Treating Troubled Adolescents

Family Therapy:

The Treatment of Choice for Adolescents

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O chestnut tree, great rooted blossomer,
Are you the leaf, the blossom or the bole?
O body swayed to music, O brightening glance,
How can we know the dancer from the dance?

—WILLIAM BUTLER YEATS

AS YEATS (1928) suggests, to think of a part as separate from the whole, of an active subject like a dancer independent of the dance, is absurd. Treating the troubled adolescent apart from an ongoing social context is equally absurd. And yet there are therapies that do just that—treat the troubled adolescent in isolation or solely in terms of a developmental stage subject to a variety of predictable problems.

Of course there is a pediatric, or purely biological, view of adolescence: just as frogs evolve from tadpoles, so do human adults develop from adolescents. This is unarguably true, and no doubt there are physical changes that have very real psychological consequences. But this view does not take us far in trying either to understand or to treat the problems associated with troubled adolescents. We need something more. It is my contention that adolescence must be looked at as a social, rather than a biological, transformation and that this psychosocial approach is the only useful way of conceptualizing the problems and advancing the possibilities for effective treatment.

"Adolescence," then, does not exist apart from a defined social context. To appreciate this fact, we need only to consider that a hundred years ago our grandparents neither conceived of nor experienced adolescence as we do today. As Michael Rutter argues, the very idea of adolescence is a creation of the psychosocial forces at work at a given time.

Adolescence is recognized and treated as a distinct stage of development because the coincidence of extended education and early sexual maturation have meant a prolonged phase of physical maturity associated with economic and psychosocial dependence; because many of the widely held psychological

theories specify that adolescence *should* be different; because commercial interests demanded a youth culture; and because schools and colleges have ensured that large numbers of young people are kept together in an age-segregated social group (Rutter 1980).

Philippe Aries (1962) further contends that the current phenomenon of adolescence arose after World War I. At that time, he argues, young soldiers began to perceive themselves as a distinct and exploited class and subsequently longed to retain their distinction and rebelliousness as a form of protected self-differentiation, a way of distancing themselves from the older generation in control.

Thus "adolescence" has come into existence to fill a need. It is a creation of social forces at work in our culture and cannot be considered apart from its social context. Therefore, it follows that our treatment of the problems associated with adolescence must also take into consideration the social context. In other words, what is needed here is a contextual therapy. Without such a therapy we risk falling into the trap Gregory Bateson (1979) noted in his "dormitive principle": we expend our energies treating the *name* of the problem rather than the context that creates and maintains it. As therapists treating adolescents, we should not be in the business of treating the name of the difficulty—delinquency, suicidal behavior, anorexia, and so on. Instead we should be focusing our attention on the social context that is creating and maintaining the problem at hand.

Why Family Therapy?

The most powerful social therapeutic intervention for working with adolescents is family therapy. Out of the multifaceted context impinging on the adolescent—family, peers, school, idols, culture—the ecologically oriented therapist starts with the pivotal point, which is the family. The family is the social environment out of which the adolescent emerged. It is the source of the most enduring relationships and the adolescent's primary financial support. And the family frequently has the most resources with which to make changes.

Of all the social systems impinging on the adolescent, changes in the family have the most effect on the youngster. These changes include those within individual family members, such as midlife crisis, illness, and career decisions, as well as changes in family development, like children leaving home,

divorce, and parents approaching retirement. The adolescent is extremely vulnerable to such contemporary changes within the family structure.

The existence of a disturbed adolescent in a family serves as the silent canary does in a mine—it is a tipoff that there are problems in the system. In addition to being strongly affected by the family context, adolescents in turn affect the context of which they are a part. The very presence of a troubled adolescent in the family creates pressures that require the therapist to pay attention to the other family members. It is only ethical that the therapist address the problems of the context as a whole. Not to do so—to treat just the adolescent in isolation—is to fail the other family members.

What is the Power of Family Therapy?

Family therapy is an approach that transforms dysfunctional interactional patterns between significant individuals and social forces in a person's life. There are a number of reasons why this approach is particularly powerful. First, the family therapy model allows the clinician to see causation as circular as well as, at times, linear. This means that, rather than focusing always on a chain of cause and effect, the therapist has the flexibility to look at the system as a self-reinforcing circle—in some cases a vicious cycle—or as a self-feeding chain reaction. Let us take as an example a case we will explore further in the chapter on violence. In this circular system, the father comes home drunk and fights with the mother. Not surprisingly, the mother and children talk about the man behind his back and are very cold toward him. The father then feels so bad about being treated this way that he goes out and drinks, and the whole circular reaction begins again.

In some cases the therapist can deem a sequence linear and intervene appropriately—for example, by telling parents, "The two of you, by always bailing your son out of jail, are allowing him to stay a delinquent."

The power of circular causation is that the therapist can enter any part of the system, work with as many parts of the system as are available, and eventually transform the entire system. In our example of the violent family, obviously it is not enough to treat just the adolescent who is having problems because of the father's violence. By entering the system, the therapist can disrupt the circular pattern and begin to

effect change for all family members.

The family therapy approach is further distinguished by its emphasis on including all significant people and attempting to work with all of the contemporary social forces that are maintaining behavior. Unlike therapies that deal with troubled relationships in a person's life by role-playing and discussions between strangers or by discussion of the problems individually with the therapist, the focus is always on real people with whom the adolescent has difficulties as well as on a search for options to ameliorate those difficulties.

Another characteristic that makes the family therapy model so powerful is that it deals with contemporary social patterns that the therapist actually sees in operation. The great advantage here is that the therapist can work with these patterns, observe change, and gauge the success of the therapy as it goes along.

Lastly, the power of the family therapy model derives from the central notion of the multifaceted self. This is a positive, optimistic approach that regards each individual as having functional facets that can be expressed if the context changes. Thus the problem resides not in the individual but in the context, and by changing the context, different, more functional behaviors can be allowed expression. This approach is very different from diagnostic therapies which look for "illness" embedded in the individual and often confirm the self-fulfilling negative expectation that many such therapy models encourage. Family therapy believes in the perfectability of people—it believes in selves that, to paraphrase Walt Whitman, are large and contain multitudes. By transforming the context, the family therapist seeks to bring forth the best from that multitude, to enhance social interactions, and to allow people to function as capably as possible.

Why is Family Therapy Effective?

How effective is the family therapy model in treating troubled adolescents? A considerable amount of research has demonstrated it to be effective indeed. One study of anorexic children by Salvador Minuchin, Bernice Rosman, and Lester Baker (1978) found that within two to seven years follow-up, 86 percent of the adolescent patients not only were symptom free but were functioning well in terms of their

psychosocial status. Additional studies have demonstrated that compared to other forms of treatment, family therapy is equal or superior in effectiveness (Goldenberg and Goldenberg 1985).

There are a number of specific reasons why family therapy is so effective. In the first place, characteristically it leads to the rapid amelioration of problems. For example, the cases cited in this book, in which I was the primary therapist, had an overall treatment course that lasted from four to nine months. The treatment of such severe problems by other therapy models generally would have required a much longer period of time. Now, I am suggesting not that my particular therapeutic approach is unique, but rather that the model itself is especially effective. Many studies have confirmed that family therapy is a brief therapy that leads to a more rapid amelioration of symptomatology than do other treatments, such as psychoanalysis or individual therapy (Bruch 1973).

Another reason why family therapy has proven so effective is that it involves all of the significant people in the life of the adolescent. This inclusiveness means that changes tend to be maintained, because the family system itself, not just individuals, is being transformed. In other words, since all family members undergo change, their mutual changes tend to reinforce and maintain one another. In other therapies the therapist may successfully work with a patient and help bring about the emergence of greater self-awareness or functional self-expression. But often the patient then goes home only to be reprogrammed to follow the old rules of the system and to find the old counterproductive patterns re-emerging. With family therapy, however, all members are a part of the transformation, so the chances for maintaining new, more productive behaviors are much greater.

Family therapy is also more effective because it actively respects the family members by including them in the treatment process. It sees the family not as an external encumbrance that is likely to disrupt therapy, not as a necessary evil, but instead as a resource to facilitate healing. The very idea of family therapy implies confidence in the family as a place for healing. This is a radically different notion from that which informs most other therapies—that a child goes to an expert to be "fixed" because the family has failed and, once fixed, will return home somehow distanced from the old, bad family context.

One last point about the effectiveness of family therapy: it costs less. Because the course of treatment is shorter, because all family members receive treatment but are not billed individually, and because the

recidivism rate is much lower, the family therapy approach is less expensive and a more productive use of resources (Lieberman 1987).

Who Are Our Patients?

Before going on, it is important to understand just what we mean by the "troubled adolescent" population. What we do *not* mean is that *all* adolescents, as a group, are prone to serious developmental problems. However, one should keep in mind that the popular understanding of adolescence is that it is a time of deep emotional difficulty. Indeed, the psychoanalytic view has long supported this idea, seeming to regard adolescence as a period of psychosis with everyone in the appropriate age group a potential patient. "The teens are emotionally unstable and pathic," G. Stanley Hall (1904) remarks in an early work. "It is a natural impulse to experience hot and perfervid psychic states characterized by emotion." Later psychoanalytic literature continued to support the idea of adolescence as a normal period of emotional instability and disequilibration (Blos 1979).

But the latest studies contradict the notion that *Sturm and Drang* is a normal, necessary part of adolescence. Indeed, Daniel and Judith Offer (1975) found that only 20 to 30 percent of the adolescent population experience severe difficulties, and that psychic storm and stress are not at all the norm. As the Offers say, those adolescents who are in the midst of severe identity crises and turmoil are not just experiencing a normal part of growing up. What they are experiencing is abnormal, and they are in need of help. The Offers' conclusions have been supported by the work of researchers such as Michael Rutter (1980) and Stella Chess and Alexander Thomas (1984), who have done large-sample, longitudinal studies that confirm that normal adolescents are not necessarily pathic. Our patients, then, are that 20 to 30 percent of adolescents who are experiencing severe developmental problems.

What Are the Issues that Respond to Family Therapy?

This book is based on the premise that adolescents dealing with severe developmental problems respond best to a family therapy approach. There are a number of common issues that surface frequently in our patients and that need to be discussed briefly here.

IDENTITY

The quest for identity is central to the very experience of adolescence, and identity issues often represent a major area of conflict. How do we understand "identity"? Erik Erikson (1958) defined it as some central perspective and direction that each youth must forge for him or herself, "some working unity, out of the effective remnants of his childhood and the hopes of his anticipated adulthood." This view seems to presuppose that the adolescent grows up in a vacuum. But the view of family therapists in general is that not only is the adolescent struggling for identity, the other members of the family are also changing. And it is within this family context that the search for identity gets played out.

There are many possible scenarios within the family context that might provoke an identity "crisis." Is there a disabled sibling, for example, drawing off the family's emotional resources and leaving the adolescent unconfirmed? Is the child struggling for identity in a social situation in which there is a paucity of role models—for example, a family with no adult females? These are the kinds of problematic identity situations that a contextual therapist can best address, by working to create a context within the family that will nurture the transformation from child to adult, pulling together, as Erikson put it, all of those effective remnants and hopes. Family therapy offers a more complete system of therapeutic intervention. Meeting individually with an adolescent struggling with identity issues would be valuable only to the extent that the therapist might provide a substitute role model while helping the adolescent to find someone in his/her socialized environment.

The family therapy approach to issues of identity is supported by research that suggests that adolescent maturity is gained within the context of progressive and mutual definition of the parent-child relationship, with the emphasis for the adolescent placed on maintaining rather than leaving the relationship (Grotevant and Cooper 1985). The family therapist looks at actual interactions and seeks to enhance the process of identity formation by encouraging negotiation between generations. It is this process of negotiation that builds a sense of self in the adolescent; it is a process of confirming mutual respect.

In contrast to traditional conceptions of adolescence as a time for breaking the parent-child bond, family therapy seeks to bring about a gradual renegotiation of the bond "from the asymmetrical authority

of early and middle childhood toward, potentially, a peer-like mutuality in adulthood" (Grotevant and Cooper 1985). To achieve identity, Erikson (1968) says, adolescents must forge for themselves some central perspective and direction. Family therapy places its emphasis on a process of forging *with* and *together*. After all, the goal for the family is not to have the child *run* away from home, but to *walk* away from home, and in so doing maintain an appropriately supportive relationship for both generations.

SOCIAL COMPETENCE

The development of social competence is another essential task during adolescence. As Steven Brion-Meisels and Robert Selman (1984) have pointed out, this involves the "construction of new strategies for dealing with changes in interpersonal relationships and for redefining the adolescent's sense of self in the light of new societal and social realities." What better place is there for constructing such strategies and redefining one's self-image than the family. After all, the family is a laboratory for learning social skills; as such, it should become a primary resource for the therapist in addressing difficulties the adolescent may have in this area.

Family therapy can enhance social competence by transforming the adolescent's indwelling social rules of interaction. These rules are formed and maintained by the family and tend to be generalized to external situations. A good example of this extension of family rules to nonfamily social situations is the case of the adolescent who has difficulty in dealing both with siblings and with peers. In situations such as this, the problem can result from the siblings not being on an equal footing with one another within the family. There may be a coalition between one parent and one of the siblings that causes the troubled adolescent to feel incapable of successfully negotiating stable, fair, and flexible relations. The child in coalition who operates from a position of perceived power may refuse to negotiate with peers altogether, while the child subject to the coalition may feel powerless, so may not learn negotiation skills because they are seen as useless. In either case, the result is a problem in socialization in which the adolescent fails to operate competently with peers. By working within the family to redefine the indwelling social rules, the therapist can help the troubled adolescent reform his or her social self into one that is better able to approach both peers and outside power figures such as teachers or employers.

The power of family therapy to address patterns of social interaction works not only from the family

outward to the world, but also the other way around. Family therapy can intervene in the adolescent's external social environment—school, peers, community, job—to correct dysfunctional patterns that in turn affect the family. Looking at the real-world context as it affects the adolescent's social development can lead to some surprising insights. For example, the common wisdom is that employment enhances social competence in adolescents. This may be true in many cases, but recent research has found that it does not apply to all situations. Although work may improve personal responsibility and self-management, it does not necessarily build social responsibility, especially where adolescent boys are concerned. In fact, according to research by Lawrence Steinberg and associates (1982), employment may lead to diminished involvement in school, family, and peer commitments, to the development of cynical attitudes toward work, and to an increase in undesirable practices such as cigarette and marijuana smoking.

In addressing the issues of social competence, then, family therapy truly becomes an ecological therapy: it can intervene in a variety of social systems that influence adolescent behavior and that may be helping to create or maintain dysfunctional social patterns.

ADOLESCENT NARCISSISM

Narcissism in adolescence is characterized by the adolescent thinking of him or herself as the focus of family attention. For the troubled adolescent, such narcissism produces a sense of omnipotence and the feeling that one does not have to accommodate to social realities and, therefore, does not have to change.

Family therapy deals with dysfunctional narcissism by attempting to create for the adolescent the experience of developmental estrangement. This experience consists of those moments of existential realization that the adolescent is on his own and must come to terms with the fact that Mom and Dad will not always salve his wounds, come to his rescue, or bail him out of difficult life situations. In this process the job of the family therapist is to monitor and support change as it occurs. Estrangement is an important goal of family therapy in that it obliges the adolescent to change. The shedding of adolescent narcissism and the acceptance of necessary change is part of maturation, and this, of course, is what family therapy is all about—helping the child to grow up.

SEPARATION

Growing up inevitably involves separation, the process through which the adolescent leaves home to become autonomous. Separation is a central task for all adolescents but often can become extremely stressful for both the adolescent and the family. Functional separation requires leaving without alienation, and this is one of the key goals of family therapy. To encourage a functional breaking away, the therapist must help not only with the separating adolescent but also with those people from whom he is separating. All of these individuals must gradually let go and then reconnect. Family therapy works to make this aching but rewarding process a reality.

Plan of the Book

In this chapter I have laid out what I believe to be the important issues of adolescence. In the one following I develop a therapeutic approach to adolescent difficulties. In addition, I introduce and explain some of the therapeutic and assessment tools I believe especially useful, among them the four-dimensional model and the identification of the homeostatic maintainer and the process parameters for brief therapy.

The developmental issues discussed in the opening chapters manifest themselves in behavioral problems for the troubled adolescent. The clinical chapters that follow illustrate approaches for dealing with and resolving such problems. Each clinical chapter covers a serious problem of adolescence: delinquency, runaway, violence, incest, suicide, and disability. These chapters include a discussion of the problem, principles of treatment, and a clinical case. Each case study includes the following: an assessment of the family and the goals of therapy; transcripts of one or more clinical sessions, annotated to highlight adolescent issues and therapeutic approaches; a case follow-up.[1] A summary of changes in the family that led to an amelioration of the problem is also given.

The final portion of the book deals with the parents as a subsystem and covers both single-parent and couple situations illustrated by appropriate clinical case studies. The final chapter reveals the results of a two-and-a-half-year follow-up of one of these families.

Notes

1 The focus of this book is on what I identified as the turning points in therapy. Space limitations have precluded, in most cases, the inclusion of the work behind these turning points, i.e. the work with subsystems, the "chinese boxes" described in the next chapter. One important "box," or subsystem, is the therapist and the adolescent—together with siblings and maybe even peers. I believe it is important to do such work parallel to the family work. The therapist can function as a key transitional element in some of these systems until others—ideally immediate family members and peers—are seen as supportive enough to assume this function.

This subsystem therapy deals with individual issues—ones that the adolescent may not yet feel comfortable discussing with his or her parents, such as goals, motivation, and fears. *The family issues are not discussed.* If they were, then the sessions, much like safety valves, would diffuse pressure that instead is essential to derive the family to change: the therapist could undermine his or her own work with the family.

A question that always surfaces here: how to carry on a parallel therapy with the youngster—one that entails a contract for privileged information—and also work with the parents and the youngster in a context in which the youngster may be exposed? In my experience, participants have, with the exception of certain rare cases, understood that the therapist's allegiance is to a higher value, to the relationships and welfare of *all* participants. Families seem to understand the meta-rule that the therapist will move as is necessary for the safety of all