Communication in Relationships with Adolescents: Implications for Assessment and Treatment

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Ever since G. S. Hall (1904) described adolescence as a period of "storm and stress", researchers have attempted to describe the specific physiological, emotional, cognitive, and social changes that characterize this developmental period. Recently, Arnett (1999) noted that conflict with parents is a major contributor to the turbulence of this period. Adolescents' and parents' contrasting desires and experiences contribute to this increase in conflict. Adolescents' desire for independence and peer acceptance often contributes to the tendency to conform to peer group norms and influences and to resist and challenge parental directives and adult authorities. At the same time that adolescents are seeking more autonomy, many parents have difficulties relinquishing control, resulting in conflictual parent-adolescent communication pathways and potentially escalating negative consequences for all involved (Laurson, Coy & Collins, 1998; Steinberg, 1990).

While adolescents may also have difficulty communicating with their peers, siblings, teachers, and other adults, the focus of this chapter will be on communication in parent-adolescent relationships. The choice to focus on this latter relationship is partly theoretical in that adolescence is a developmental phase that requires a restructuring of the parent-child relationship in which communication plays a central role. Moreover, research has demonstrated that how parents and adolescents negotiate the developmental tasks of adolescence can take an emotional toll on mothers, fathers, and adolescents (Larson & Richards, 1994).

The evidence for the incidence of dysfunctional parent-adolescent communication is robust. Montemayor and Hanson (1985) reported that naturalistic observations revealed that conflicts between parents and their adolescent children occurred at a rate of 2 conflicts every three days, or an average of 20 per month. Paikoff and Brooks-Gunn (1991) observe that such conflicts increase in early adolescence, compared with preadolescence, with conflict intensity highest in mid-adolescence. While the number of daily conflictual episodes increases and becomes more intense, the amount of time that adolescents spend with their parents declines (Larsen & Richards, 1994). As a result, parents report that adolescence is the "most difficult stage" of their children's development (Buchanan, Eccles, Flanagan, Midgley, Feldlaufer, & Harold, 1990).

Research indicates that most parent-adolescent conflict tends to be about apparently mundane issues such as personal appearance, curfews, telephone usage, completing chores, homework, and the like (Rae, 1992). Arnett (1999) cautions, however, that such conflict between adolescents and their parents may <u>not</u> be as trivial as it seems on the surface. Such seemingly mundane conflicts may be "proxies" for concerns over more complex and sensitive issues involving trust, independence, peer influences, risky behaviors, and sexuality. Conflicts about appearance, curfew, friends, and dating may represent the parents' attempts to restrict and control their adolescent sons and daughters. The parents' agenda can come into conflict with the adolescents' yearnings for independence and peer acceptance, thus contributing to familial distress (Robin & Foster, 1989; Smetana, 1996). Several investigators have found that frequent and often intense relationship breakdowns between parents and adolescents can have severe effects contributing to the youths' externalizing and internalizing problems including delinquency, running away from home, substance abuse, adjustment disorders, low self-esteem, and depression (Adams, Gullotta & Clancy, 1985; Dekovic, 1999a; Schwartz, Dorer, Beardslee, Lavor, & Keller, 1990). On the parents' side such ongoing conflict has been found to contribute to parental dissatisfaction, depression, anger, and marital distress (Montemayor, 1983; Montemayor, 1986; Robin & Foster, 1989). Steinberg and Steinberg (1994) in a study of parents of adolescents found that 40% of parents experienced two or more of the following over the family's transition into adolescence: lowered self-esteem, diminished life-satisfaction, increased anxiety and depression. Such parental distress was worse among parents whose adolescents were actively involved in the individuation process; worse among parents whose adolescent is the same sex; worse among parents who have invested relatively less energy in work and marriage; and worse among parents who have been divorced.

Of course, <u>not</u> all youth and their parents experience adolescence as a tumultuous period of "storm and stress". In fact, most adolescents and their parents are able to satisfactorily negotiate, and even enjoy, the many challenges and developmental tasks of this period (Offer & Offer, 1975; Offer, Schonert-Reichl, 1992). Steinberg (2000) reports that studies among samples of adolescents, drawn from schools rather than clinics, revealed that around 75% of teenagers reported having "happy and pleasant"

relationships with their parents. Of the remaining 25% who evidence parent-adolescent conflict, most families had histories of family difficulties that <u>preceded</u> their child's entry into adolescence. Thus, adolescence can act as a catalyst to exacerbate long-standing familial distress (Rutter, Graham, & Chadwick, 1976). For example, conflictual parent-adolescent relationships have been found to contribute to later developmental and adjustment difficulties. Researchers have discovered an association between families characterized as being less emotionally warm, less active in resolving problems, and more conflicting in nature and adolescent delinquency (Borduin, Henggeler, Hanson, & Pruitt, 1985). Furthermore, Paternite and Loney (1980, as cited in Marshall, Longwell, Goldstein, & Swanson, 1990) report that the single best familial predictor of teenager aggressive tendencies and future aggressive-antisocial behavior were ratings of conflictual parent-child relationships.

Given the likelihood of negative consequences resulting from dysfunctional parent-adolescent relationships, the goal of treatment is to improve communication between parents and adolescents. This view is supported by Hill (1998) who proposes that effective management of conflict can promote a successful transition into adult roles and responsibilities. Investigators who have developed interventions designed to reduce parent-adolescent distress have highlighted the need to assess the nature of interpersonal conflict in order to improve parent-adolescent communication and negotiation skills (e.g., Barkley, Edwards & Robin, 1999; Robin & Foster, 1989; Szapocznik, Perez-Vidal, Brickman, Foote, Santisteban, Hervis & Kurtines, 1988). It is not clear, however, whether it is the quantity, intensity, source, perceived discrepancy, and/or emotional impact of the conflict between parents and an adolescent that contributes most to poor parent-adolescent relations. Thus, it is critical that clinicians concentrate their efforts on understanding the nature of negative familial interactions in order to develop procedures that can assess and alleviate familial conflict.

The goal of this paper, therefore, is to outline a comprehensive cognitive-behavioral family systems therapeutic approach that will be useful in guiding clinical decision making and interventions.

History of Therapeutic Approach

The space restraints of this Chapter do not permit a review of all of the diverse interventions that have been developed to address parent and adolescent communication problems. But such parent-adolescent communication problems may be only one aspect of the presenting clinical problem. The therapist must be sensitive to selecting adjunct treatments that address the many needs of all of the family members. For example, when a syndrome such as delinquent behavior, ADHD, or depression are a major source of parent-adolescent conflict, several integrative adjunctive therapeutic techniques should be employed. As Dekovic (1999b) concluded:

> An intervention that aims at only one component is <u>not</u> likely to be
> effective. Such fragmented interventions have poor long-term
> outcome and often lead to unnecessary duplication of efforts. Current
> knowledge suggests that instead of dealing with separate, independent
> and isolated problems, it is necessary to design more complex
> interventions characterized by more comprehensive and simultaneous
> efforts to alter multiple domains of functioning and to intervene in
> each of the relevant settings (e.g., family, school and peer groups).
> (p. 668)

A great deal of converging research underscores the need for a comprehensive, intensive, and integrated treatment approach in order for a clinician to effectively intervene in conflictual parent-adolescent relationships (Hengeler & Borduin, 1990; Meichenbaum, Pelham, Gnagy, & Chronis, 2000).

The need to focus on extra-familial influences, such as the adolescents' associations with deviant peers, is highlighted by the findings that from late childhood to adolescence, factors outside of the family become increasingly more predictive of adolescent problem behaviors (Dekovic, 1999b; Dishion, Andrews, & Crosby, 1995; Patterson, Reid, & Dishion, 1992). As therapists formulate intervention strategies that focus on parent-adolescent conflict, there is a need to keep in mind how these extra-familial factors not only impact the nature and course of treatment, but also the maintenance and generalization of treatment gains and adherence to treatment regimens.

The need for such a comprehensive systemic approach is underscored by the "humble" effectiveness of treatment outcome studies with parents and adolescents. Barkley, Edwards and Robin (1999) observe in their recent book on treating Defiant Teens that the overall treatment efficacy with this population is only a 35% improvement rate. In contrast, the improvement rate for parent-child interventions is 60% to 65%. In fact, the most effective interventions are for children who are less than six years of age. With these qualifying findings in mind the remaining focus of this Chapter will be on assessing and treating parent-adolescent conflict.

A number of clinical researchers have proposed psychoeducational and cognitive-behavioral training programs for alleviating parent-adolescent conflict (Barkley, Edwards, & Robin, 1999; Patterson & Forgatch, 1987; Robin & Foster, 1989; Smith, Molina, & Eggers, 1995; Steinberg, 2000). Table 1 enumerates the various program skills that have been taught to reduce parent-adolescent conflict. It is important to note, however, that simply teaching skills may in part be responsible for the unflattering efficacy of some programs; because simply teaching skills is often insufficient. Robin and Foster (1989) propose that some family members experience a performance deficit rather than a skills deficit. Family members can, at times, communicate positively, resolve conflicts, and suppress negative behaviors, but they fail to do so in conflicting and affectively-charged situations. Cognitive barriers such as dysfunctional conflict-engendering beliefs, affective barriers such as anger, and interpersonal barriers such as triangulation, cross-generation coalitions, and shifting parental coalitions (Szapocznik & Williams, 2000) often get in the way of family members responding and negotiating in a constructive fashion.

Insert Table 1 about here

Robin and Foster (Foster & Robin, 1997, 1998; Robin 1979, 1981; Robin & Foster 1984, 1989), who are considered major contributors in the field of parent-adolescent conflict, propose that family problem-solving, communication patterns, belief systems, and family structures mediate the intensity, frequency, and pervasiveness of

family conflict. Therefore, to treat family conflict they have developed a Behavioral Family System Therapeutic Approach that includes the following components:

a) educating and teaching family members how to negotiate conflict, focusing on solution-specific disputes by means of psycho-education;

b) remediating negative communication patterns and nurturing self-regulatory affective and cognitive skills such as learning how to communicate without antagonizing;

c) cognitively restructuring dysfunctional conflict-engendering beliefs and attributions such as helping families notice, catch, understand, and alter their over-determined, often exaggerated and irrational beliefs about autonomy, entitlement, ruination, fairness, perfection, respect, and intentionality;

d) engaging family members in problem-solving and behavioral contracting;

e) engaging in self-monitoring and practicing applying these skills;

f) learning to challenge their belief systems through personal experiments at home.

Such a behavioral family systems approach considers and addresses both skills and performance(motivational) deficits.

Theoretical Constructs on Which the Approach is Based

An Information-Processing Model of Communication

Theoretical frameworks are beneficial for clinicians to assist in guiding clinical decision-making and interventions. In this section we offer an information-processing model that highlights the central constructs of communication and conflict, but that is also influenced by the adolescents' emerging self-identity, the family members' cognitions, emotions, and associated communicative behaviors, as well as ecological extra-familial factors, such as peers and contextual influences such as neighborhood and workplace factors. Two central theoretical constructs, **communication** and **conflict**, are fundamental to any understanding of parent-adolescent relationships.

The nature of communication.

An analysis of how the communication process works provides a framework for understanding the nature of dysfunctional conflict-engendering communication. The goal of initiating communication is to express, either verbally or nonverbally, some form of

intention. This communicated <u>INTENT</u> will have an <u>IMPACT</u> on the recipient of the communication, and in turn, as a result of feedback from the recipient, there will be an Impact on the sender of the communication. At this most basic level, miscommunication may take place if the message sent is not the message the partner receives. Thus, communication breakdowns may arise as a result of the ongoing failure to effectively communicate intentions. For example, adolescents may miscommunicate to their parents their desires and needs for greater autonomy by skipping their curfew (Intent = need for autonomy). A parent may attribute their adolescent's skipping of curfew as being a deliberate attempt to annoy him/her (Impact = attempt to annoy), rather than perceiving it as being an inherent need of the adolescent for autonomy. Repeated instances of such miscommunication, where the Intent and Impact differ will result in an increased frequency and intensity of parent-adolescent conflict. This circular pattern can not only continue, but it can all too readily escalate.

Intent and Impact only serve as the basic goals and outcomes of communication—much more takes place. If we take a step back and delve deeper into exploring other facets of communication that exist between the communicating of Intent and the receiving of Impact, we can explore ways in which miscommunication occurs and determine a significant source of conflict. To help examine communication in greater detail, a model of communication is presented that is similar to that described in Fincham, Fernandes, and Humphreys (1993). Figure 1 displays the theoretical pathways of communication. Although one may conceptualize effective communication in terms of specific behavioral skills (i.e., appropriate voice level, eye contact, and attention), the model proposed by Fincham et al. illustrates that cognitive processes such as encoding and decoding messages, expectations, cognitive appraisal, and attributions are also critical to understand the nature of communication failures. This view is consistent with that held by Robin and Foster (1989) and others (Barkley, Edwards, & Robin, 1999) who emphasize the importance of addressing irrational beliefs to ameliorate parent-adolescent conflict.

Insert Figure 1 about here

The first cognitive step, according to the proposed model, is ENCODING. Encoding involves turning one's intent into words and conveying those words to the recipient in a way that is consistent with the intent. Encoding is influenced by one's self-identity, communication goals, cognitions such as expectations and attributions, and behaviors. Self-identity, goals, cognitions, and behaviors are shaped and tempered by such factors as one's past experiences, present mood, and current concerns. Miscommunication may result when the communicator chooses the wrong or vague words, uses contradictory tones such as sarcasm, or undermines the message intent by nonverbal behavior, for example, using folded arms or glaring.

The second cognitive process, DECODING, requires the recipient of the message to accurately interpret (Decode) the message so that it reflects the communicator's intent. As with Encoding, Decoding is influenced by one's self-identity, communicated goals, cognitions (defined above), and behaviors. Similarly, these communication functions are shaped and tempered by the recipient's past experiences, present mood, and current thoughts. Accurate Decoding may be marred by these same influences, particularly by the attributions and perceptions held by the listener.

One final comment about this communication model is that it is recursive and cyclical. It is recursive in that each of the members' of the communicating unit has a continual impact in influencing the ways in which messages are encoded and decoded. It is cyclical in that each member bi-directionally influences the behavior of the others as a repetitive interactional coercive pattern occurs, as described by Patterson and Forgatch (1987). Moreover, the history of communication experiences between the parent and adolescent, their current goals, and emotional and cognitive states, interact in determining the communication effectiveness. An example of this bi-directional and cyclical pattern was offered by Steinberg (2000) in his analysis of a parent-adolescent conflict that involves the failure of an adolescent to keep his room clean. Such noncompliance may hold very different meaning and elicit very different emotional reactions in parents and adolescents. Steinberg notes that parents may be bothered more intently by this noncompliance and are more likely to hold onto the affective aftermath because they view the issue as "right or wrong", while the teenager is likely to view the decision to not

clean up his room more dismissively, as a "personal choice and his own business". This clash of views and values, this violation of parental expectations has all the ingredients for an increasingly escalating parental-adolescent conflict. Behind the conflict is a clash of outlooks, meanings, and intents.

<u>The nature of conflict.</u>

The above-mentioned model of communication can be used to explain the context of parent-adolescent conflict. When communication fails, conflict is likely to result, and in turn, such conflict can contribute to further communication failures. A key component of the model is that conflict arises when incompatible and dysfunctional cognitions or behaviors occur along any of the theoretical communication pathways depicted in Figure 1, and thereby, thwart the communication process between parents and adolescents. For example, an adolescent may have a normative developmental goal, such as the desire to be more independent. Using the proposed model, it is apparent that this goal, though appropriate and not in itself confrontational, may result in a communication breakdown. The extent of the eventual conflict depends on the ways parents and the adolescent encode and decode communication and behaviors. When an adolescent exerts his/her autonomy by staying out past curfew, parents may decode and interpret this behavior as a "defiant act," as a personal threat to their authority, and as a deliberate attempt to provoke them. Thus, the initial autonomous-seeking behavior can result in an escalating chain reaction of hostile attributions, a violation of parental expectations, and thwarted communication goals on the part of the parent and adolescent. These are expressed through negative communication behaviors, such as arguing, followed by withdrawal. Regardless of how the negative behaviors are expressed, the end result is likely to be parent-adolescent conflict. Over time this conflict can change the parents' and adolescent's goals so that they become more self-serving and hostile, thus leading to even more ingrained and irrevocable conflict. This can lead to increased avoidance and further escalation.

A good example of this parent-adolescent distress was offered by Szapocznik and Williams (2000), who studied parent-adolescent conflict in Hispanic families in Miami. They found that the process of acculturation disrupted the family unit and led to parent-adolescent conflict. The adolescents' normal striving for independence combined with

their acculturation to the American values of individualism was in conflict with their Hispanic parents' tendencies to preserve their family's integrity by adhering to cultural values of strong family cohesion and parental control. This culturally-based conflict between individualism and independence <u>versus</u> cohesion and control resulted in ongoing parent-adolescent "battles," with accompanying attributions, expectations, and conflictual communication breakdowns. Family-based interventions were required to address these bicultural differences.

<u>Factors Influencing Communication Pathways</u>

Other components of the present information-processing communication model are the role of self-identity, cognitions, behaviors, and the ecological context in which the communication takes place. Each of these will be examined before we consider the assessment and treatment implications.

<u>Emerging self-identity.</u>

Adolescence is a period rife with new challenges. Associated with this developmental time period are rapidly changing demands in academic achievement, social relationships, independence, and intimacy. Acknowledging that this is an important transitional period, Erikson (1968) suggested that adolescence is characterized by a need to assume a unique and autonomous role in society. The extent to which an adolescent is unable to develop an acceptable "adult" identity may result in impairment in various domains, including interpersonal communication.

The study of Hispanic adolescents illustrates the general desire by adolescents to develop a self-identity that is autonomous. This process of developing autonomy may begin by adolescents increasing their affiliation with peers and by their challenging adults' directives. The adolescent's desires for autonomy and motivation to gain acceptance of others are often experienced at the expense of parental supervision. The avoidance of such adult supervision raises parental concerns about the adolescent's increased opportunities for engaging in high-risk behaviors such as substance use, sexual activity, antisocial behaviors, and other risky behaviors, many of which may co-occur (Hawkins, Catalano, & Miller, 1992; Jessor, 1991). The adolescent's expression of autonomy is often appraised by parents as being "risky" and "reckless", and can thus

result in conflict. The fear of possible negative consequences for their child's behaviors may result in the parents' reluctance to relinquish control.

In many parent-adolescent relationships, parent-adolescent conflicts are functional. That is, within the safe haven of a family an adolescent may learn negotiation and compromise strategies over time. However, the absolute imposition of a parental "will" that is contrary to their adolescent's desire for autonomy, can put a child at even greater risk for experiencing negative consequences. For example, the failure to successfully negotiate such differences of opinion may contribute to familial distress, communication breakdowns, avoidance and parent-adolescent conflict, as adolescents decode their parents' enforcement of rules as being "unfair". Research by Ary, Duncan, Duncan, & Hops (1999) found that the imposition of the parents' wills and the associated resulting conflict, led families to experience even higher levels of conflict and lower levels of parent-child involvement. Ary et al. further noted that these conflictual family interactions are related to adolescent association with deviant peer groups one year later. Thus, the change in self-identity associated with the transitional stage of adolescence, along with parents who absolutely impose their will on an adolescent may inadvertently inhibit the natural development of negotiation skills. Obviously, these skills are adaptive, and a failure to learn how to compromise may result in negative repercussions for the adolescent in later life.   This process highlights the need for treatment protocols of parents and adolescents to involve cognitive restructuring of conflicting beliefs and expectations.

Parent and adolescent cognitions.

Along with the emerging self-identity of adolescents, the beliefs and attributions of adolescents and their parents are integral factors in leading to miscommunication and conflict. As noted earlier, Robin and Foster (1989) proposed that irrational beliefs and attributions are central components that mediate the frequency, intensity, and pervasiveness of family conflict. According to Robin and Foster (1989) and Barkley, Edwards and Robin (1999), both parents and adolescents may develop conflict-engendering belief systems. These beliefs can color the ways participants interpret (i.e., encode/decode) information. For parents, these fixated beliefs most commonly include: the notion that their adolescent behaves intentionally and maliciously to annoy them;

expectations of perfect obedience and compliant behavior; thoughts that they should <u>not</u> give their adolescents freedom because they will abuse it and endanger their lives; feelings of self-blame for their adolescents' behaviors; and thoughts that their adolescents should appreciate all that the parents do for them.

The most common types of conflict-engendering beliefs adopted by adolescents include: feelings that their parents' restrictions are unfair and are intentionally designed to thwart them; thoughts that they should have complete autonomy and be accountable only to themselves; and thoughts that love and appreciation are associated with receiving material goods.

Research on parents' and adolescents' beliefs and attributions underscores the role that such affectively-charged cognitions play in the conflict process. For example, differences in the beliefs held by parents and adolescents about autonomy have been found to differentiate between normal and clinic-referred adolescents and their parents (Robin & Kopeke, 1990). Reed and Dubow (1997) found that adolescents' negative beliefs about their parents significantly and uniquely predicted negative communication beyond the effects of directly observed communication behavior. Grace, Kelly, and McCain (1993) reported that negative attributions by mothers and their teenage daughters contributed to the increased rate of conflict. The beliefs that the other's behavior was intentional, selfishly motivated, and blameworthy exaggerated the level of their parent-adolescent conflict.

The proposed information-processing model highlights that breakdowns in communication can contribute to such maladaptive beliefs and to distressing emotions such as anger. These, in turn, can further contribute to conflictual communication. For example, repeated errors of encoding and decoding can lead to increased negative attributions that become self-fulfilling prophecies. As both Barkley et al. (1999) and Foster and Robin (1998) highlight, interventions with parent-adolescent conflict need to address dysfunctional beliefs, changing expectations, conflict-engendering attributions, and accompanying emotions and behaviors. Thus, it is important for clinicians to understand not only the nature of the current conflict, but also the history of the conflictual relationship.

<u>Behavior.</u>

A number of researchers have highlighted the importance of both the nonverbal and behavioral features of communication (Barton & Alexander, 1981; Fincham et al, 1993; Kaslow, 1996). It is <u>not</u> only what is said, but how and when it is said that can undermine or enhance communication. Whether a message is conveyed with sarcasm or affirmation, with begrudging compliance or enthusiasm plays a critical factor in the communication process. In short, when people communicate, their words, tone, gestures, and behaviors each influence the way that their messages are interpreted (Decoded). For example, an adolescent saying to his parent, "I'll be home by 10:00 p.m." in a scoffing tone of voice while rolling his eyes conveys a completely different message than an adolescent who says, "I'll be home by 10:00 p.m." in a neutral tone of voice while making eye contact. The information processing model therefore highlights that the way messages are sent and received (Encoded / Decoded) and the various cognitive and affective factors associated with the messages contributes to the overall success of communication and to parent-adolescent conflict.

Contextual and ecological factors.

The focus of the discussion thus far has been on parents and adolescents. Researchers who have adopted an ecological developmental perspective following the lead of Bronfenbrenner (1979) have highlighted the need to consider extra-familial factors in explaining and treating parent-adolescent conflict. They highlight that a family is "nested" in an ecological context of other settings such as school, the neighborhood, and the larger cultural community. For example, research indicates that the parents' dissatisfaction with their workplace, the absence of social supports, the influence of deviant peers, the absence of after-school activities, and the absence of parent-involvement with peers and the school, have each been found to contribute to parent-adolescent conflict (Szapocznik & Coatsworth, 1999). Moreover, contextual factors such as ethnic, racial, and socioeconomic status may play a role in the nature of parent-adolescent conflict. For example, Szapocznik & Coatsworth (1999) reported that African-American, Asian-American, and minority families who raise their adolescent offspring in high-risk urban areas, are each much more likely to use authoritarian rather than authoritative parenting styles. In contrast, parents with a European and Hispanic background were more likely to employ authoritative parenting practices. Considering

Steinberg's (2000) claim of the importance parenting style has on the nature of conflict in the home, Szapocznik and Coatsworth's (1999) findings suggest that the quantity, type, or effects of conflict may differ among ethnic groups as a function of parenting styles. As McGoldrick, Giordano and Pearce (1996) highlight, there is a need to consider the family's ethnicity and other cross-domain influences in any assessment strategy and family therapy approach of parent-adolescent conflict.

<center>Methods of Assessment and Intervention</center>

Before delineating specific assessment strategies, it is necessary to identify important parameters of parent/adolescent communication. Three general classes of factors have been identified as contributing to the incidence and intensity of parent-adolescent conflict. These include characteristics of the <u>adolescent</u>, <u>parents</u>, and <u>relationship factors</u>. A brief consideration of these varied factors will provide a framework for understanding what information should be obtained in the assessment process. In considering <u>adolescent factors</u>, research indicates that parent-adolescent conflict tends to be more frequent when the following components are present: where the adolescent is experiencing early maturation (especially in adolescent daughters); where the adolescent has externalizing and internalizing problems, and related mental and physical difficulties; where the adolescent is caught up in the individuation process; where the adolescent evidences low academic achievement and associates with deviant peers; and where the adolescent experiences high exposure to stressors (Ary, Duncan, Duncan & Hops, 1979; Colten & Gore, 1991; Dekovic, 1999b; Hawkins, Catalano & Miller, 1992; Steinberg, 2000; Szapocznik & Coatsworth, 1999).

<u>Parental factors</u> such as marital status (divorce), parenting style (authoritative, authoritarian, permissive), parenting behaviors (parental involvement, supervision, monitoring), parental psychopathology (depression, substance abuse, history of antisocial behavior), and parental stressors (marital distress, job stressors that spillover into the home) have each been found to influence parent-adolescent conflict (Dekovic, 1999; Galambos, Sears, Almeida, & Kolaric, 1995; Steinberg, 1990; Steinberg, Mounts, Lamhorn, & Dornbusch, 1991). Such parental factors may have a negative impact on their children that extends beyond parent-adolescent conflict. For example, Schwartz, Dorer, Beardslee, Lavor, and Keller (1990), reported that mothers who are highly critical,

hostile, and emotionally over-involved have three times greater risk of raising a child who will develop a depressive disorder, substance abuse disorder, or conduct disorder.

In considering these parental factors there are two important observations to keep in mind. First, as Smetana and Gaines (1999) caution, most studies of parent-adolescent conflict have involved Caucasian, middle class, two-parent families. They emphasize that the meaning of conflict may be different for parents and adolescents, depending upon their ethnic, racial, and SES status. The second observation concerning parental influences is that some parental factors may prove more important than other types of factors in mediating outcome depending upon the developmental stage of the child. For example, Rey and Plapp (1990) reported that parental overprotectiveness and lack of caring occurred more frequently in children diagnosed with Oppositional Defiant Disorder and Conduct Disorder compared to a control group of children without disruptive behavior disorders. In adolescence, poor parental supervision and poor communication have been associated with oppositional and risky behaviors (Miller, Forehand, & Kotchick, 1999). Research has also demonstrated that family management styles play a key role in mediating the nature of parent-adolescent relationships and outcome. For instance, poor family management practices, especially coercive interactions, lack of parental involvement, and poor parental supervision contribute to youth's association with deviant peers and to parent-adolescent conflict (Dishion, Andrews, & Crosby, 1995; Patterson, DeBaryshe, & Ramsey, 1989; Patterson, Reid, & Dishion, 1992). Thus, parents and adolescents with conflictual relationships may be negatively reinforced by avoiding problems in the short run, but this avoidance may exacerbate problems in and out of the family system over time.

The nature of the relationship between the adolescent and his or her parents has also been found to be critical. For instance, the most intense conflicts have been found between mothers and daughters than with any other dyads (Smetana, 1996). The gender of the family members is only one background factor that influences parent-adolescent conflict. Dekovic (1999) reported that the history of the parent-adolescent relationship proved more important in influencing such outcome measures as the level of adolescent depression and self-esteem, than did the parent-adolescent interaction behaviors in specific conflict situations. Research has indicated that the level of parent attachment and

emotional closeness also plays an important role in influencing parent-adolescent conflict (Dekovic, 1999; Holmbeck, 1996, Steinberg (2000).

It is also critical to evaluate the nature of the parent-adolescent negotiation and conflict-resolution processes. For instance, Smetana and Gaines (1999) found that in about 1/3 to 1/2 of parent-adolescent conflict situations, the conflict is resolved by the adolescent submitting to the parents. In the other 1/2 to 2/3 of disagreements, the parent concedes, uses threats and punishments, compromises, seeks a mutual solution, or lets the issue go unresolved. Parents and adolescents from clinically-referred distressed families, relative to non-distressed families, have been found to have communication and negotiation skills deficits, as well as cognitive (beliefs) and emotional (anger) barriers that get in the way of their effectively resolving such conflicts (Foster and Robin, 1998). These results underscore the need for clinicians to assess the history of familial relationships, as well as the negotiation skills that occur during the current parent-adolescent conflict.

Given that dysfunctional relationships can be influenced by and affect so many aspects of the family system, it is critical to perform a comprehensive <u>functional assessment</u> prior to intervening, as enumerated in Table 2. A functional analysis (Scotti, Morris, McNeil, & Hawkins, 1996) during the assessment phase will remind clinicians to attend to key factors that may influence communication and contribute to parent-adolescent conflict, including antecedents and consequences of parent-adolescent conflict. This analysis involves obtaining information from multiple informants (parents, adolescents, siblings, peers, and teachers), through various methods. These include:

a) structured and unstructured interviews;

b) self-report measures of family functioning completed by both the parents and the adolescent;

c) naturalistic reports and self-monitoring of behavioral frequencies of home-based conflict;

d) lab-based observations of dyadic and familial interactions;

e) responses to hypothetical scenarios, as obtained from interviews and questionnaires;

f) reflective sampling (listening and reacting to audio-tapes of their observations);

g) assessment of related ecological factors.

Given the present space limitations and the fact that comprehensive reviews already exist, we will not enumerate the specific self-report measures that can be used to assess parent-adolescent conflict (see Foster and Robin, 1998 for a comprehensive review).

Insert Table 2 about here

The major focus of the assessment is to help the participants: a) specify and define as clearly as possible (operationalize) examples of the parent-adolescent conflict that brought them in; b) identify the times, antecedents, and situations when these behaviors occur; and c) consider the functions or reinforcing properties of these behaviors. As part of the functional analysis, the clinician should determine the setting events that influence the occurrence of the conflictual behaviors (who is present; where and when does the conflict occur, and over what issues); the antecedents (parental demands, poor school performance - telephone call from the principal); and the consequences (how resolved, imposition of consequences, escalation). There is also a need to map the nature of the parent-adolescent coercive cycle that Patterson and his colleagues have described (Patterson & Forgatch, 1987). Such tracking on a collaborative basis with family members not only serves assessment purposes, but it will also educate and engage the family members on how to anticipate, recognize, interrupt, and alter conflict-engendering behavioral patterns.

The functional analysis must, however, go beyond the focus on directly observable behaviors and assess, as noted in the model, the role that the parents' and adolescent's cognitions (beliefs, expectations, attributions) and feelings (motivational goals, emotional reactions) play in conflict situations. As noted, it is not only what the participants do in a conflictual situation, but also the meaning (present and past) that they ascribe to others and to their own behaviors that contributes to communication breakdowns. As we will consider, effective interventions need to target not only the

alteration in communication patterns, but also the cognitions that precede, accompany, and follow such interactions.

In summary, the assessment process needs to determine the degree to which the parent-adolescent conflict is a reflection of a skills deficit in the areas of communication, negotiation, conflict resolution, problem-solving, and parent management, and also the degree to which the parent-adolescent conflict reflects performance deficits where a variety of barriers (beliefs, expectations, attributions, dysfunctional emotions, cross-domain social influences such as peer pressure, marital distress, job dissatisfaction and the like) contribute to the parent-adolescent conflict.

The assessment process would not be complete, however, if it only focused on deficits and excesses, barriers, and stressors. The assessment process should also focus on potential strengths that family members possess, as these may prove valuable in treatment planning. These strengths may include individual, social, and extra-familial contextual factors that can be accessed and strengthened. The level of affectional ties, shared beliefs, specific talents, the degree of social supports, the readiness to change, the degree of parental involvement, the availability of social services, and other potential moderating or mediating factors should be part of the assessment process. The role of protective factors that can buffer families from negative outcomes should be built into assessment and treatment regimens.

Lastly, it should be emphasized that we do not consider assessment to be distinct from treatment. Using a detailed functional analytic approach, clinicians integrate the assessment with treatment. The focus of the assessment should be to identify behaviors and cognitions that will be targeted by the treatment. Treatment should be multifaceted and individually tailored to account for the antecedents, consequences, and setting events that influence the target behaviors (Scotti, Morris, McNeil, & Hawkins, 1996). Assessment then continues throughout treatment and progress toward treatment goals is continually monitored. Based on the ongoing functional analysis, multisystemic interventions are added, deleted, or modified, with the goal of providing the most effective treatment for the needs of the individual family.

Major Symptoms, Syndromes, and Problems Treated Using a Multifaceted Approach

The impairing nature of parent-adolescent conflict (noted earlier in this Chapter) has received attention from the Diagnostic and Statistical Manual of Mental Disorders: 4th Edition (DSM-IV) under the category of Parent-Child Relational Problems (V61.20), highlighting the need for clinical attention (American Psychiatric Association, 1994). Since parent-adolescent conflict is not a DSM-IV Axis I diagnostic category, we will view it from the perspective of a relational diagnosis of dysfunctional family patterns (Kaslow, 1996). When assessment identifies diagnosable disorders in the family members that contributes to parent-adolescent conflict, then specific assessment procedures and interventions tailored to those specific disorders should be added to the clinical regimen (as demonstrated in the case illustration below).

A number of diverse intervention programs have been developed to treat parent-adolescent conflict in the presence of comorbid psychopathology. Many of these programs target specific adolescent problems such as reducing delinquent, aggressive, and substance-abusing behaviors (Functional Family Therapy developed by Alexander and Parsons, 1982; Barton & Alexander, 1981; Multisystemic Therapy developed by Borduin, Henggeler, Hanson, & Pruitt, 1995; Henggeler & Borduin, 1990; and Strategic Therapy as implemented by Szapocznik & Kurtines, 1989; Szapocznik & Williams, 2000). Other targeted problems include adolescents with disruptive behavior disorders (Barkley, Edwarrds, & Robin, 1999; Barkley, Guevremont, Anastopoulos & Fletcher, 1992; McCleary & Ridley, 1999; Robin, 1998), depression (Kazdin & Mariano, 1998; Lewisohn, Clark, Rhode, Hops, & Seeley, 1996), and eating disorders (Foreyt, Poston, Winebarger, & McGavin, 1998; Robin, Bedway, Siegel, & Gilroy, 1996). In lieu of comorbid psychopathology and its associated problems, in addition to parent-adolescent conflict, treatment must be comprehensive and integrative. Henggeler & Borduin (1990) highlight the importance and effectiveness of treating behavior problems in children and adolescents through a multi-faceted approach, whereby, individual-, familial-, and social-systems are addressed.

The following case illustrates a comprehensive integrative approach to treating parent-adolescent communication problems and accompanying behavioral problems in a clinical setting. It conveys how a multifaceted model can guide treatment planning.

Illustrative Case of Multifaceted Treatment of Parent-Adolescent Conflict

Todd is a 14 year and 2 month old adolescent who was referred by his pediatrician because of the high-level of parental-adolescent conflict, parent-adolescent defiance, and problems associated with his diagnosis of ADHD. Todd's difficulties paying attention, constant fidgeting, low frustration tolerance, and poor peer interactions contributed to a high stress level in the home. Todd was the middle of three children and he would often get into fights with his older and younger brothers.

Initially, a detailed functional assessment was performed, and Todd and his parents were interviewed. They engaged in self-monitoring behavior and completed self-report measures. In addition, behavioral ratings were completed by Todd's teacher.

According to the parents' and teachers' report on the Connors Rating Scales (Conners, 1996; Loney & Milich, 1982; Pelham, Milich, Murphy, & Murphy, 1989) Disruptive Behavior Disorders Rating Scale (Pelham, Gnagy, Greenslade, & Milich, 1992), and the parents' reports on the Child Behavior Checklist (Achenbach & Edelbrock, 1981), Todd met the DSM-IV criteria for ADHD (combined type) and oppositional defiant disorder. Todd's behavioral difficulties were evident across situations and they were further complicated by his accompanying academic failures and peer rejection. While his oppositional behavior led to coercive parental interactions, he had not gotten into trouble with the law, nor engaged in any antisocial behaviors. His preoccupation with his computer seemed to keep him out of trouble, but not out of conflict with his parents. Todd had been treated for the last year with methylphenidate. His parents reported that while the medication "gets him through the school-day", he is a "terror to deal with" at home. Although medication ameliorated some of his disruptive behavior at school, intensive psychosocial treatment was needed to remediate maladaptive parent-adolescent interactions.

Parent-adolescent conflict was directly assessed with (1) the Issues Checklist (Prinz, Foster, Kent, & O'Leary, 1979), which measures the frequency and intensity of

specific family issues, (2) the Conflict Behavior Questionnaire (Robin & Weiss, 1980), which measures parent and adolescent communication patterns, and (3) a family session, during which the family had to negotiate and solve a familial problem (time to go to bed). The results of the assessment revealed a family in marked distress. The major issues raised on the Issues Checklist included Todd not fulfilling his responsibilities, having trouble in school and with homework, and sibling fighting. Items concerning drugs and lying were not endorsed. The Conflict Behavior Questionnaire and the family negotiation session allowed for observation of Todd and his parents' cognitions and communication behaviors. In terms of cognitions, Todd expressed that his parents are "bossy" and "nags" and they do not trust him to be alone, treating him like a "little kid". Todd's parents expressed that they feel that their son acts intentionally to annoy them and "drive us crazy", and that their son does not deserve to be trusted because he cannot take care of himself or follow directions. In addition to these cognitions, it was noticed during their discussion that each member of the family frequently interrupted the others, rarely made eye contact, had difficulty controlling their anger, and regularly wandered off-topic.

It should further be noted that Todd's mother was mildly clinically depressed, as evident on the Beck Depression Inventory. Her husband's distancing behaviors, intermittently mixed with an aggressive confrontational style, contributed to a moderately high level of marital distress.

Case Formulation/Treatment Plan

Todd's family represents a typical case that is treated using a multifaceted intervention approach. The components of the treatment included:

a) An 8-week summer treatment program (STP) (Pelham, Gnagy, & Greiner, 1994; Pelham & Hoza, 1996) for adolescents to help Todd learn to manage his ADHD symptoms, oppositionality, and anger, and to foster social skills with peers. A central component of the program was daily social skills and conflict-resolution skills training. Equally important was a daily jobs period. Todd's interest in computers provided a means to have him perform a summer job in which computer skills were necessary and in which he could engage in coached and supervised peer and adult interactions.

b) A concurrent 8-session group parent-training program that educated Todd's parents about the nature of ADHD and helped them develop better parenting skills to avoid coercive interactions. The material covered in these groups involved selected components from a number of psychoeducational and cognitive-behavioral training programs (see Table 1) (Barkley, Edwards, & Robin, 1999; Patterson & Forgatch, 1987; Robin & Foster, 1989; Smith, Molina, & Eggers, 1995). The group sessions included such topics as: understanding teen misbehavior and ADHD; reviewing the principles of behavior management; teaching parents effective problem-solving and negotiation strategies; addressing ways to deal with unreasonable beliefs and expectations; and providing strategies for disciplining and rewarding their adolescents.

c) Three parent-teenager negotiation training sessions were implemented following Todd's first 4-weeks of participation in the STPA. The negotiation training sessions involved Todd and his parents learning and practicing communication and negotiation skills. The ultimate goal of this training is to "promote developmentally appropriate communication, problem-solving, and personal responsibility" (Smith, Molina, & Eggers, 1995, p.1). These goals are achieved by having parents and their teenagers practice discussing conflictual topics, proposing solutions, evaluating suggestions, and reaching a compromise, in the presence of a clinical facilitator. Once a compromise is reached, the discussants write a contract that reflects their compromise and indicates the consequences for both abiding and violating the contract. Following each interaction, the facilitator engages the family members in a discussion of their effectiveness in negotiating. In each subsequent session, the facilitator fades his/her involvement in leading this discussion.

d) Follow-up booster sessions in which the therapist met with Todd and his parents to ensure maintenance of the skills taught, followed by meetings with Todd's parents and teachers in order to establish an individualized behavioral plan to address Todd's academic and behavioral problems at school.

The need to go beyond simply a parent management approach and a skills training program with children such as Todd was underscored in an experimental study by Barkley et al. (1992) who found that although adolescents with ADHD improved following treatment, most did <u>not</u> show significant improvement relative to the functioning of children in a control group.

The authors have experience that indicates that there is a need to directly target the parent-adolescent conflict as in the treatment plan above. But, before targeting the parent-adolescent conflict, therapists need to engage parents in the therapy process in order to reduce the high likelihood of dropouts (Foster and Robin, 1998). Szapocznik and Williams (2000) have described, from a brief strategic family therapy perspective, a variety of techniques that can be used to engage parents, to elicit their commitment, and to improve their motivation to change and remain involved. Clinicians need to be as concerned about these engagement procedures as they are about the specific skills they wish to teach (Kazdin, Holland, & Crowley, 1997). Given the recalcitrant nature of Todd's behavior, the long history of parent-adolescent conflict, and the multiple other stressors (mother's depression, father's job dissatisfaction, marital discord, Todd's ADHD and ODD, the high stress level at home with the other children and the limited social supports available to the family) there was a need to focus on the engagement processes of therapy. For example, Foster and Robin (1998) highlight the potential value of having parents discuss extrafamilial stressors, their own child-rearing experiences, "strengths" and behaviors that they would like to see continued. Clarifying the parents' misconceptions about treatment and discussing the potential benefits of treatment will nurture the hope and effort required to undertake the challenging tasks of altering the parent-adolescent pattern of interactions.

Of course, "Engagement is probably a necessary but <u>not</u> a sufficient condition for treatment success" (Foster & Robin, 1998, p. 634). After engagement was addressed, the strategy of focusing on Todd's ADHD behavior and educating his parents about ADHD and on ways to improve their parenting skills led to improvement sufficient enough that the family could now work on improving their communication and problem-solving skills (as enumerated in Table 2). The skills training program, especially the focus on ways that Todd's father could control his anger and work collaboratively with his wife, was

critical. An examination was also made of Todd's dad's conflict-engendering beliefs and attributions that acted as anger triggers. For example, the transition from viewing Todd's behavior as being intentionally motivated to viewing his behavior as a by-product of his ADHD was a major step in the therapy process. These cognitive and affective changes were then strengthened with daily practice and feedback.

The family also came together in formulating a mutual "family" plan (with the help of the therapist) to become a more active team and stay involved in helping Todd improve his school performance and further develop his computer skills.

Post Termination Synopsis

The initial task of treatment that involved skills training for Todd and psychoeducation skills training for his parents was supplemented by a plan to enhance the family's commitment and involvement in treatment by using a number of engagement procedures. The second major task of treatment focused directly on the parent-adolescent conflict after the initial high level of oppositional behavior and coercive family interactions were reduced. The third task of treatment focused on generalization training by ensuring that Todd and his parents practiced skills, anticipated possible barriers, and worked as a "team" to effect change in Todd's school (develop a parent-school recording program with behavioral contracting built in). Booster sessions were added to the treatment regimen in order to ensure maintenance of the treatment effects over time.

Research on Efficacy and Effectiveness of Multifaceted Treatment of
Parent-Adolescent Conflict

While the long-term effectiveness of this program has yet to be evaluated, parents and STPA staff completed improvement and satisfaction ratings at post treatment. These ratings indicated that all four of Todd's clinical counselors and his parents felt that he had improved in his communication and problem-solving skills. Moreover, Todd's parents indicated that their son was pleasant to interact with at post-treatment, that they were extremely satisfied with the program, and that this program was much more effective in changing their adolescent's problems than were other programs. At least for this case, the high rate of satisfaction and improvement speaks to the program's <u>effectiveness</u>.

As for the program's efficacy, although our case study does not constitute grounds that this is an empirically-supported treatment, components of this program have been empirically demonstrated elsewhere to foster significant changes. For example, conducting problem-solving communication training (teaching negotiation skills, cognitive restructuring, and practicing problem-solve skills) has been widely noted to reduce the degree of conflict in the home between parents and adolescents (Foster, Prinz, & O'Leary, 1983; Robin, 1981; Robin & Foster, 1989; Robin, Kent, O'Leary, Foster, & Prinz, 1977; Barkley, Guevremont, Anastopolous, & Fletcher, 1992). In addition, providing parents with psychoeducational training and skills training has also demonstrated to be effective in decreasing reported conflict (McCleary & Ridley, 1999).

It is difficult to provide "hard" summative evaluation data on the efficacy of various intervention programs because clinicians have advocated so many different treatment formats (see Foster and Robin, 1998, for a discussion of alternative treatment approaches). For example, some therapists have proposed initially seeing the family members alone, with co-therapists seeing the adolescent, especially when the initial level of conflict is high. Family members are seen together (Everett, 1976) only after some improvement. Some therapists have advocated seeing the family members together from the outset (Szapocznik & Williams, 2000). Other therapists have proposed that adolescents would benefit most from group treatment with other adolescents (Hall & Rose, 1987), while other therapists, such as Dishion, McCord, & Poulin (1999) have reported on the dangers of putting high-risk adolescents in the same treatment group because adolescent misbehaviors may be inadvertently exacerbated by association with deviant peers. Still other combinations of treatment formats have been proposed.

Because there are so many different approaches to the treatment of parent-adolescent conflict and because such psychosocial treatments have not been adequately evaluated, the authors have adapted the strategy of enumerating the "core task " of treatment that should be incorporated in treatment approaches of parent-adolescent conflict (see Table 3). Families seen in a clinical setting typically have a history that includes years of conflict. Thus, treatment of this conflict has to be intensive and long-term. After initial treatment, programs for maintenance and relapse prevention (booster sessions during important developmental transitions) are essential. Table 3 highlights the

variety of components that need to be addressed in the treatment of parents and adolescents, as illustrated in the case study.

Insert Table 3 about here

Future research will need to specify the algorithms that will allow for the development of standardized treatments that can be empirically validated. At this point, Dekovic's (1988) observation that single component interventions are unlikely to prove effective with parent-adolescent populations that have dysfunctional communication patterns is most appropriate. Whether those interventions focus on relationship enhancement, social skills and communication training, parent training, or family therapy in its various forms, they are likely to result in only statistical, but not clinically significant changes. More is not always better, and a simple focused intervention approach will likely prove to be inadequate. It is asserted in this Chapter that the best approach to parent-adolescent conflict involves the following components: thorough functional assessment of the nature and scope of parent-adolescent conflict; consideration of barriers and strengths to treatment; engagement of all family members in the program; maintenance of family engagement; addressing of distorted cognitions and dysfunctional communication and problem-solving skills; continual monitoring of progress; and building in relapse prevention.

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Table 1

Illustrative Skills Taught To Family Members in Therapy to Reduce Parent-Adolescent Conflict

Educate about teen misbehavior and the nature of conflict

Teach to recognize and deal with unreasonable beliefs and expectations

Improve listening and attending skills

Improve deliverance of requests, commands, transitional warnings

Teach authoritative parenting skills (warmth, involvement, firmness, consistency, nurturing adolescent independence)

Improve communication, problem-solving, negotiate solution-specific solutions

Instruct how to "notice, catch, interrupt, and alter" coercive interactions

Establish behavioral contracts

Nurture effective discipline strategies

Educate about monitoring and supervising adolescents

Instruct how to appropriately praise

Increase parent involvement in adolescent's school and after-school activities and peer associations

Improve social supports

Support parents' sense of acceptance

Table 2

Functional Analysis: Domains to Assess

<u>**Adolescent Variables**</u>
Age (early / late maturing)
Gender
Race and ethnicity
Family constellation, density of siblings, birth order
Sexual preference
Diagnosable classification and comorbidity (present / past) (age of onset)
Physical and mental health (early maturing; externalizing and/or internalizing problems)
Intellectual level
Academic performance (current / past)
Involvement in supervised after-school activities
Sense of belonging to the school
Attachment history
Peer associations (prosocial, deviant)
Talents and hobbies
Coping skills and strengths
Career plans (amount of current after-school work)
Exposure to present stressors (major stressors, daily hassles)
Experience of past stress (loss, maltreatment, victimization)
Past treatment / Services received
Motivation to change / Level of involvement

<u>**Parent Variables**</u>
Current Age and Age at which had child
Marital status (present / past)
Gender
Race and Ethnicity
Level of acculturation
SES
Highest Level of Education
Occupation, Employment status, Job satisfaction
Diagnosable disorder (present / past)
Level of marital distress
Parental stressors (financial, legal, health, burden of care)
Level of family functioning
Parenting style (authoritative, authoritarian, permissive)
Parenting behaviors (involvement, supervision, monitoring)
History of own child rearing
History of previous treatment / services
Motivation to change / Level of involvement

<u>Relationship Variables</u>

      Communication, negotiation, conflict-resolution and problem-solving skills

      Evidence of coercive process and evidence of "exceptions" (i.e., skills deficits
          versus performance deficits)

      Beliefs, attributions, expectations, dysfunctional feelings (anger) for both parent
          and adolescent

      Interpersonal skills evidence with others (generality)

      Emotional context and affective climate

<u>Ecological / Contextual Variables</u>

      Residence (neighborhood factors, crime, number of moves)

      Work stressors

      Racial stressors

      Social supports

      Peer influences on adolescent

      Possible Agency barriers (waiting list, insurance, transportation, child care)

Table 3

"Core Tasks" of Treatment with Parent-Adolescent Conflict

Establish a Therapeutic Alliance

Foster Engagement and Involvement in Treatment

Provide Psychoeducation

Nurture Hope

Teach Skills

Foster Generalization

Anticipate and Address Possible Barriers

Have Participants "Take Credit" (Self-Attributions) for changes

Conduct Relapse Prevention

Foster Maintenance of Improvement (Use Booster Sessions and Follow-through)