.

**Selection of sessions.** All videotapes in the data set (Friedlander et al., 2008b) that had previously been rated for clients’ alliance behaviors on the SOFTA-o (Friedlander et al., 2006a, 2006b) constituted the pool of potential sessions. The 20 videotapes reviewed for this study were those in which one adolescent in the family demonstrated either (a) only negative SOFTA-o engagement behaviors (receiving ratings of -3, -2, or -1), or (b) both positive and negative engagement behaviors during the session (receiving a rating between -1 and +1). In other words, the selected sessions required the presence of at least one negative engagement behavior on the part of an adolescent. (Sessions with only positive alliance behaviors were not reviewed because these sessions were unlikely to have a disengaged adolescent).

Of these 20 tapes, 10 were selected for the subsequent identification of positive and negative engagement. These 10 sessions met the SOFTA-o criteria, suggesting they were most likely to include markers of adolescent disengagement. That is, the sessions in which only negative engagement behaviors were observed were likely to be unresolved engagement events, whereas sessions in which both negative and positive engagement behaviors were observed were expected to contain at least one successful engagement shift.

From this pool of 10 sessions, the final videotapes were selected for analysis based on the consensus of two clinically experienced judges (the investigator and one
female doctoral student in clinical psychology) about whether (a) either at least one successful engagement shift occurred in the session, or (b) no engagement shifts occurred, i.e., the adolescent remained disengaged throughout. Thus, successful shift events were operationally defined as sessions in which there was a clinically evident change from negative to positive in the adolescent’s engagement-related attitude or behavior by the end of the session. By contrast, unsuccessful shifts were defined as sessions in which the two judges concurred that a meaningful shift in adolescent engagement did not occur by the end of the session.

It should be noted that although some positive SOFTA-o engagement behaviors may have been evident in the successful sessions, the judges decided where the actual shift occurred based upon a clinical review of the videotapes rather than by solely relying on the SOFTA-o behaviors. This reliance on clinical judgment was used because there were likely to be subtle changes in attitude or behaviors, not captured by the SOFTA-o, that signaled a meaningful engagement shift.

After the qualitative analysis was completed, the previously-rated client behaviors on the SOFTA-o were re-examined in order to assess the degree of congruence between the adolescent’s quantitative engagement ratings and the emerging qualitative results. In addition (a) the adolescent’s post-session perceptions of the session on the Session Evaluation Questionnaire (Stiles & Snow, 1984), and (b) the adolescent’s pre-treatment list of target complaints (Battle et al, 1967) were reviewed as additional data sources to triangulate the qualitative findings.
Instruments

**System for Observing Family Therapy Alliances.** The SOFTA-o (Friedlander et al., 2006a, 2006b) is an observational tool for assessing four dimensions of alliances in family therapy, including *Engagement in the Therapeutic Process, Emotional Connection with the Therapist, Safety within the Therapeutic System, and Shared Sense of Purpose within the Family.* Specific verbal and nonverbal behaviors are clustered within each dimension and require low-level inferences. There are two versions of the SOFTA-o: The client version focuses on behaviors that reflect thoughts and feelings about the alliance (both positive and negative), whereas the therapist version assesses interventions that contribute (or not) to the alliance.

Ratings on the SOFTA-o are obtained by trained judges who observe a videotaped or live session, marking both the frequency and intensity of specific positive and negative alliance-related behaviors as they occur, while referring to the operational definitions of each behavior in the training manual (Friedlander et al., 2004). After the entire session has been observed, raters assign global ratings (-3 = extremely problematic to +3 = extremely strong) to each client using operational definitions of each dimension, a set of rating guidelines, and by considering the valence (positive or negative), frequency, intensity, and clinical meaningfulness of the observed behaviors. For example, when no alliance behaviors are observed, a global rating of 0 (unremarkable or neutral) would be assigned. Rater must assign ratings between +1 and +3 when only positive behaviors are observed, or -1 to -3 when only negative behaviors are observed. Instances when there are both positive and negative behaviors, ratings must be between +1 and -1.
The SOFTA-o yielded average intraclass correlations ranging from .72 to .95 for the four dimensions (Friedlander 2006a). Construct validity for the SOFTA-o has been demonstrated with various samples of outpatient couples and families (Beck, Friedlander, & Escudero, 2006; Friedlander et al., 2006b; Friedlander, Lambert et al., 2008; Muñiz de la Peña et al, 2009). In terms of Engagement, results showed, for example, that clients who reported their sessions to be relatively better demonstrated higher SOFTA-o Engagement ratings than clients who rated their sessions relatively worse (Friedlander, Bernardi, & Lee, in press), and clients whose behaviors indicated greater Engagement in session 3 also tended to report a stronger perceived alliance with the therapist (Escudero, Friedlander, Varela, & Abascal, 2008).

In the present investigation, only the Engagement in the Therapeutic Process global ratings and individual observed behaviors were of interest. As described above, behaviors and global ratings were used to identify potential sessions for inclusion in the task analysis. In the SOFTA-o, Engagement in the Therapeutic Process is operationally defined as:

“the client viewing treatment as meaningful; a sense of being involved in therapy and working together with the therapist, that therapeutic goals and tasks in therapy can be discussed and negotiated with the therapist, that taking the process seriously is important, that change is possible” (Friedlander et al., 2006a, p. 270).

This dimension of the SOFTA-o contains a set of observable verbal and nonverbal behaviors, e.g. “client indicates agreement with the therapist’s goals” (positive), and “client expresses feeling ‘stuck,’ questions the value of therapy, or states that therapy is not/has not been helpful” (negative). A table of client and therapist Engagement
behaviors in the SOFTA-o is provided in Appendix A. Although only the adolescent’s Engagement behaviors were used to select shift events for analysis, the therapist’s behaviors are listed in the Appendix because they were reviewed during the analysis of the selected engagement shift events.

The sessions selected for review and final analysis had previously been rated by one of three different teams of raters. All of these teams achieved adequate interclass correlation reliabilities, i.e., ≥ .70.

**Target Complaints.** An additional quantitative measure that was used to inform the qualitative results is the Target Complaints questionnaire (TC; Battle et al., 1967), which all clients completed at pre- and post- treatment. This instrument asks clients to identify in writing up to three problems for which they are seeking help and then rate their current level of distress for each problem on a 1 (low) to 10 (high) scale. In the larger study from which these sessions were drawn, pre-/post- changes on the TC were significant, pre $M = 7.57$, $SD = 2.41$; post $M = 4.86$, $SD = 2.20$, $t(40) = 7.03$, $p < .0001$, Cohen’s $d = 1.53$ (Friedlander et al., 2008).

**Satisfaction with Therapy.** This 5-item Client Satisfaction Scale (Tracey, & Dundan, 1988), was modified slightly to reflect the family context. Each item was rated on a 1 = low to 7 = high scale, and scores could range from 5 to 35.

**Session Evaluation Questionnaire.** In the original data set (Friedlander et al., 2008b), clients aged 12+ and therapists completed the Session Evaluation Questionnaire (SEQ, Version 4; Stiles & Snow, 1984) to report the perceived impact of each session. The SEQ data for the selected sessions are reported in the Results chapter in order to inform the qualitative results.
The SEQ contains two evaluative session dimensions, Depth and Smoothness, and two dimensions of post-session mood, Positivity and Arousal. Items are 24 bipolar adjectives that are rated on 7-point semantic differentials reflecting session impact (e.g. safe-dangerous, difficult-easy, valuable-worthless) and post-session mood (e.g. happy-sad, involved-detached, angry-pleased). Clients also rated the therapist on 3 additional items: skilled – unskilled, warm - cold, and trustworthy - untrustworthy. After some items are reverse scored, the totals are summed and averaged, so that each scale score can range from 1 (low) to 7 (high). In the larger sample from which the cases were drawn, internal consistencies were Depth $\alpha = .86$ (client) and .85 (therapist), Smoothness $\alpha = .85$ (client) and .86 (therapist).

**Demographic questionnaire.** A brief questionnaire was used in the original investigation (Friedlander, et al., 2008b) to gather demographic information about the therapists who participated in the study. Therapists were asked their gender, age, professional degree, extent of family therapy training and experience, and primary theoretical orientation. Demographic information about the families was obtained during the pre-screening interviews with the parents.

**Procedure**

The successful and unsuccessful sessions selected for the qualitative analysis were transcribed verbatim from the videotapes by a research assistant. To ensure accuracy, each transcription was checked against the videotapes for accuracy by the investigator. All names or other identifying information were deleted for the analysis.

**Research teams.** In addition to the investigator, two doctoral-level graduate students in clinical psychology composed the two research teams. Two judges were
involved in the initial selection of successful change event cases. All of the judges were White, female, doctoral students, between the ages of 25 and 39, with some previous clinical experience.

These judges and one additional person were trained in qualitative analysis. This process began with the investigator as the facilitator, who familiarized the other judges with the nature of the study and described the qualitative analysis process.

Mutually agreed upon goals, common language, and rules were established. Rules specified the judges’ obligations, a tentative time table for work to be completed, agreement on subsequent steps in the process, and discussion of remuneration for their involvement. Once the judges were informed about the nature of the investigation and discussed all of the elements in the rational model as a starting point for the analysis, they proceeded to complete the qualitative analysis of the task environment.

Selection of change events. The investigator and one of the judges independently observed the 10 videotaped sessions and then compared their results. Together, they identified sessions in which there seemed to be clinically meaningful positive shift in adolescent engagement and sessions in which no such shift occurred. The disengagement marker for both kinds of events needed to include a specific behavior that both judges had independently identified and/or a negative SOFTA-o Engagement behavior that had been previously rated. As listed in Appendix A, the two negative behaviors in the SOFTA-o are “client expresses feeling “stuck”, questions the value of therapy, or states that therapy is not/has not been helpful” and “client shows indifference about the tasks or process of therapy (e.g. paying lip service, “I don’t know” or tuning
out”. These two judges also identified the point in each successful session where a resolution to the shift event was apparent.

**Qualitative Analysis**

A qualitative analysis was used to identify in-session processes that seemed to account for a significant, positive shift in adolescent engagement in family therapy. The qualitative analysis involved an intensive comparison of the four videotapes and transcripts of the two successful and the two unsuccessful shift events so as to refine the rational model (Fig. 1, p.27).

For all of the events, the transcribed dialogue used in the qualitative analysis was that which began immediately following the disengagement marker that had been identified by the judges. For the successful events, the engagement shift moment previously identified by these judges, signaled the resolution, i.e. that a positive engagement shift had occurred. The unsuccessful events were analyzed beginning with the disengagement marker until the end of the session.

A constant comparison inductive method (Strauss & Corbin, 1990) was used to identify the mechanisms of change (i.e., client behaviors and therapist interventions) in the task environment of the resolved (i.e., successful) events that were absent in the unresolved events (i.e., those in which an engagement shift was not apparent). That is, the two original judges and one an additional individual, a White, female, doctoral student, reviewed and compared the videotapes and transcripts of the selected change events to identify therapist and client behaviors that differentiated the successful from the unsuccessful events. Behaviors under consideration included therapist-adolescent interactions, therapist-parent interactions, and adolescent-parent interactions. While the
videotapes and transcripts were reviewed, a running list was kept of all observed therapist interventions and client responses that seemed to move toward greater engagement. The observed interactions were then clustered logically and named by consensus. As each element in a successful event was identified and named, it was searched for in the other events. This constant comparison is the heart of the analytic inductive method used in previous task analyses of family therapy (e.g., Coulehan et al., 1998; Friedlander et al., 1994). As was done in previous studies of this kind, the elements that were included in the refined model were those that characterized all of the successful events but not all of the unsuccessful events. That is, some of the elements were expected to be present in the unsuccessful events as well, but not all. In this way, a refined model of the successful engagement shift event was created, with elements that distinguished the successful from the unsuccessful cases.

Although it is considered desirable in a task analysis for the identified behaviors to occur in a sequence of steps, this result is not essential (e.g., Coulehan et al., 1998). That is, elements in the task environment were expected to be recursive, as illustrated in Figure 1 (the rational model). Indeed, because this initial stage of the task analysis is highly discovery-oriented, the original rational model could have been entirely disconfirmed by the emerging data. The three judges negotiated to consensus in order to arrive at the descriptive labels for each element in the task environment of the final refined model.
Chapter III

Results

In this chapter, the four sessions are described. Table 1 contains a complete listing of target complaints for each of the four adolescents, along with the adolescent’s reported distress level rating associated with each complaint. The elements that emerged in the qualitative analysis are described in this chapter, along with the refined conceptual model of the successful or positive engagement events. Finally, the quantitative data for each adolescent are presented and discussed.

Positive Engagement (PE) Events

**PE Family 1.** Participants in this session were a white mother and daughter, aged 14, seen by Therapist A. The session focused on the daughter’s relationship with her father, the mother’s difficulty communicating with her estranged ex-spouse, and the daughter’s personal hygiene and household responsibilities. This was the sixth session of 10 completed sessions.

During the pre-screening interview, the daughter identified her target complaints as (1) “my Dad left us,” (2) “my Dad is being a butt head,” and (3) “my Mom made me [come for counseling].”

The marker began from the start of the session, when the daughter seemed to be “paying lip service” to the therapeutic process. This is the SOFTA-o Engagement behavior, “client shows indifference about the tasks or process of therapy (e.g. paying lip service, “I don’t know” or tuning out).” For example, in the first 10 min of the session, the daughter gave approximately 20 responses. Of those responses, 13 included statements such as “yep,” “sure,” “good,” “I don’t know,” or an affirmative “uh huh,”
### Table 1

**Pre-Treatment Target Complaints**

<table>
<thead>
<tr>
<th>Event</th>
<th>Adolescent Age/Gender</th>
<th>Session No.</th>
<th>Adolescent Target Complaints</th>
<th>Distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>PE1</td>
<td>14/Female</td>
<td>6</td>
<td>1. My father left us.</td>
<td>6</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>2. My father is being a butt head.</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3. My mom made me [come]</td>
<td>3</td>
</tr>
<tr>
<td>PE2</td>
<td>12/Female</td>
<td>3</td>
<td>1. Divorce between my parents</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. Stress because of father.</td>
<td>5</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>3. Events that have happened in the last month.</td>
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<tr>
<td>NE1</td>
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<td>1. Communication</td>
<td>6</td>
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<td></td>
<td></td>
<td></td>
<td>2. [None reported]</td>
<td>--</td>
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<td>3. [None reported]</td>
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<td>3</td>
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<td>2. None</td>
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<td>3. None</td>
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</table>

*Note:* PE = positive engagement event; NE = negative engagement event. Level of current distress for each target complaint listed by the client was rated from 1 = low to 10 = high.
each of which was expressed with little emotion or observable interest in the discussion at hand.

The resolution occurred approximately 17 min into the session, when the daughter shared a solution to a problem that was being discussed, i.e., “I was going to like, when I went over to see my sister and brother on Sunday, I was going to ask them if they wanted to do something for [father’s] birthday. You didn’t know about that.” Engagement was maintained for approximately 10 min during which the daughter was visibly more engaged in the process of therapy. That is, she paid closer attention and became involved in the discussion, and she explicitly agreed with a proposed solution to a family problem. Ten min later, however, the daughter resorted to responding with brief comments and expressed little emotion or interest in the remaining discussion.

**PE Family 2.** Participants in this session were a White mother and two daughters, aged 4 and 12, seen by Therapist B. The youngest daughter slept throughout the session. The mother raised various issues related to the family’s adjustment to their recent abandonment by the father and the girls’ resistance to his weekly supervised visitation. This was the third of 10 completed sessions.

The older daughter’s three target complaints included (1) “divorce between parents,” (2) “stress because of father,” and (3) “events that have happened in the last month” (see Table 1).

In the marker, the daughter was “tuned out” to much of the conversation between the therapist and her mother, evidenced by frequent use of statements such as, “I don’t really know,” “I can’t put my thoughts into words,” or by laughing in response to questions while drawing on a pad of paper.
The resolution occurred approximately 27 min into the session, when the daughter offered an authentic response to the problem being discussed, stating “She [mother] never tells me like if she’s upset or something. That’s why I hate it [her mother’s inability to sleep at night].” This positive engagement behavior is the SOFTA-o Engagement behavior, “client introduces a problem for discussion.” That is, her apparent willingness to name her feelings (regarding her mother’s grief) permitted the therapist, mother, and daughter to address her concerns directly. The daughter remained more actively engaged in the therapy for the remainder of the session.

Negative Engagement Events

**NE Family 1.** Participants in this session were an African-American father and his 15-year-old son, seen by Therapist C. The discussion focused on the son’s “failure” to meet to his father’s expectations around the house, attending school regularly, and finding part-time employment. This was the fifth session of 6 sessions, after which the family dropped out.

During the pre-screening interview, the son listed the only target complaint as “communication” (see Table 1). The son’s disengagement remained steadfast throughout the session, as evidenced by lack of eye contact with either his father or the therapist, by giving only one word or minimal answers to questions, or by declining to respond altogether.

**NE Family 2.** Participants in this session were a White mother, son (age 14), and daughter (age 11), seen by Therapist A. A number of topics were discussed during this session. Initially, the mother raised the son’s concern about the stigma of having a mental health diagnosis. Next, the discussion focused on the family’s ongoing adjustment
to the death of the father, two years prior, and the son’s resistance to attending therapy sessions.

The son completed the Target Complaints questionnaire, but listed all three possible complaints as “none,” rating his distress level as 0 for each. This was the third session of 10 completed sessions.

The marker for disengagement was the son’s refusal to make eye contact with anyone else in the room; in fact, he looked away from everyone. He often responded with one word answers or not at all. At one point, when the therapist asked him if he was responding with what he thought she wanted to hear, or if he really meant what he said, his response was clear: He was simply responding with what she wanted to hear. When asked, he refused to agree to return for further sessions.

**Comparative Qualitative Analysis**

Successful engagement events were selected by identifying family therapy sessions in which the adolescent member demonstrated a notable shift in positive engagement behavior during the course of therapy, as agreed upon independently by two clinically experienced judges. Markers and resolutions were identified independently and then agreed on by both judges. Next, these judges, plus a third judge, observed the videotapes of both sessions from the marker for disengagement to the resolution while reading the transcripts of the session.

The judges conducted a microanalysis of the four change events. A line-by-line comparative analysis of the speaking turns of all family members and the therapist during the task environment (i.e., the period between the marker and the resolution) allowed the judges to identify specific verbal behaviors that preceded the resolution in each positive
engagement event. Next, the list of specific verbal behaviors was examined carefully and grouped based upon similar thematic qualities. As each kind of behavior was identified in one event, it was searched for in the other three events. This was the constant comparison method described by Strauss and Corbin (1990).

Finally, after the behavioral indicators were grouped by theme, each group was assigned a descriptive label that best accounted for the behaviors in each element. Each descriptive label was agreed upon by consensus. Elements that emerged in the two positive engagement events were searched for in the two negative engagement sessions. To be accepted as an element in the successful group, the element needed to be absent in one or both of the unsuccessful sessions.

The results of the qualitative analysis of positive engagement events, described below, were subsequently used to refine the model of a successful adolescent engagement event. Specific examples are provided in the text below to illustrate each element in the model.

**Elements in the successful change events.** As shown in Figure 2, six elements in the task environment were identified; five therapist strategies and one parental strategy (support). The five therapist elements included (a) structuring the therapeutic conversation, (b) fostering autonomy, (c) building awareness of systemic issues, (d) rolling with resistance, and (e) understanding the adolescent’s subjective experience (see Table 2). Although not included in the model, we found that the communication style of the therapist, particularly in the successful events, underscored the importance of fundamental therapeutic skills that facilitate positive change. In our sample, we observed more of these behaviors in the two successful engagement cases than the two
### Table 2

**Elements in the Task Environment of the PE Events**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Description</th>
<th>Behavioral Indicators</th>
</tr>
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</table>
| Structuring the Therapeutic Conversation (STC)             | Therapist attempts to structure the conversation to facilitate engagement or elaboration on a specific topic.                                 | • Using off-topic discussions to build rapport  
• Eliciting parent/adolescent interactions using enactments  
• Switching the focus of the conversation between the parent and the adolescent  
• Taking the focus off the adolescent (after multiple questions with limited response)  
• Bringing the adolescent's attention/focus back to the topic at hand |
| Fostering Autonomy (FA)                                   | Therapist distinguishes between the parent’s and the adolescent’s thoughts/feelings, pointing out that the adolescent is able to make some decisions independently. | • Prompting honest responses and differing opinions  
• Validating the adolescent's feelings/thoughts  
• Inquiring about a feeling/thought that the adolescent is struggling to voice |
| Building awareness of systemic issues (BASI)               | Therapist draws attention to an issue that is relevant to the entire family rather than solely to either the parent or the adolescent.           | • Eliciting perspectives from other family members on a specific topic  
• Validating the family’s experience  
• Asking the parent to fill in the gaps of the adolescent’s response  
• Referring to a family goal or a problem that is relevant and of interest to everyone |
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Description</th>
<th>Behavioral Indicators</th>
</tr>
</thead>
</table>
| Rolling with Resistance (RWR) | Therapist responds to the adolescent’s disengagement in a positive and nonjudgmental manner. | • Sensitive level of questioning  
• Reframing disengagement positively  
• Maintaining a calm demeanor  
• Asking here-and-now questions about the adolescent’s reluctance or resistance |
| Understanding Adolescent's Subjective Experience (UASE) | Therapist attempts to understand the adolescent’s unique perspective. | • Giving examples/options for responding  
• Clarifying what the adolescent is feeling/thinking  
• Expanding on the adolescent's reasoning  
• Offering a tentative label for the adolescent’s feelings  
• Using leading questions  
• Probing for elaboration |
| Parental Support              | Parent provides encouragement                                               | • Encouraging the adolescent to respond honestly  
• Participating in enactments suggested by the therapist  
• Validating the adolescent’s experience |
unsuccessful cases. That is, the therapists in the successful events more frequently used open-ended questions, summaries and reflective statements, probes for clarification of thoughts and feelings, and conveyed empathy for the adolescents’ experiences.

Notably, there were no observable or remarkable adolescent behaviors that demonstrated movement towards engagement, except that the two adolescents in the PE sessions did, at times, establish eye contact with the therapist and other family members, whereas the adolescents in the negative engagement cases failed to maintain eye contact for virtually the entire session. The judges noted that the adolescents in the positive engagement sessions seemed to be more attuned to the discussion at hand and seemed more at ease within the therapeutic environment.

*Structuring therapeutic conversation (STC)* referred to therapist attempts to structure the conversation with family members, or a dialogue between parent and child. To do so, the therapists facilitated engagement by eliciting elaboration on topics, focusing on off-topic discussion to build rapport, fostering parent/adolescent interactions using actual or hypothetical enactments, alternating the conversation so that the focus did not stay solely on the reluctant adolescent, giving respite to the adolescent after multiple questions with limited response, and redirecting the adolescent's attention back to topic at hand. This element was present in both of the PE events.

For example, in PE 1, the therapist focused the discussion on a safe topic during the first five minutes of the session. At nine minutes into the session, the therapist quickly responded to the mother’s complaint about the father and redirected the conversation back to the topic at hand, thus attempting to engage the adolescent in the discussion:
Th: Now is [name of older sister] your older sister?

D: Yeah, and my brother, they live together.

M: He was going to give [mail] to her. “She can go over there and see her and not me.” “Well you’re the one that’s not pregnant.” “Yeah, but I’m her father.” That’s all right. I’m counting the days. I said, “Don’t start with me,” and I hung up on him.

Th: When was the last time you saw your Dad?

D: Mmmm. I don’t know.

In PE 2, the therapist began the session with an innocuous discussion about the adolescent’s desire to volunteer during the summer months. At four minutes into the session, the therapist redirected the conversation in order to inquire about the mother’s experience during the last week, which provided the adolescent with a moment of reprieve by structuring the conversation to include the other family members. At 14 minutes into the session, the therapist prompted a hypothetical enactment between mother and daughter, which was mildly successful at prompting a response from the daughter about her thoughts and feelings:

Th: So, what would be an example of the way you would talk to Mom? If you were to talk to your Mom as if your Dad had just left, what kinds of things would you say to her? Is that what you would say, “Thank goodness, I’m free now,” or would you be more inclined to say, “I’m so frustrated. That was a waste of my five hours.” I mean, what would you be saying?

D: I don’t know. I’d have trouble saying my thoughts.

Th: What did you say this week? Or what did you want to say this week?
D: I don’t know, I forgot.

Th: What would you imagine [older daughter] or what did [older daughter] say this week? You came back and thought there was some discomfort about your not being home.

M: I think she was a little agitated that I wasn’t at home. I don’t think, I realize that, you know, I’m the one she’ll take things out on because I’m safe to do that--. I still think it bothered her that I wasn’t--. I just went to Sam’s Club.

Th: Can you ask her? Can you ask [older daughter] here if – did she feel frustrated with you or what were you feeling?

M: Were you upset that I went out with [name of family member]?

D: I was upset because she got to leave and I didn’t get to leave.

The therapist attempted a second enactment at 22:00 min, when she asked the daughter how she wanted to respond to her mother:

Th: And what do you want to say to your mom about that?

D: I don’t really know what to say.

M: You usually tell me to “get over it.” Right?

D: Oh, yeah.

In another instance (PE 1), the therapist was able to redirect the conversation back to the topic of discussion after the daughter was distracted (she was opening up a granola bar), and her mother urged the daughter to share the treat.

M: If you’re going to eat it, share it with others.

D: Do you want one? [to therapist]
Th: No thanks. But thank you for offering. So what do you think?

D: Do you want one. (tosses treat to her mother)

Th: What do you think about going over on his birthday?

D: I don’t know it depends on if there are other people there.

Th: Uh huh.

_Fostering autonomy (FA)_ included the therapist’s attempts to build awareness of the distinction between the parent’s versus the adolescent’s thoughts and feelings, and to support the adolescent in making decisions for herself. These behaviors included using statements to elicit honest responses and differing opinions, using validating statements that emphasized the adolescent's thoughts and feelings, and inquiring about a thought or feeling that was presumably difficult for the adolescent to describe independently. Taken together, these behaviors appeared to result in a safer therapeutic environment for the adolescent to express thoughts and feelings openly.

In the PE 1 session, the therapists emphasized the importance of the adolescent being honest about what she thought and felt, indicating that it was all right if the adolescent did not agree with the opinions of others. For example, the therapist said, “You know, you don’t have to do that here [agreeing to be nice]. In fact, it’s really much better that you don’t. If something doesn’t feel right, or you don’t like something, or you don’t want to do something, don’t agree to do it. Because that’s not going to be helpful to you or anybody else.”

The therapist in both of the PE sessions attended to the adolescent’s unique experience as it pertained to the situation at hand and validated how the adolescent was managing to cope with difficult family situations. For example, in the PE 1 session, the
family was discussing the adolescent’s difficulty negotiating the communication impasse between her parents. In response, and at several points through the task environment, the therapist highlighted the difference between the parents’ impasse and the adolescent’s personal relationship with her father. She said, for example, “But what goes on between your Mom and him is separate from what goes on between you and him.”

The therapist in the PE 1 session also made statements acknowledging the difficult position that the adolescent must endure as a result of the family turmoil:

“But, it’s pretty hard to be a teenager in that situation. To be living at home with someone who’s upset all the time. And so you’re kind of between, it sounds like a really good, nice person who is upset a lot of the time and then your Dad, with whom it sounds like you have a fair bit of conflict.”

In the same event, the therapist said,

“So it’s just boring to you. See, I’m not you. I’m not inside your skin. The way you’re describing it, it sounds like it would be painful. But it sounds like it doesn’t bother you.”

Likewise, in PE 2, the therapist clarified the adolescent’s personal perspective when the mother attempted to label the daughter’s feelings, as illustrated here:

M: I know that she gets frustrated with me when I get upset.

Th: Is that true? Is it hard for you to see your mom upset all the time?

D: Yeah, I guess.

In the positive engagement cases, the therapist initiated a conversation about a topic that was likely to be difficult or taboo for the adolescent to bring up. For example, PE 1, the therapist said,
“Tell me if-- I’m just throwing out ideas here. I may be right, I may be wrong. Do you have any kind of sense of loyalty to your mom and you don’t want to betray that by going to see your dad?”

In PE 2, the therapist said,

“And you know, it would be okay for you to talk to your dad about your feelings about her [father’s girlfriend] about how she came up to you and, you know, and that really bothered you. You know, she was kind of coming up to you in the bowling alley and, I don’t know. That would be up to you. It wouldn’t be inappropriate to do that.”

Finally, one of the more interesting interventions involved the therapist’s attempt to support adolescent autonomy. This was conveyed by challenging the parent to relinquish control to her daughter over certain decisions that had a direct impact on the adolescent’s life. For example, in PE Family 1:

Th: Well, you know, you’re telling her she [daughter] has to.

M: (Interrupts) It’s his birthday. It’s his birthday.

Th: But still, even so, it really needs to be her choice. You can facilitate it, but I wouldn’t make her do it. Do you want to go over there on his [father’s] birthday?

D: I don’t know.

Building awareness of systemic issues (BASI) included the therapist’s attempts to consolidate the issues raised by both the adolescent and the parent in an effort to establish a shared sense of purpose. Therapist behaviors that were represented in this element included (a) efforts to elicit perspectives from all family members regarding a specific
topic in order to gain a more complete understanding of the problem, (b) indicating that the issues under discussion were, indeed, a family experience, (c) asking the parent to fill in the gaps of the adolescent’s response in order to encourage understanding, and (d) making reference to a family goal or a problem for discussion based on its relevance and interest to everyone.

In both PE sessions, family members discussed the change in family structure subsequent to the fathers’ departure from the home. In several instances, the therapists acknowledged the changed family structure, noting that the adjustment was having an impact on all members. In PE 1, the therapist said,

“That’s a very good point. When your family kind of changes, some of the old traditions come to an end, and you do have to develop new traditions. Something special between the two of you [mother and daughter] that you do.”

In PE 2, the following exchange took place:

Th:  So how did this week go?
D:  Umm. Different?
Th:  Well I mean-- Your goal really has been to become a different kind of family now. So, how did any of it go?

Moreover, in each positive engagement session, the therapists acknowledged the difficulty of the family adjustment on the teen by offering a different perspective on the situation as well as discussing the impact of change on other family members. For example, the PE 1 therapist noted, “

Not that you know of. You just don’t feel like it [visiting with father]. I’m wondering, you know, I suspect that this isn’t his wanting, his missing you and
not seeing you is probably more than just to bug your Mom. I think that he probably does genuinely miss you. I know he isn’t the perfect Dad, none of them are….”

Still later:

“Because you know, I think it might go a long way in terms of him still feeling connected to you and maybe, hopefully, you can maintain your relationship. He’s always going to be your dad and, you know, no matter what. You know he’s less than perfect. They all are. Maybe he’s not in every way the dad that you’d like him to be.”

The PE 2 therapist said,

“But, in any case, it sounds just the way you [mother] describe it [visitation arrangements], I feel frustrated just hearing--. It sounds to me like your lives are really being compromised in some way by this court ruling that you visit with your father every Sunday, kind of whether you want to or not. Because of necessity, which I absolutely hear is a reasonable necessity, your father to have supervision; it’s really like being put into a box.”

Somewhat later, the therapist noted:

“I don’t know this man, but the way you’re describing it, it sounds like the decision isn’t made about what works for you, or what works for L____, or what works for you. It’s really kind of about what works for him and you’re having to kind of deal with that.”

*Rolling with resistance (RWR)* involved observable attempts by the therapist to resist responding negatively to the adolescent’s disengagement, to persist in obtaining
some response from the adolescent using a titrated or sensitive amount and level of questioning, to reframe the teen’s disengagement in a positive manner, speaking a calm and respectful demeanor, and explicitly discussing the adolescent’s resistance in here-and-now terms. That is, in each instance the therapist responded in a nonjudgmental manner to the teens’ negative engagement behaviors. For example, in the PE 1 session, the adolescent responded with several one word answers and displayed minimal interest in the topic by filing her nails, searching through her purse, and fidgeting with her hair and sweatshirt. On one occasion, the therapist responded by questioning the motive behind the adolescent’s response in a light-hearted manner:

Th: So are you agreeing with me just to be nice?

D: Nope.

Th: Okay. Just checking.

In PE 2, the therapist attended directly to the adolescent’s behavior, i.e. drawing on a pad of paper, by reframing the behavior as a positive coping mechanism:

“So what do you do to kind of get away from it all and kind of mentally relax a little bit? I notice that you’re good at drawing. Is that something that helps you to kind of escape a little bit? Do you do any drawing?”

Later, the therapist readdressed the adolescent’s lack of response by, again, reframing the behavior as a coping strategy rather than suggesting that the behavior was unproductive or inappropriate in therapy. In fact, the therapist used the opportunity to seek further understanding of the adolescent’s other coping strategies outside the therapy room:

“One thing that strikes me is that it seems, [older daughter], that you don’t kind of, at least here, you don’t put a lot of these things into words, that you seem to be
someone who copes by extracting yourself. That if you can be with friends or you could be with your animals, then you could get away from it a little bit.”

**Understanding the adolescent's subjective experience (UASE)**, was behavioral strategy most frequently exhibited by the therapists. This element in the task analysis reflected the therapist’s attempt to clarify the adolescent’s subjective experience in order to gain a better understanding of the teen’s unique perspective on a specific problem. To achieve this result, the therapists gave examples or offered options for the adolescent’s response, asked for clarification about what the adolescent was feeling or thinking, expanded the adolescent’s reasoning in a respectful and curious manner, offered a tentative emotional label for what the adolescent was expressing (also seeking verification of the label’s accuracy), and probed for greater elaboration in order to better understand the adolescent’s subjective experience.

An interesting therapeutic technique involved the use of what appeared to be leading questions. These leading questions were semi-structured questions in which the adolescent was offered only a few options. This structure was clearly an effort to direct some type of response from the adolescent, either in agreement or rebuttal. For example, in PE 1:

**Th:** You just don’t want to [visit with father]. I’m kind of sensing that there may be something more than just boredom or not.

**D:** Not that I know of right now.

Later in the session:
Th: So I hear that you are still open to him [father]. Catching up on your lives
so that -What would be a reasonable amount of time for you to spend with
him that wouldn’t be too boring?

D: I don’t know.

Th: An hour? Two hours?

D: Probably.

Th: Two hours.

D: Yeah, probably. Somewhere around there.

In PE Family 2:

Th: I’m thinking that [not wanting to spend time with father, but being forced
to anyway] must be hard. Five hours is a long span of time to feel that no
one’s paying any attention to you.

D: It doesn’t bother me.

Th: It doesn’t bother you. Okay. So, you just do what for five hours? Do you
read a book or--

D: Hang out, do fun stuff, it depends.

Th: How do you feel about that part?

D: Really bored.

Often, in the course of discussion, the adolescent’s response was somewhat
unclear. To aid the adolescent to express herself, the therapists in both PE sessions asked
questions in an attempt to gain a better understanding of the adolescent’s thoughts and
feelings. For example, in PE 1:
Th: Now I know that you are, you know, it’s a little boring to go over to your dad’s, and do you have any other objections to going over to your Dad’s except that it’s boring and he’s away from the rest of your life?

D: I don’t know.

Th: What would it be like for you to maybe to go over and spend an hour with him and just catch him up on what your life is like and stuff like that?

Later, the therapist asked, “What would feel right for you?” [regarding what to do about her father’s birthday]. In PE 2:

Th: So what is that [spending time with father] like? How do you handle that?

[Older daughter], you’re not telling me much about how you feel. But, when it’s over, when the five or six hours is finally over and your Mom comes back home, what are you feeling in that moment?

D: Relieved.

Th: So it’s a positive thing. Relief that he’s gone, and what else?

D: Free to do whatever I want now.

Somewhat later, the following exchange occurred:

Th: And your mom seems like she’s upset a lot of the time. And what are you feeling when you’re mom’s upset?

D: It seems like she’s the only one besides [aunt] who is still upset about the whole thing.

Th: What do you mean by that? She is the only one?
Finally, in some cases, the therapists were able to label the adolescents’ experiences, leading to a deeper understanding. For example, in PE 2, the therapist attended to the adolescent’s frustration about the family’s adjustment:

Th: So you’re really kind of wishing that this will all go away, and things could kind of go back to the way they were before?
D: Yeah.

Th: So this is kind of like a big monkey wrench in your life. It sounds like, in the past, your father was there but [he] was never really that involved with you, it was more your mom. And now you are almost seeing more of your father than you did before. Is that true?
D: Yeah.

Later in the session, the therapist deepened her understanding of the adolescent’s thoughts and feelings by labeling her responses in emotional terms:

Th: So you are worried about your mom?
D: Yeah, I guess.

In the two positive engagement sessions, both mothers used specific parental encouragement that seemed to contribute to the adolescent becoming more engaged. Throughout both PE sessions, the mothers were notably attentive to their daughter’s behaviors during the session, and generally refrained from expressing any thoughts of blame or hostility. In addition, both mothers were willing to engage in hypothetical enactments requested by the therapist. In PE 1, the mother explicitly told her daughter that she could be open during the session:
“Let me say something [daughter] . Whatever you say here, I’m not going to be offended, if you say something that’s going to hurt my feelings. Okay? It’s been bugging me that I forgot to tell you every time we come here. Whatever you say, it doesn’t offend me, it doesn’t bother me.”

In PE 2, the mother expressed genuine concern for her two daughters and their adjustment to the altered family situation:

“I feel that it’s such an inadequate, unrealistic that a four-year-old is going to... I get the “recreational purposes” visits. I can see where it’s very difficult for both of them [daughters] to like it’s normal [that] their father’s home, kind of thing. It’s not like that anymore. I would like to see it [visitation] broken up, but he refused to do that. Two and a half hours twice a week. Maybe that would be more manageable, difficult also in other respects.

Later on:

“I think that she [daughter]--, I think her friends are a good deal of support for her. I know when it was really tough, she was drawing, drawing houses. I think last week, on the computer, she would write me a little note and I would respond. We would go back and forth.”

**Examination of the NE events.** The two negative engagement events were carefully examined in total to determine whether any of the elements that were present in the positive engagement events appeared at any point during the course of the negative engagement sessions. As shown in Table 3, none of the therapist elements was present in NE 1 and two of the five therapist elements were present in NE 2. Parental support was absent in both NE sessions.
Table 3

Elements Observed in Each of the Four Events

<table>
<thead>
<tr>
<th>Elements</th>
<th>PE Events</th>
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<th>NE Events</th>
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<tbody>
<tr>
<td></td>
<td>PE 1</td>
<td>PE 2</td>
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<td>---</td>
</tr>
<tr>
<td>Parental Support</td>
<td>X</td>
<td>X</td>
<td>---</td>
</tr>
</tbody>
</table>

Note: STC = Structuring Therapeutic Conversation; FA = Fostering Autonomy; BASI = Building Awareness of Systemic Issues; RWR = Rolling with Resistance; UASE = Understanding the Adolescent’s Subjective Experience
In contrast to the two positive engagement session, off-topic discussion was not observed at the start of either NE session. To the contrary, in both cases, within the first two to three minutes, the discussion quickly moved to an important topic, about which the family members were notably concerned. For example, in NE 3, the therapist’s introductory statement immediately directed family members to discuss the son’s decision about whether he would be attending therapy and how the past week had been. The father responded that he would let his son talk because the therapist had indicated in the last session that, perhaps, he (the father) talked too much. In fact, heated topics were discussed throughout the session, with little reprieve for the therapist or either family member. In NE 4, the session began with the mother raising a concern on behalf of her son regarding the stigma of being diagnosed with depression and seeking mental health services. It was notable that at no time during the therapist’s response to the concerns did she directly ask the son about his concerns; rather, she focused solely on the mother’s view of the adolescent’s concerns.

Next, in the positive engagement events, the use of hypothetical enactments seemed to facilitate some communication between family members. In the NE 4 session, the therapist did not propose any such enactments throughout the entire course of the therapy session. Conversely, the therapist in NE 3 did attempt to facilitate at least two enactments between father and son. When she prompted the father to respond to the son, he answered with a lengthy diatribe regarding the son’s failure to live up to his (the father’s) expectations. Although the therapist did attempt to guide the father to use more effective methods for engaging his son, the father failed to alter his behavior. Also, during the session, the therapist encouraged the son to discuss his future plans with his
father. However, rather than providing space for the conversation to take place, the therapist mediated much of the discussion, such that the dialogue remained almost entirely between therapist and family members rather than between father and son.

There were no attempts to foster autonomy, or build awareness of systemic issues in the NE 3 session; rather much of the session focused on helping the son understand the father’s concerns about him. To the contrary, in the NE 4 session, the therapist spent a majority of the time emphasizing that the issues being discussed were reflective of a family problem. At one point in the session, the therapist encouraged the mother to respect her son’s decision about whether to attend therapy and requested that she refrain from punishing him as a way to coerce his participation. During this interaction between therapist and mother, the son physically changed his position and seemed to be tuning into the conversation somewhat more. Unfortunately, this potential for engagement was passed by. After it was suggested that the son could chose whether or not to take part in treatment, the mother began to cry and expressed concern about whether her son “will make the right choice.” Subsequently, the therapist responded by focusing more on the impact that the son’s choice to come to therapy would have on his family questioning his willingness to be of help to his mother. Thus, to the apparent detriment of the adolescent’s engagement, the therapist ignored the son’s expression of autonomy (i.e., his direct refusal to attend sessions and his disagreement about feeling depressed).

Finally, there was no evidence of the rolling with resistance element in either of the negative engagement events, nor did the therapists seek to gain a deep understanding of the adolescents’ subjective experiences. As previously stated, in both cases, the therapists tended either to focus primarily on the family experience, at the cost of
understanding the adolescent’s unique perspective on the situation, or the therapists encouraged the adolescents to consider what other family members were thinking and feeling rather than asking them for their personal reactions to what was taking place.

**Refined Model**

The comparative analysis of the two positive engagement and two negative engagement events were used to refine the original rational model of a successful engagement shift event. Figure 2 illustrates the refined model of successful engagement shift events, of which reflects the key elements that were present in both successful events. As described above, three of the six elements were present in one of the two unsuccessful change events. The six elements in the refined model were structuring therapeutic conversation, fostering autonomy, building awareness of systemic issues, rolling with resistance, understanding the adolescent’s subjective experience, and parental support. As shown in the Figure, the therapist elements did not occur in any particular sequence. The parental support element occurred adjacent to all five therapist elements. For that reason, the Figure shows bi-directional arrows.

First, in the rational model, it was anticipated that in the task environment, the adolescent would communicate his or her thoughts or feelings about the problem, goals, or tasks of therapy. This class of behavior became a source of evidence for the successful resolution in the refined model. However, the resolution was expanded to include the adolescent suggesting a solution to a problem or communicating his or her thoughts in an authentic manner.

Second, it was expected that the therapist would validate the adolescent’s reluctance to participate in therapy and encourage him or her to share these thoughts and
Figure 2

Refined Model of the Successful Engagement Shift Event

Marker
Adolescent demonstrates disengagement

Task Environment
Structuring Therapeutic Conversation
Fostering Autonomy
Building Awareness of Systemic Issues
Rolling with Resistance
Understanding Adolescent’s Subjective Experience

Parent encourages the adolescent.

Resolution
Adolescent demonstrates a positive engagement shift.
feelings with other family members. This element, called *rolling with resistance*, was found to be present in both successful events. There was one difference, however, i.e., the adolescents did not offer their thoughts on the topic voluntarily. Rather, the adolescent’s reluctance was either reframed by the therapist as a coping strategy or briefly addressed before returning to the discussion at hand.

Third, there was no evidence suggesting that the adolescents recognized some motivation for engagement. However, it was observed that the adolescents in the two successful shift events were more likely to maintain intermittent eye contact and offered more responses to questions posed by the therapist than did the adolescents in the two unsuccessful cases.

Fourth, it was expected that either the therapist or parents would offer information, support, or clarification in an effort to engage the adolescent. Indeed, the present analysis suggests that the therapists’ support of the adolescents’ autonomy, and the therapists’ attempts to better understand the adolescent’s subjective experience were evident in the two successful change events.

Finally, parental support was a factor in creating an environment for honest and open expression on the part of the adolescent. The parents’ willingness to participate in actual or hypothetical enactments, which seemed to elicit the adolescent’s thoughts and feelings about a problem, was an additional element in the task environment.

The therapists in these sessions helped the adolescents to recognize the collaborative, or systemic, nature of the presenting problem. This seemed to be an important element, but it was not used to excess in these events. That is, the teen was
shown that his or her behavior was not only a response to but also a stimulus for other family members’ behaviors.

**Triangulation with Quantitative Data.**

The quantitative data for the four cases analyzed in this investigation were inspected for their congruence with the present qualitative results. Table 4 shows the adolescents’ satisfaction scores, rated at the end of therapy. Table 5 shows the adolescents’ Depth, Smoothness, Positivity, and Arousal scores on the SEQ, which was administered immediately after the sessions analyzed here. Table 6 shows the four adolescents’ SEQ ratings of the therapist in terms of Skill, Warmth, and Trustworthiness.

The tables show that total satisfaction scores reported by the adolescents in the positive engagement events were notably higher than those reported by the adolescents in the negative events. On the other hand, the two adolescents in the successful cases had fairly similar scores on the SEQ, when compared to the two adolescents in the unsuccessful cases. Notably, the four teens’ scores tended to be lowest on the Positivity scale, which was consistent with these adolescents’ lack of engagement. The greatest difference between the successful and unsuccessful engagement cases on the SEQ was scores on the Smoothness scale, which indicated that the two adolescents who became more engaged saw the sessions as somewhat easier and smoother than did the two teens in the unsuccessful events. Interestingly, the daughter in PE1 evaluated the session as notably less valuable on the Depth scale than did the other adolescent in the positive case.

In both of the successful engagement cases, the content of the adolescents’ target complaints, listed before the therapy began, was consistent with the topics discussed during the session of interest. It is noteworthy that during both of the successful
engagement events, near the point at which the sessions shifted in a positive direction, the topic of discussion switched from a focus on adjusting to the fathers’ absence to how to handle situations at home (i.e., personal hygiene, completing homework, and agreeing on bed time routines). It may be that this change in topic represented a switch from a difficult topic to a topic that was perceived as either safer or more directly relevant to the adolescents’ day-to-day lives, thus resulting in increased motivation to engage in the session. It is also notable, that both adolescents in the negative engagement cases provided either no response or a minimal response on the pre-therapy Target Complaints questionnaire. The adolescent in NE2 wrote “none” three times on the questionnaire. These data suggest that, in contrast to the teens in PE1 and PE2, the adolescents who did not shift toward positive engagement had very little motivation to attend any therapy sessions whatsoever.
Table 4

Satisfaction with Therapy Data

<table>
<thead>
<tr>
<th>Event</th>
<th>Adolescent Age</th>
<th>Session Number</th>
<th>Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>PE1</td>
<td>14</td>
<td>6</td>
<td>4.20</td>
</tr>
<tr>
<td>PE2</td>
<td>12</td>
<td>3</td>
<td>5.80</td>
</tr>
<tr>
<td>NE1</td>
<td>15</td>
<td>5</td>
<td>--</td>
</tr>
<tr>
<td>NE2</td>
<td>14</td>
<td>3</td>
<td>2.20</td>
</tr>
</tbody>
</table>

*Note:* Satisfaction was rated at the end of treatment; averaged scores could range from 1 = low to 7 = high; the adolescent in NE1 did not complete the measure.
Table 5
Session Evaluation Questionnaire Data

<table>
<thead>
<tr>
<th>Event</th>
<th>Adolescent Age</th>
<th>SEQ Depth</th>
<th>Smoothness</th>
<th>Positivity</th>
<th>Arousal</th>
</tr>
</thead>
<tbody>
<tr>
<td>PE1</td>
<td>14</td>
<td>4.50</td>
<td>4.16</td>
<td>2.50</td>
<td>4.33</td>
</tr>
<tr>
<td>PE2</td>
<td>12</td>
<td>2.66</td>
<td>6.00</td>
<td>4.16</td>
<td>2.00</td>
</tr>
<tr>
<td>NE1</td>
<td>15</td>
<td>5.16</td>
<td>4.00</td>
<td>3.16</td>
<td>2.83</td>
</tr>
<tr>
<td>NE2</td>
<td>14</td>
<td>4.00</td>
<td>4.00</td>
<td>3.33</td>
<td>3.33</td>
</tr>
</tbody>
</table>

Note: SEQ scale scores were averaged so that 1 = low, 7 = high.
### Table 6

**SEQ Adolescents’ Ratings of the Therapist**

<table>
<thead>
<tr>
<th>Event</th>
<th>Adolescent Age</th>
<th>SEQ Evaluation of Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Skilled</td>
</tr>
<tr>
<td>PE1</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>PE2</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>NE1</td>
<td>15</td>
<td>7</td>
</tr>
<tr>
<td>NE2</td>
<td>14</td>
<td>7</td>
</tr>
</tbody>
</table>
Chapter IV

Discussion

Adolescent engagement in the treatment process is a critical task in conjoint family therapy (Liddle, 1995; Rubenstein, 2005), but it can be quite difficult to achieve. The purpose of this study was to develop a conceptual model of engaging a reluctant adolescent in the process of family therapy. An intensive microanalysis was conducted of a small sample of engagement shifts to refine a rational model of the change event that could be empirically tested in future research.

The initial stage of a task analysis was conducted with two successful and two unsuccessful adolescent engagement events, drawn from an archival data set of family therapy cases with low-income, at risk youth. In each event, the marker was adolescent disengagement, observed by behaviors such as showing indifference in the tasks or process of therapy, tuning out, avoiding eye contact with others in the room, giving only one word or minimal answers to questions, or declining to respond all together.

Results of the qualitative analysis indicated that the task environment, the middle phase of the change event, involved five therapist elements: (a) structuring the therapeutic conversation, (b) fostering autonomy, (c) building awareness of systemic issues, (d) rolling with resistance, and (e) understanding the adolescent’s subjective experience. These elements seemed to increase the adolescents’ motivation to engage in the process, observed by the teens’ relatively more meaningful, genuine expression of a feeling and/or a suggestion for solving the problem under discussion.

One parent element, support, was also observed in both of the positive engagement events and neither of the negative engagement events. Parental support was
observed when either (a) the parents either agreed to participate in an actual or hypothetical enactment, suggested by the therapist, with their child in order to gain a better understanding of the adolescent’s subjective experience, (b) when the parent directly encouraged the teen to respond openly to the therapist’s questions, or (c) when the parent expressed understanding and validation of the adolescent’s experience.

Review of the therapists’ and parents’ behavioral indicators in the positive engagement cases reveals marked consistency with various behavioral indicators (client as well as therapist) in the two SOFTA-o (Friedlander et al., 2006a) dimensions Safety and Shared Sense of Purpose. For example, therapist indicators such as prompting honest responses and differing opinions or inquiring about a feeling/thought the adolescent is struggling to voice (fostering autonomy), and using off-topic discussions to build rapport and taking the focus off the adolescent after multiple attempts to elicit a response (Structuring the Therapeutic Conversation), are consistent with SOFTA-o therapist contributions to Safety Within the Therapeutic System, which include “Therapist helps clients to talk truthfully and not defensively with each other,” and “Therapist changes the topic to something pleasurable or non-anxiety arousing when there seems to be tension or anxiety” (p. 279). Furthermore, the behavioral indicators for Building Awareness of Systemic Issues are consistent with several of the observable therapist behaviors on the Shared Sense of Purpose Within the Family dimension (e.g. “Therapist emphasizes commonalities among clients’ perspectives on the problem or solution”) (p. 280). In terms of the parental element in the present model, behavioral indicators of support are consistent with SOFTA-o client observable behaviors in the Safety Within the
Therapeutic System dimension, i.e. “Client encourages another family member to ‘open up’ or to tell the truth” (p. 273).

Two of the elements discovered in the positive engagement events were also observed in one of the negative events (NE2): Fostering Autonomy and Building Awareness of Systemic Issues. It may be that the elements from both successful events that were not present in NE2 are the crucial elements for facilitating a successful resolution. On the other hand, although these two elements were observed in NE2, the potential positive impact on the adolescent may have been negated by subsequent interactions with either the therapist or parent (i.e., shortly after fostering autonomy, the therapist in PE2 encouraged the teen to “make the right choice”). Interestingly, NE1 was the only one of the four families that dropped out of treatment, and the only case that did not contain any of the elements in the refined model.

A set of quantitative data were examined to determine the degree to which they were consistent with elements in the refined model, inasmuch as triangulation of self-reported data sources contributes to the validity of qualitative results. In considering these data, it is important to note that their validity is questionable, given the adolescent clients’ resistance to attending the therapy sessions. However, there are some consistencies that are worth noting. First, the lack of pre-therapy target complaint data from the NE1 and NE2 adolescents, compared to the complete lists made by the other teens, was consistent with the determination of negative versus positive engagement shifts. That is, the two adolescents who did not shift toward engagement apparently saw little or no purpose for attending therapy in the first place, an attitude that is likely to have contributed to their refusal to engage in the process in the selected session. Interestingly, one of these teens
(NE1) listed “communication” as his (only) target complaint, and he rated it “6” on a 10-point scale of current distress, indicating that he did have some interest in the outcome of therapy. However, he may have felt that there was too much emphasis being placed on his involvement, and not enough on his father’s contribution to the communication problem, or that hope about resolving the communication problems diminished as therapy progressed.

All four adolescents had low Positivity scores, consistent with the difficulty that they were appearing to have in the session. Yet, the satisfaction scores at the end of therapy clearly showed that the NE1 and NE2 adolescents had a notably less positive experience in therapy than did the PE1 and PE2 adolescents. These data support the inference that a positive engagement shift was actually made by these adolescents.

Finally, all four adolescents’ post-session ratings of the therapists’ qualities were generally positive. It was expected that the teens who shifted towards engagement would have somewhat more positive ratings than the other two teens. Interestingly, the adolescent in NE1, whose session showed no positive therapist or parent elements whatsoever, rated the therapist as highly as possible, i.e., 7s on all three semantic differential scales. This result suggests that the reason for his disengagement was not due to negative feelings toward the therapist.

Comparison with Previous Research

The purpose of this discovery-oriented exploratory analysis was to extend the literature in a meaningful way. The study focused on the engagement of adolescents, who are most often brought to treatment by their parents and tend to resist the therapeutic process, especially when they feel blamed for the family’s difficulties.
The original rational model was developed based on the literature on engaging adolescents in treatment and three specific previous studies. First, a task analytic investigation of family members’ shift from disengagement to sustained engagement in problem solving with each other (Friedlander et al., 1994) suggested that the successful resolution to a disengagement impasse consisted of 5 steps. In the first step, the therapists encouraged the clients to express their personal contributions to the impasse. Similarly, the therapists in the present study structured the conversation in a way that seemed to facilitate dialogue between family members and achieve a greater understanding of the adolescents’ subjective experiences. In the second and third steps of Friedlander et al.’s “sustaining engagement” study, family members were able to validate each other’s perspective on the impasse. The present analysis did not, however, find that family communication about the impasse was a major contributor to greater adolescent engagement; indeed, in none of the events did any validation occur between family members. Rather, the present analysis suggested that therapist “rolling with the resistance” may have been more influential. That is, the therapist’s reframing of the teen’s resistance seemed to be effective in prompting greater adolescent engagement in the task environment. That is, the therapists’ interventions in the two successful events were more consistent with the fourth step in Friedlander et al.’s sustaining engagement model, by virtue of validating and accepting the resistance. In the present cases, it was unclear whether the adolescent or other family members developed any new understanding about the teen’s resistance to the therapy process.

It is noteworthy, however, that there are critical differences between Friedlander et al.’s (1994) study of sustaining engagement and the engagement change events
analyzed in the present study. That is, the focus of Friedlander et al.’s study was to understand how family members, who were disengaged from each other, began collaborating in problem solving on a specific topic. In the present study, by contrast, the focus was elements that contributed to greater adolescent engagement in the therapy process in general. Thus, it is quite likely that differences in the nature of the change events under study accounted for the observed differences.

Interestingly, the PE1 teen’s engagement behavior appeared to be episodic in nature. That is, her engagement did not last the entirety of the session; rather, the adolescent reverted back to observable disengagement behaviors after approximately 10 minutes of engagement. Conversely, once the teen the PE2 became engaged in the therapy process, she appeared to remain engaged through the remainder of the session. In this way, it is possible that, despite differences in the present study and Friedlander et al.’s (1994) study of sustaining family engagement, the consistencies may represent behaviors that are likely to not only elicit an adolescent’s engagement, but also may serve to sustain his or her engagement as well.

Second, Diamond et al. (1999) examined therapist alliance-building behaviors said to be involved in overcoming an impasse with adolescents in family therapy. The authors found that the impasse could be resolved by the therapist (a) attending to the adolescent’s experience, (b) orienting the teen to the collaborative nature of therapy, (c) helping the teen formulate personally meaningful goals, (d) presenting oneself as the adolescent’s ally, (e) challenging control and contingency beliefs, and (f) addressing issues of honesty, trust, and confidentiality in therapy. Specifically, these five therapist
strategies were observed more extensively in five cases in which alliance improved than in the five cases in which it did not improve.

The results of the present study indicated that the therapists in the successful cases also attended to the adolescent’s experience and that this element, which was not present in either negative engagement case, was likely important in facilitating engagement. However, neither the successful nor the unsuccessful therapists appeared to present themselves as an ally, nor did they try to formulate meaningful personal goals with the adolescent. Rather, these therapists focused more on orienting the adolescents to the collaborative nature of therapy, i.e., by building their awareness of systemic issues. The therapists also challenged the teens’ control and sense of agency by fostering autonomy more extensively in the positive engagement sessions than in the negative ones.

The third relevant study was Coulehan et al. (1998), who found that to transform family members’ view of the presenting problem (from intrapersonal to interpersonal), (a) family members shared their constructions of the problems, interpersonal aspects of the problem were highlighted, and exceptions to the problem were recognized; (b) parents mentioned positive attributes about the problem child, the contribution of family history or structure were recognized, and the family strengths associated with change were identified; and (c) family members expressed hope for the possibility of change. Although the nature of Coulehan et al.’s change event differed from adolescent engagement, it was expected that parents’ mention of positive attributes about the teen, addressing interpersonal aspects of the problem, or expressing hope for the possibility of change would be present in the successful engagement events.
None of the elements in Coulehan et al.’s (1998) model seemed to contribute to an adolescent engagement shift in the present study. However, it was evident that the present parents’ willingness to (a) voice support by encouraging the adolescents to express themselves openly, and (b) to engage in a family enactment, actual or hypothetic, was an important element in the two successful events. By doing so, these parents may have been behaving in ways that were consistent with Coulehan et al.’s model, i.e., demonstrating hope for change, acknowledging aspects of the problem in the family other than the teen, or conveying a positive outlook on the teen’s efforts to cope with the problem.

**Implications for Practice**

It was reasoned that elucidating the mechanisms that potentially improve adolescent engagement within a family therapy context would be practically meaningful for therapists who work with teens in conjoint family therapy. Results suggested that a therapist’s nonjudgmental acceptance, respect, and validation of the adolescent’s experience can positively contribute to a successful engagement shift. Demonstrating interest in the adolescent’s unique perspective on the problem and respecting his or her sense of autonomy, while promoting an awareness of the family as a unit, may be a successful strategy for promoting involvement and engagement in the therapeutic process and simultaneously deepening the therapeutic relationship. Conversely, pushing the teen to talk, confronting his or her avoidance of important material, and failure to reframe parental blame may negatively impact an adolescent’s willingness to engage in the therapy process. Thus, it seems critical to create a safe environment for the adolescent’s authentic expression. Finally, these results reflect other authors’ belief that engagement
is not a state but rather a process in family therapy (Szapocznick et al., 1996), and efforts to support adolescent involvement need to be nurtured throughout a session and, potentially, throughout treatment.

An interesting observation during the examination of the videotapes related to the possible varied functions of their disengagement. That is, the four adolescents seemed to be disengaged for a variety of reasons. The adolescent in PE1, for example, was somewhat resistant to participating in the therapy process, but perhaps only superficially. That is, although she conveyed an aloof demeanor, she was generally attentive to the topic at hand, as evidenced by various intermittent comments. In this sense, her disengagement may have been merely a facade that she was hiding behind in order to avoid discussing an uncomfortable topic. Conversely, the adolescent in PE2 seemed to function much differently. She seemed most concerned about upsetting her mother, who had been struggling to cope with her husband’s recent abandonment. When the mother started to cry during the session, the adolescent looked at her briefly and then withdrew from the discussion. Clearly, the girl was sensitive to her mother’s grief and wanted to avoid discussing this painful topic so as not to further upset her mother. The adolescent in NE1 was caught in a notably tense situation prompted by his father’s tendency to blame and challenge his decisions. If the boy’s behavior was a way to protect himself from the father, his disengagement behavior could be construed as defensive. Finally, in the last case, NE2, the adolescent was simply not interested in participating whatsoever; thus, his disengagement behavior appeared to be more avoidant in nature.

On the other hand, any family member’s disengagement may simply result from boredom, anxiety, or depression. The quality and “feel” of the disengagement behavior
involves inferences about an adolescent’s reason for pulling back from the therapeutic process. Thus serious consideration needs to be given to the function of adolescent behavior in order to select a strategy that will be most likely to facilitate an engagement shift. For example, teens who are avoidant, when pressed to comment on the impact of a family problem on themselves, may be quite reluctant to offer any “grist for the mill.” However, the same question, when posed to a teen who is defensive or superficially disengaged, may help family members see how one person’s behavior influences the behavior of others in a systemic fashion.

**Strengths and Limitations**

In terms of limitations, this discovery-oriented investigation involved a small sample of sessions from a fairly homogenous sample of therapists (all white women) and families (i.e., low income, predominantly white, single parent). Lack of diversity limits the generalizability; the engagement process may well differ for children from families of different cultures, economic groups, and family structures. Moreover, both adolescents in the successful change events were girls, whereas those in the unsuccessful events were boys. Thus, the degree to which therapist and client gender played a role in the positive engagement of the girls and the negative engagement of the boys is unknown.

Moreover, as this was only the first phase of a task analysis, the results must be interpreted cautiously. That is, the limitations are the small sample of events and the lack of empirical validation of the emerging model with a new sample of engagement events. Additionally, given the limits of clinical observation, it may be difficult to determine if the unsuccessful shift events were due to unobservable phenomenon such as attitudes or expectations.
It is quite possible that differences in the presenting problems in the four cases contributed to variations in the adolescents’ engagement behavior, so that different approaches in terms of therapeutic technique and timing were required for each case. Of note, the presenting problems in the two successful cases were father abandonment, not conflict between the teen and the parent who attended the session, but in the two unsuccessful cases, the parent-child conflicts were in fact the problem. Thus, it is not surprising that the mothers in PE1 and PE2 were more encouraging and supportive than the parents in NE1 and NE2.

Finally, this analysis was dependent on observable, in-session behavior. Thus, if a family member was holding a secret, for example, the process of engagement could have been negatively influenced. Likewise, the therapists’ inability to successfully engage two of the adolescents may have been influenced by these adolescents’ subjective sense of safety with their parents, which was not assessed in this study and was unknown to the investigator.

Unlike some other task analyses, the present study compared successful change events to unsuccessful ones and compared the qualitative results with the family members’ post-session perceptions of the therapeutic process and reasons for seeking help. Also, one therapist saw both a PE case and a NE case and used some of the same elements in both cases. The fact that these elements were apparently successful in one case but not the other supports the inference, made earlier, that the function of the disengagement may have differed for these two adolescents.
Reliability and Validity

The present discovery-oriented study is an example of change process research. In compliance with stipulations described by Moon, Dillon, and Sprenkle (1990), the design used criterion-based sampling, pattern exploration, detailed descriptions and observations, process in context, and a discovery-oriented methodology. The emphasis on practical clinical relevance addresses the call for micro-analytic research to understand important change processes that facilitate successful outcomes in conjoint family therapy (Horvath, 1994).

Reliability of the findings was supported by the repetition of elements across the successful events (and in the absence of most elements in the unsuccessful events). As recommended by Moon et al. (1990), the comparison of successful and unsuccessful events supported the validity of the emerging model. Validity was further enhanced by triangulating the qualitative results with data from other sources. In this case, the refined task environment was compared with questionnaire data (SEQ, Target Complaints, Satisfaction with Therapy) and the relevant literature, i.e., clinical literature on engaging reluctant adolescents in therapy and empirical studies by Friedlander et al. (1994), Coulehan et al. (1998), and Diamond et al. (1999).

Directions for Future Research

Given that the present study and resulting model of successful adolescent engagement in family therapy represents only the initial stage of a discovery-oriented task analysis, future research needs to be conducted to explore the validity of the refined model with a greater number of family therapy cases with adolescent members. In particular, future researchers might focus on elements that were not relevant for these
four cases, but were evident in the two studies whose focus most clearly approximated the present study, i.e., Diamond et al. (1999), and Friedlander et al. (1994).

Finally, it would be interesting to explore the function of the adolescent’s disengagement and adjust the present model accordingly. It is quite likely that different therapist and parent behaviors are needed to promote positive adolescent engagement depending on the reasons for, and the manifestation of, the adolescent’s disengagement.

**Conclusion**

There is little doubt that active efforts to engage reluctant adolescents in the process of family therapy are needed to produce positive outcomes in therapy. The context needs to be safe enough for the adolescent to express himself or herself openly, authentically, and without discouragement or retribution from other family members. The present results suggest that therapists can contribute to successful engagement by seeking to understand the adolescent’s subjective experience; fostering the adolescent’s sense of individuality, balanced with awareness of the systemic issues at hand; and by structuring therapeutic activities, such as actual or hypothetical enactments between family members. Although resistance from the adolescent can present a difficult challenge and, without doubt, be quite frustrating, the therapist’s ability to “roll with the resistance” may well be rewarded with greater adolescent engagement at a later point in the therapy session.

Clearly, other family members have an important impact on an adolescent’s motivation to engage in the therapeutic process. In particular, parental-child interactions should be studied in order to better understand the conditions that do or do not produce positive adolescent engagement. Because it is likely that adolescents choose to disengage
for a variety of reasons, discovering the elements that best foster engagement in different kinds of situations is the next step in ensuring positive therapy outcomes for adolescents and their families.
References


### Appendix A: Engagement in the Therapeutic Process behaviors in the SOFTA-o
(Friedlander et al., 2006a, 2006b)

<table>
<thead>
<tr>
<th><strong>Client Engagement</strong></th>
<th><strong>Therapist Engagement</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Client indicates agreement with the therapist’s goals.</td>
<td>Therapist explains how therapy works</td>
</tr>
<tr>
<td>Client describes or discusses a plan for improving the situation</td>
<td>Therapist asks client(s) what they want to talk about in the session</td>
</tr>
<tr>
<td>Client introduces a problem for discussion</td>
<td>Therapist encourages client(s) to articulate their goals for therapy</td>
</tr>
<tr>
<td>Client agrees to do homework assignments</td>
<td>Therapist asks client(s) whether they are willing to do a specific in-session task (e.g. enactment)</td>
</tr>
<tr>
<td>Client indicates having done homework or seeing it as useful</td>
<td>Therapist asks client(s) whether they are willing to follow a specific suggestion or do a specific homework assignment</td>
</tr>
<tr>
<td>Client expresses optimism or indicates that positive change has taken place</td>
<td>Therapist asks client(s) about the impact or value of a prior homework assignment</td>
</tr>
<tr>
<td>Client complies with therapist’s request for enactment</td>
<td>Therapist expresses optimism or notes that a positive change has taken place or can take place</td>
</tr>
<tr>
<td>Client leans forward</td>
<td>Therapist pulls in quiet client(s) (e.g. by deliberately leaning forward, calling them by name, addressing them specifically)</td>
</tr>
<tr>
<td>Client mentions the treatment, the therapeutic process, or a specific session.</td>
<td>Therapist asks if the client(s) have any questions</td>
</tr>
<tr>
<td><em>Client expresses feeling “stuck,” questions the value of therapy, or states that therapy is not/has not been helpful</em></td>
<td>Therapist praises client motivation for engagement or change</td>
</tr>
<tr>
<td><em>Client shows indifference about the tasks or process of therapy (e.g. paying lip service, “I don’t know” or tuning out</em></td>
<td>Therapist defines therapeutic goals or imposes tasks or procedures without asking the client(s) for collaboration</td>
</tr>
<tr>
<td>* Therapist shames or criticizes how clients did (or did not do) on prior homework assignment.*</td>
<td></td>
</tr>
</tbody>
</table>

*Note. Negative behaviors are indicated in italics.*