Attachment and Family Therapy: Clinical Utility of Adolescent-Family Attachment Research*

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The divide separating research and clinical work is narrowing. New therapies have been informed by research from specialties such as developmental psychology and developmental psychopathology. In this article, we attempt to illustrate the usefulness of research on attachment relations for family-based therapy with adolescents. We examine the clinical utility of adolescent attachment research within the context of multidimensional family therapy, an empirically supported treatment model that has incorporated developmental research, including basic research on attachment, in its assessment and intervention framework.

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Up to now the family therapy movement has done better in the area of how-to-change-it than of what-to-change. Descriptions of the creature that family therapists are out to get have been notoriously unsatisfactory. Clinicians know that there is something rustling about in the bushes, but nobody has done a good job of finding it and explaining what it is.


Foundations of Family Therapy

The interface between clinical and developmental processes has been a subject of considerable interest within the scientific and treatment communities (Rutter, 1997). Developmental theory and research have informed clinical practice, and new treatments systematically target developmental processes (see Henggeler, Schoenwald, Borduin, et al., 1998; Liddle, 2002). These therapies use knowledge about research-established risk and protective factors to inform assessment and intervention. Although exemplars exist about how to use research findings in clinical theory, model development, and practice (e.g., Liddle, Rowe, Dakof, & Lyke, 1998; Liddle, Rowe, Diamond, et al., 2000), more of this translational work needs to be done (Cicchetti & Toth, 1995; Shirk, Talmi, & Olds, 2000). As new findings emerge, and as specialties of research synthesize available empirical...
knowledge, new opportunities to mine the clinical implications of this work materialize. In the current era of systematic therapy development and treatment accountability, an accurate and clinically useful knowledge base about human development and dysfunction is more important than ever before. This article focuses on research findings in the area of adolescent-family attachment. Clinical vignettes and transcript material illustrate how research advances in this content area have been useful in our therapy development and research (Liddle, Dakof, Parker, et al., 2001; Liddle & Hogue, 2001).

It is reasonable to expect that attachment research holds promise as a source of clinical influence. The empirically established connection of solid attachment relations to developmental outcomes is widely known (Henry, Feehan, McGee, et al., 1993; Tarter, Vanyukov, Giancola, et al., 1999). Attachment offers a systemic conceptual framework about human development and dysfunction. Its tradition and content are in harmony with family therapy’s sensibilities. For instance, attachment theory and research have respected, understood, and exploited the interplay between individual and interpersonal/transactional functioning. The transgenerational perspective of attachment theory and research is another aspect of attachment and family therapy compatibility (Doane, Hill, & Diamond, 1991). Attachment theory and research on the development-enhancing attachment relationships have been used to create prevention interventions for teen problem behaviors. Studies conducted by Allen and colleagues, for instance, demonstrate how key aspects of attachment can serve as organizers for adolescent problem prevention programs (Allen, Philiber, Herrling, & Kuperminc, 1997). Other clinical applications of attachment research in clinical work are underway as well (e.g., Johnson, Maddeaux, & Blouin, 1998; Luthar & Cicchetti, 2000; Sexson, Glanville, & Kaslow, 2001). Finally, by definition and from its outset, attachment has focused on and elucidated the developmentally informative and life-long influencing parent-offspring relationship system—a core emphasis of (and similarly, a “by definition” aspect of) family therapy.

Attachment relations in the adolescent years, and the second decade of life generally, are particularly interesting. Adolescence is a time of transformation. Changes are required across many life spheres. Family relations must change dramatically. For example, adolescents need to remain connected to their parents while at the same time increasing their autonomy from their families and deepening their connection to peers of both sexes. These changes are interdependent. They occur in tandem. Autonomy does not develop in isolation; it grows in the context of a changing but still close relationship with one’s parents. These processes constitute difficult balancing acts for non-clinical samples of teens and parents. When we consider teenagers and family members who are seen in clinics, those adolescents and their parents experience serious and sometimes long-term interpersonal and familial stress, along with stress associated with negative events in extrafamilial systems such as schools, or with legal matters. For these adolescents and families, the developmental challenges are enormous.

Broadly defined, attachment reflects one’s degree of confidence that significant others, usually family members, will provide support and protection and will remain within emotional proximity (Birigen, 1994; Bowlby, 1979). The quality of the family attachment system is largely a function of the attachment relationships among family members. This means that more organized, flexible, and cohesive
families tend to be characterized by secure attachment among their members, while more distant and conflicted families tend to be characterized by avoidant and insecure attachment (Cobb, 1996). Secure attachment in adolescence is strongly related to trusting and warm relationships with one’s parents (Tacón & Caldera, 2001). Insecure adolescent attachment is associated with ambivalence and distance between the adolescent and one or both parents (Maio, Fincham, & Lycett, 2000). Parents’ attachment security matters a great deal as well. Mothers who were poorly attached to their own parents as teenagers tend to have detached and chaotic relationships with their children (Newcomb & Loeb, 1999). Generally speaking, it is the network of attachment relationships within the family, more than any single relationship, that determines the overall health or dysfunction of the family environment (Sroufe, 1988).

In this article, we focus on the dismissive form of attachment, which is highly predictive of a host of negative outcomes, including drug abuse, delinquency, and other forms of socially destructive behavior in adolescence and adulthood (see, Rosenstein & Horowitz, 1996). Dismissive attachment signifies distance from and lack of concern for interpersonal relationships. One of its origins is poor goodness-of-fit between child temperament and parental tolerance and personality (Bates, Pettit, Dodge, & Ridge, 1998).

Family therapy targets the family attachment system—the nexus of relationships within the family (Biringen, 1994; see Endnote 1, p. 472). Treatment shifts the family’s attachment system away from dismissiveness and toward greater security. This is accomplished by creating a secure base within the family. Defined as a relational atmosphere that provides family members with access to safety and validation when needed, a secure base facilitates both connectedness to the family and exploration (e.g., social relationships) outside the family (Byng-Hall, 1999). Among other things, family therapy targets observed interactions among family members as one pathway to changing attachment relationships. Attachment relationships offer a framing device for interventions. An attachment mind-set enhances a therapist’s overarching conceptual framework (i.e., assessment and corresponding intervention domains). A parent’s and adolescent’s attachment orientation is an important clue to their developmental level. Attachment style determines how the teen and parent relate to the world and how each derives meaning from external and relational events (Best, Hauser, & Allen, 1997). An attachment orientation provides a ready-made, logical, easily understandable frame within which one’s clinical work can be explained to families. In one example, an attachment framework has facilitated a therapeutic focus on the family’s relationship system rather than on individual members’ shortcomings or mistakes (Johnson et al., 1998).

WHAT IS ATTACHMENT IN ADOLESCENCE?

Although attachment in adolescence builds on attachment in childhood, and attachment styles are likely to be stable from childhood to adolescence (Weinfeld, Sroufe, & Egeland, 2000), attachment is different in adolescence than in childhood. Adolescents’ relational networks expand well beyond the family’s boundaries and into extrafamilial domains, and this influences intrafamilial attachment relationships. Problems in school, for example, impact various spheres of development, including parent-child relationships.

Some parents are not aware that a decrease in parental attention is normative. They may need to be reassured that a less frequent use of the parental safety net is developmentally appropriate in adoles-
cence (Steinberg & Silverberg, 1986). For instance, in one case the mother noted: “It seems like he doesn’t need me any more. We used to have such a great relationship. But now he only comes to me every now and then.” The therapist normalized the mother’s distress: “Adolescents want and need to be independent. But they still need their parents. It’s just that you’re needed in different ways now.” Therapy has an educative component. Often, therapists can outline these new ways of relating for parents who have difficulty making the adjustment to the adolescent’s and family’s new stage of development. Self-help books (e.g., Steinberg & Levine, 1996) can be very useful in communicating accurate, research-informed information and guidance. Although changes in parenting practices requires more than the provision of information (e.g., Schmidt, Liddle, & Dakof, 1996), bringing accurate knowledge and tailoring this knowledge into one’s change strategies creates the kind of complex intervention approach that is more likely to have success with clinical phenomena that are themselves complex and multidetermined.

A teen’s progression into a more active and autonomous role within the family has obvious treatment implications. First, therapists must regard the adolescent as a full participant in family treatment (Holmbeck & Updegrove, 1995). The adolescent’s point of view is instrumental to therapy’s launch and to its success. Facilitating teen input into all aspects of the therapy process is important. One characteristic of distant and conflicted families is a weak emotional bond between parent and adolescent. In these families, adolescents often feel that their feelings and opinions are unimportant (Allen, Moore, & Kuperminc, 1997). Concomitantly, parents tend to feel that they have little or no influence over their adolescents (Patterson, Bank, & Stoolmiller, 1990). Under these circumstances, of course, parent-adolescent communication is ineffective. Talk often focuses on squabbles about trivial events, and the poor relationship between teen and parents tends to cycle negatively with new, more difficult developmental and relational challenges. Family interventions that achieve substantive input from both adolescent and parent enable a workable therapeutic system to form. It is from this platform that the real work of therapy begins—the articulation and working of core relationship/therapeutic themes (Liddle, 2002).

**Autonomous Relatedness:** As adolescents become more active participants in their families, they also extend their network of significant relationships beyond the family (Steinberg & Silverberg, 1986). As peers become more important, increased distancing between parents and offspring is normative (Conger & Ge, 1999). Therapists must help parents interpret these events as normal, indeed important new developments for their teen. Parents who adjust their parenting styles in response to their teens’ changes are more likely to have psychologically healthy adolescents than parents who coercively attempt to constrain their adolescents’ extrafamilial involvements. Parents in this latter group place their youngsters at risk for academic problems, drug involvement, and delinquency (Gray & Steinberg, 1999). Adaptive adjustments in parenting include granting more autonomy, inviting the adolescent to participate in family decisions, and discussing parental monitoring issues in a more democratic way (Barrera, Castro, & Biglan, 1999). Although clearly there are cultural and contextual variations in these adaptive accommodations (e.g., inner-city parents tend to modify their family management styles [particularly monitoring] to a lesser extent than do suburban parents), all families must alter their
parenting styles to some extent as their children grow into adolescence.

This excerpt between a mother (Mo) and a therapist (Th) addresses the complexities of adaptation in families with changing parent-teen relationships.

**Mo:** He’s my baby. I don’t want him to grow up. I want him to be my baby.

**Th:** But he’s sixteen years old. Maybe he needs to talk to you and relate to you differently than he used to.

**Mo:** What do you mean? I’m still his mother, and he’s still my son.

**Th:** Of course, but things change when kids become teenagers. He needs some more leeway from you now. He still needs you to be there. He still needs your love and support, that’s for sure, but he’s ready to do more for himself now.

**Mo:** So it is possible for us to still have a good relationship, even though he’s different than he used to be?

**Th:** Of course.

Contrary to the myths of adolescence, the youngster’s widening social radius and desire for increasing autonomy do not preclude strong family relationships. Most adolescents report feeling close to their parents and wanting to maintain close family ties (Ohannessian, Lerner, Lerner, & von Eye, 1998). Moreover, adolescent self-esteem, psychosocial competence, peer acceptance, and school performance are associated with familial attachments (Allen, Moore, Kuperminc, & Bell, 1998).

What does change between childhood and adolescence is the degree of emotional dependency on parents (Lieberman, Doyle, & Markiewicz, 1999). As adolescents acquire the capacity for self-direction and independent thought, their attachments to parents can become sources of mutual support (Best, Hauser, & Allen, 1997). Mutuality of support signifies a bidirectional affective exchange between parents and adolescents, such that each party acknowledges and understands the other’s feelings and viewpoints. Whereas children serve mostly as recipients of family support, in adolescence relationships between parents and teens become more reciprocal (Collins, 1990). The changing relations in the family can cause stress, but they can also lead to adolescents and parents becoming support sources for one another.

In dismissive families, mutually supportive relationships are unlikely to be present. Therefore, family therapy uses the adolescent’s increasing intellectual and emotional capacities to create bidirectional relationships with parents. The presence of bidirectional and supportive relationships is one aspect of the secure base. The next vignette includes a 17-year-old boy (Adol) and his estranged father (Fa), along with the therapist (Th). It shows how treatment capitalizes on an adolescent’s ability to reciprocate parental overtures and expressions of feeling.

**Fa:** Right now, me and you are just starting to get back in tune, you know what I mean? It’s not going to happen overnight. First of all, you’ve got to feel like you can trust me to where you can come to me with anything—I don’t care how bad it may sound, I don’t care how negative it may be.

**Th:** Because you’re there for him. Tell him that.

**Fa:** I want you to be able to say to me, “Dad, I need you.” And then I look in your face and say, “Billy, I’m here for you. I’m not here for you as your friend, as your buddy. I’m here for you as your father.” I hear what you’re saying. I feel your pain. I feel it right here [pats his chest]. I
want you to understand that I'm going to be there for you. That's why I'm going through these legal problems with you because you're my son, and I love you. I can't say that I'm going to be there for you yesterday, because yesterday is already gone. But what I can say is that I'm going to be there today, tomorrow, the next day, and the next day. That's why you're with me now.

Th: What do you think about what your dad said?

Adol: I trust him. I believe everything he says. I'm there for him too. I'm going to give him my word too.

Th: You tell him then.

Adol: I say, if you're going to be there, I'm going to be there too. I'm going to cooperate. Just like you love me, I love you too. Ain't nothing going to stop us from you being my daddy or from me being your son. Like you said, we can't do nothing to help the past, but we can do something to help the future.

The developmental push for self-direction and autonomy is accomplished concurrently with changes in family relations. Relationships in the family can become destabilized as adolescents extend their social networks beyond the family (Silverberg, 1996). Healthy family functioning, in the form of the secure base, is dependent on the balance of collaboration within the family and exploration outside the family (Allen & Hauser, 1996). This dynamic interplay—a dialectical process—between collaboration and exploration has been termed autonomous relatedness (Allen & Land, 1999). Autonomous relatedness allows the adolescent to draw on (and provide) family support while still pursuing extrafamilial involvements. If autonomous relatedness is established, the adolescent begins to make significant contributions to the family. When parents not only sanction autonomous relatedness in their adolescents but also display it themselves, the teen is more likely to become a prosocial adult (e.g., employed, involved in stable interpersonal relationships; Allen & Hauser, 1996).

In the following clinical example, a 16-year-old male (Adol) confronts his mother's desire to date:

Th: So, Michael, how do you feel about your mom wanting to start dating again?

Adol: I don't like it. She's my mom, and I should be her first priority.

Mo: You are my first priority. I just want a relationship in my life now so I don't have to be alone anymore.

Th: Michael, you don't think it's possible for your mom to have a boyfriend and still be a good mother for you?

Adol: I don't know—I guess maybe she could.

Th: Well, you have friends, don't you?

Adol: Yeah.

Th: Do you think it bothers your mom that you don't spend all your time at home with her?

Adol: I guess not.

Mo: Well, it doesn't.

Th: Then couldn't it work the other way around? Couldn't your mother have a boyfriend and still be there for you?

Adol: She could, but that would be a change, a change for me.

Internalization of Disrupted Attachment as a Relational Characteristic: Dismissive family attachment networks and adolescent attachment styles often result from either attachment disruptions in the
family’s history (Kobak, 1999) or disruptions in initial attachment formation (i.e., poor goodness-of-fit between parents and young children; Allen et al., 1997). Disruptions in childhood attachment relationships are likely to be internalized as relational problems in adolescence (Thompson, 1999). Therapy addresses these relational problems in terms of the adolescent’s primary relationships with family members, as a means of changing the teen’s and family’s relational style. Changes in relational styles indicate that internalized attachment representations may have been modified, and thus the effects of prior disruptions have been reduced (Rutter & Sroufe, 2000).

When attachment style becomes internalized in adolescence, it becomes a personality characteristic that generalizes to relationships outside the family (e.g., peer relationships). Generalization of attachment style from family to peer relationships can be particularly problematic for adolescents who show an internalized dismissive attachment style. For example, teens from conflicted and detached families may search for attachment security in peer relationships (Lahey, Gordon, Loeber, et al., 1999). The peers to whom they turn are often similarly detached from their families (Burks, Dodge, Price, & Laird, 1999). Detachment from the family and other positive social institutions is associated with deviance and antisocial involvement (Rosenstein & Horowitz, 1996), especially when adolescents have joined socially detached peer groups. This segment illustrates how detachment from family plays a role in antisocial affiliations:

**Adol:** I had a dad, but he was doing his own thing, you know, so I used to have no chance of goal achievement or stuff like that. So I started off wanting to be a thug. I didn’t care what nobody told me. I started smoking weed, and then, the more I smoked weed, the more it messed my head up to get out there and get more money. When I started smoking weed I used to get greedy. I used to get money, I used to go up the street, and the boys—the big time drug dealers—they used to always see me and come sit with me, and they’d give me money when I’d get ready to leave. They used to be gamblers, so when I’d get the money from them, I’d go gamble. I used to be real lucky—that’s how I got my name, because I would always hit the big craps hand. I used to think I was bad or something.

Here is another example of a teen who lacks any type of healthy base for relationships and autonomous, adaptive functioning because of severe inconsistencies with caregivers.

**Th:** So here’s a little boy who’s seven years old, he doesn’t speak English, he comes to this city from Puerto Rico, he doesn’t know what’s going on, he meets both his parents—never met ’em before, lives in a bunch of different neighborhoods, goes to live with strangers. Boy, that was a lot. How easy do you think that was for you, as a little a little seven-year-old boy?

**Adol:** To me it was easier than it should’a been, because I didn’t really know like the mother and father routine. All I knew was, I was somewhere, and they said “Oh go here, oh go there.” You know what I’m saying, I didn’t grow up with my mom, I didn’t get taught no lessons or nothin’. I see all these people livin’ normal, and I’m like, man . . . what’s that?

**Th:** What is the mother and father routine? What is that?
Adol: You know, like you live, you grow up with your mother and father, and they teach you right from wrong and the do's and don'ts. You know, I didn't grow up like that. They ain't ever teach me no right 'n wrong.

Changing the adolescent's and family's attachment orientation may require an examination of the family's recollections and feelings about their past history together (Akister, 1998). Such examination draws upon the perspective taking and abstract thinking abilities that develop during adolescence. These advanced thinking capacities have important clinical implications for repairing the attachment network in disconnected and conflicted families. As adolescents develop abstract reasoning skills, they acquire a new sense of the 'big picture' (Chandler, 1987), including their role within the family and the events that have precipitated their own and their family's current condition. Although children are generally not capable of such an abstract analysis, adolescents' increasing ability to engage in higher levels of thinking provides an opportunity to guide a critical exploration of the past with the entire family.

In examining a family's past, it is critical that the therapist help the family to create a coherent story about what happened and how the family's attachment system may have been disrupted (Byng-Hall, 1995). Past events should be re-framed so as to focus on the family's attachment system rather than on individuals' faults or mistakes (Akister, 1998). The therapist emphasizes that exploring the past is not about blame. Formulating the secure base involves making sense of the past and of the feelings associated with it, so that all members' feelings and views about the past are voiced and understood. Parental substance abuse, hospitalization or incarceration, or health problems (Nurco, Blatchley, Hanlon, & O'Grady, 1999) are common in clinical samples of teens, and these are examples of events that may have shaped current events in powerful ways. Connecting the present with the past is an important aspect of clinical work with detached families (Diamond & Liddle, 1999).

Facilitating a certain accepting and nonjudgmental tone is key, but content is important as well. Trivial chitchat will not heal broken relational bonds. Open communication and the facilitation of a mutual and genuine responsiveness are instrumental to healing damaged relationships (Best et al., 1997; Fonagy, Target, Steele, et al., 1997; Kobak, 1999). Harsh parental confrontations and challenges can exacerbate existing conflict and resentment (Barrera et al., 1999; Rodgers, 1998). Through targeted interventions, adolescents and parents are helped to believe that it is safe to trust one another, in spite of past disappointments, conflicts, and betrayals. Teens who can discuss and conceptualize attachment experiences and relationships in ways that reflect balance, understanding, autonomy, and acknowledgment of the significance of attachment (Allen et al., 1998) have more favorable developmental outcomes across multiple domains than adolescents who do not develop this capacity.

The following vignette addresses a teen's understanding of his mother's prior alcoholism and concomitant unavailability:

Th: [to Mo] You were having a rough time at one point.

Mo: That's when I was drinking, and you [son] would never understand that. I didn't just drink for drinking. The only time I would drink was when some of that old stuff from when I was a child came up.
Th: It’s important for him to understand that. But there’s another issue about how your drinking problem affected both of you. You lost some time as mother and son, because when you’re using or drinking, you’re not always so ‘with it’. Does he understand all that now?

Mo: I don’t think so.

Th: [to adolescent] Do you know that your mom had a really hard life, Michael?

Adol: No, not really.

Mo: My mother died when I was his age, and we had to fend for ourselves. It was hard. When my mother passed away, my father walked out.

Th: [to adol] Did you know all this?

Adol: I’ve heard about it.

Mo: Every time I would think of all this, I used to drink. [to son] I’m talking to you too.

Adol: I remember. I used to wait for you at the bus stop in the morning after you’d been out all night partying. I used to be so happy when I’d see you get off that bus.

Mo: Well all that’s over. I’m back now.

Understanding the past from everyone’s perspective is a necessary step in creating the secure base (Byng-Hall, 1991). Feelings of blame, hurt, mistrust, and disappointment detour individual and relationship development (Shaw, Bell, & Gilliom, 2000). In order for the adolescent and parent to develop a developmental stage appropriate connection, these negative feelings underlying the distance in their relationship are addressed in treatment. Rumination, self-recrimination and/or blame are natural and common elements in this process. At the same time, if these themes are too plentiful and do not transform into more present and “what can we do now?” discussions, therapy can, as Haley (1976) warned some time ago, become nonproductive. Forgiveness and acceptance are important parts of the process of changing attachment relationships.

Externalizing problems provide a fertile ground on which to demonstrate the clinical relevance of attachment research. Externalizing problems are generally associated with dismissive attachment and with a history of disruptions in the family attachment system (Clark, Lesnick, & Hegedus, 1997). The effects of these disruptions illustrate how attachment problems have familial and intrapersonal and individual aspects. As an example, marital problems between parents are predictive of compromised parent-adolescent attachment relationships (Allen, Hauser, O’Connor, et al., 1996). Any disruption within the family attachment system impairs the family’s ability to provide a secure base.

Dismissive attachment reflects the absence of a coherent attachment system to facilitate normative and necessary family reorganizations associated with adolescence. The transition to adolescence stretches the family’s limits and strains its attachment system (Kidwell, Fischer, Dunham, & Baranowski, 1983). Even securely attached families experience noticeable parent-child distancing during early adolescence. Dismissive families, whose relationship systems are fragile and distant to begin with, can be severely compromised by a child’s passage into adolescence (Allen & Land, 1999). The adolescent’s push for autonomy, if not balanced by relatedness, can lead to family disruption and to drug abuse and delinquency (Silverberg & Gondoli, 1996). Parents not positively attached to their adolescents may implement power-assertive and adversarial disciplinary techniques intended to curtail antisocial adolescent
behavior (Dishion & Patterson, 1997). However, the result of these actions may be the opposite of what was planned, driving the adolescent farther away from the parent and toward like-minded (i.e., angry or oppositional) peers (Maccoby, 1992). In the face of such perceived powerlessness, particularly when the parent has made several unsuccessful attempts to reach out to the adolescent, parents become frustrated and feel ready to give up. However, just as teens who start treatment with a negative set and poor therapeutic alliance can change and become engaged in therapy (Diamond, Liddle, Hogue, & Dakof, 1999), parents who begin treatment with a pessimistic mind set and deleterious parenting practices can change as well (Schmidt et al., 1996). In these domains of therapy and change, research-derived knowledge about development and dysfunction is integrated into the therapeutic system which is informed by the ecological perspective and premises about change (Liddle, 1999).

**THERAPEUTIC INTERVENTION FOR DISMISSIVE ATTACHMENT**

**Attachment to Therapist**

Clinical research has found that productive family discussions are unlikely to occur until both the parents and the adolescent have come to trust the clinician and to believe that they can benefit from treatment (see Diamond et al., 1999). In attachment terms, family members must become securely attached to the therapist (Akister, 1998). It is helpful if both the parents and the adolescent feel that the clinician cares about them, is invested in their development, and seems willing to put forth the necessary effort to bring about meaningful and lasting change (Lindegger & Barry, 1999). A separate working alliance is established with each family member.

In our clinical model, Multidimensional Family Therapy (MDFT; Liddle, 2002; Liddle, Dakof, & Diamond, 1991), treatment’s initial phase establishes several working alliances inside and outside the family simultaneously. To build a relationship with the adolescent, MDFT uses Adolescent Engagement Interventions (AEI), which communicate basic attachment-related messages to teens, including that (a) there is something for them to gain from therapy, (b) they have a right to feel as they do, (c) the relational goals that they develop (e.g., being able to tell their parents how they feel) can be accomplished during the course of treatment, and (d) their participation is instrumental to treatment’s success. These messages all reflect secure attachment relationships, in the form of genuine interest, validation, desire for partnership, and acknowledgment of the adolescent’s crucial role in the therapeutic process. The characteristics of secure attachment relations are related to all of the messages communicated in the AEI, including trust, warmth, caring and commitment acceptance, validation of feelings, interest in the adolescent’s goals, and encouraging the adolescent to participate fully in the relationship (Allen & Hauser, 1996; Allen & Land, 1999; Woodward, Fergusson, & Belsky, 2000).

**Th:** I’m going to prove to you that I’m trustworthy, okay? I think I can do that. My hope is that when I do that with you, you will say: “Okay, I can deal with some of my issues here.” Do you know what I mean?

**Adol:** It means I can talk about what’s bothering me.

Engaging parents into treatment is accomplished through Parental Reconnection Interventions (PRI). The PRI, a module based on research (as is the AEI), structures therapy—provides a generic
therapeutic objective (something important to do with every case) and a corresponding set of behaviors to facilitate the objective’s achievement. Parents in dismissive and conflicted families are frustrated by their inability to communicate with or control their adolescents, and in some cases they are giving up entirely (Brown, 1993; Liddle, Rowe, et al., 1998). Therefore, reestablishing parental feelings of love toward, commitment to, and influence over their adolescents is essential in securing parents’ active participation in therapy. These positive parental attitudes and behaviors have all been found to reflect secure adolescent-parent attachment (Allen, Hauser, & Borman-Spurrell, 1996; Tacón & Caldera, 2001).

The PRI aims to facilitate parental feelings that are associated with secure attachment and protect against problem behaviors. Such protective parental feelings include warmth, investment, closeness, and concern (Deković, 1999; Palmer & Hollin, 2001). Fostering these feelings can involve challenging the parent’s disengagement, abdication, and readiness to give up.2 Engaging parents into treatment involves more than rekindling love and commitment toward the adolescent, however. Parents often spend significant amounts of in-session time discussing their own families of origin and other personal topics independent of the adolescent (Doane & Diamond, 1994). Research has shown that quality of parenting is significantly affected by the parent’s nonparenting adult life (e.g., Silverberg, 1996). For this reason, in addition to targeting his or her role vis-à-vis the adolescent, we focus on the parent as a separate person with his or her own life and issues (Liddle et al., 1991). Establishing a secure attachment relationship with parents involves assuring them that their own concerns and feelings can be addressed in treatment. Increasing the degree of stability and positive affect in a parent’s life may improve that parent’s interactions with his or her adolescent (Newcomb & Loeb, 1999). Furthermore, demonstrating to the parent that the therapist cares about her as a person, not just as a parent, can facilitate a secure parent-therapist relationship (Becker & Liddle, 2001). In the case example presented here, the mother is feeling lonely and overwhelmed. The reconnection process begins by helping this mother to feel connected and supported so that she can focus on helping her son.

Mo: I just feel so lonely and depressed. It’s not just Jason, it’s everything. I feel like my life is falling apart.

Th: We can deal with that here. This is about Jason but it’s about the whole family too.

Mo: Really? You can help me too?

Th: Yes. We do family counseling here, and that means helping everyone, including you.

Encouraging Autonomous Relatedness: In the context of a developing set of connections between the therapist and the parent and the therapist and adolescent, the therapist uses these relationships strategically to facilitate change. Individual sessions with adolescent and parent are mingled with joint sessions to facilitate communication and connection, and to titrate and try to transform unproductive conflict. That is, the therapist can use the attachment security established separately with each family member to create a new relationship between parent and adolescent. As this communication progresses, the security of attachment can transfer from the therapist to the family itself (Byng-Hall, 1999).

In the following example, the therapist acts as a mediator between David, a 16-year-old adolescent referred to treatment for cocaine abuse, and his parents. The
therapist knows that the family is disconnected and conflict-ridden. He interprets the adolescent’s statements and reframes them for the parents, and vice versa. Although the feelings discussed are mostly negative in nature, the therapist is successful in facilitating some degree of mediated conversation between David and his parents.

Th: Your father wants to talk about how to have a relationship with you where there is trust. Past events have eroded the trust.

Adol: I understood what he was saying, but I’m damned if I do, and I’m damned if I don’t.

Th: [to parents] Maybe each of you can talk about what the big picture is for you. Why is it so difficult to recapture a big picture that has the two of you being together?

Fa: David doesn’t even understand what the issue is. I think the bottom line is that David doesn’t understand why he’s not trusted.

Th: [to adolescent] What sort of relationship do you want with your parents now?

Adol: They want it to get closer, and I want it to get further apart.

Th: Explain to them why you feel that way?

Adol: I just don’t feel like I can trust them.

Building a secure family attachment system involves facilitating autonomous relatedness within the family (cf. Allen, Hauser, Bell, & O’Connor, 1994). Families with dismissive interactional process styles have been characterized as having an oversupply of independence and insufficient relatedness (Allen, Hauser, & Borman-Spurrell, 1996). Facilitating communication among family members, while continuing to support each person’s autonomy (e.g., gently reminding the parents that the adolescent is increasingly capable of participating in family decisions, and encouraging them to talk to the adolescent about their nonparenting adult lives) promotes movement toward autonomous relatedness. Helping families to process negative emotions, and using them to craft guiding themes for therapeutic work, is one way in which we facilitate closeness and relatedness (Liddle, 1994). In some conflicted and distant families, adolescents express a desire to “pay back” their parents for past abuse or neglect (Liddle et al., 1991). Themes of adolescent forgiveness and parental accountability can be used to draw the parent and adolescent closer together. Alliance building and therapist-facilitated attachment security create a safe environment in which the parent may feel free to explain to the adolescent, in an apologetic way, why he was emotionally or physically unavailable in the past. The adolescent, in turn, is provided an open environment in which to address his disappointment and anger toward the parent. Obviously, care must be taken to help the expression of these experiences in constructive ways. The honest and emotional atmosphere that results may help to establish connectedness while respecting each party’s viewpoint (cf. Tacón & Caldera, 2001).

The following case illustrates these principles. The adolescent, Marvin, has been court-ordered to treatment and to live with his father. Father and son have had no contact in many years. The therapist develops the theme of reconciliation and forgiveness to encourage both father and son to be open and forgiving and to begin forming a new relationship.

Th: I’ve been thinking about the things that you said. What I hear is that “if I had been there for him when he was younger, he wouldn’t be in this much trouble.” Some people might
look at your insight on this as a burden, but others might see it as a gift (which is the side I see you getting at). My question is this: What are you going to do with this insight? Can you use it to help yourself and your son?

Fa: To give myself the piece of mind, I will do my best to reverse the impression, you know. I still want him to grow up, and I still want him to be his own man, but at the same time, I have to instill in him what I’ve always wanted for him. I want to do now what I should have done five, six, seven, eight years ago. You know, I want to be able to sit him down and be able to say to him, “Look, this is your life. I love you, you’re my son, but this is your life. I can’t make your decisions for you.”

Th: This is really good that you say that. This is the kind of thing I’m going to help you with, with Marvin. It’s going to take time. It’s going to be hard sometimes, and you might get mad at me sometimes, because I’m going to ask both of you to do things you’re not used to. I’m going to ask you both to talk to each other in a new way. You are the one who’s going to be able to influence him. And it’s going to start with you listening to him and your son listening to what you just said. Do you understand?

Fa: Oh, yeah.

[Th. brings adol. into the room]

Fa: Your dad has something to ask you.

[Adol. laughs nervously but says nothing.]

Th: [to Fa] This is hard for your son.

Fa: He ain’t been able to talk to me for years. He knows that I know that I haven’t been there for him like I should. He hasn’t been able to really talk to me like he wants to, because I haven’t been there. It’s just like we’re starting over again. The only thing is, it’s not me talking to a little kid any more. It’s me talking to a young man, soon to be a young adult. I want him to understand that I don’t have anything against him for the trouble that he’s gotten into. I don’t like it, but just like I was telling her [therapist], a lot of the things that you’ve gotten into, I partially fault myself for that.

Th: Marvin, what do you think about what your dad is saying? I know you have things you want to tell him, so what do you think about what he’s saying? He’s saying a lot of good things. I know this is new for both of you, to sit and talk to each other like this, but I know you’ve got a lot to say.

Fa: Speak your mind. Tell me what you feel.

[Adol. smiles nervously, rolls his head around in a circle]

Th: What do you want to say to your dad?

Fa: Start with whatever you feel. I’m not going to get mad with you because you say something [I don’t like]. I want to find out what I need to do to make it better for you.

Th: And he also said that he wants to understand what you went through. By understanding what you went through, he’s going to understand you better, and you are going to understand him better by listening to what he just said.

[Adol. laughs nervously]

Th: Tell your dad the main things you want him to know.
Adol: The main thing I'd say is that it's probably been a father and son thing.

Th: You mean you wanted a relationship with your dad?

Adol: Yeah, because the kids, they'll be joking around, and they'll just start in on me. They'll say, "That's why you ain't got no daddy or nothing." I used to get so mad I had to leave and go somewhere else.

Th: Their teasing made you mad?

Adol: Yeah! I used to be mad, so I'd leave, and I'd just go chill in the park for a couple of hours, and I'd just think about it. I'd say, "Man, I don't know why that happened to me." And I'd say, "I don't even know where my daddy is at right now." I used to think, "I don't even got no daddy. I don't know where my daddy's at. If I died right now, he probably wouldn't even know until somebody else told him."

The father is encouraged to create a safe environment for his son's expression. The father is supported for assuming responsibility about being absent from his son's life. Within the secure atmosphere that has been created by both the therapist and father, the adolescent is helped to reveal his thoughts and feelings. These small steps are instrumental, early-stage movements in rebuilding the father-son relationship.

Changing Internalized Attachment Representations: MDFT attempts to re-weave the fabric of parent-adolescent attachment. A hallmark of the dismissive and conflicted family is negative emotion that quickly escalates out of control (Dishion & Patterson, 1997; Liddle, 1994). Persistent negativity is associated with a weak parent-adolescent attachment bond (Allen, Hauser, O'Connor, et al., 1996). In many cases, negative emotion is related to trauma and its long-term sequelae. In families with traumatic histories, chronic negativity can hide hurts and disappointments and cement emotional distance (Doane & Diamond, 1994). For instance, a teenager whose father abandoned him emotionally or physically is understandably reluctant and possibly afraid to embrace the father in the present, and may push him away with hostility and aggression. Until the fears and hurts have been discussed, chronic negativity will likely continue to impede therapeutic progress (Lindegger & Barry, 1999). Even when the therapist tries to intervene, parents and adolescents may still return to the subject of heated disagreement.

Mo: Take off those glasses until we finish talking.

Adol: I don't want to.

Mo: Take off those glasses. Take those glasses off until we're finished!

Adol: I want to leave them on.

Mo: Take those glasses off! It's not appropriate—don't do that! Take 'em off or I'll get up and take 'em off!

Adol: I had 'em on before!

Mo: Ain't no respect. Take those glasses off! [Gets up and attempts to pull the glasses off the adolescent's face]

Adol: I don't like the light in here.

Mo: [raising her voice]: Take 'em off! They're disrespectful. [to therapist] They're disrespectful to you, right?

Th: That bothers you.

Mo: Yeah, it bothers me!

Adol: I bought the glasses myself! They ain't bothering her!

Mo: Will you take those glasses off?

Ther: You're saying it bothers you.

Mo: I'm saying it's disrespectful!
When you talk to somebody, you’re supposed to talk to them through their eyes.

**Adol:** It ain’t being disrespectful. I don’t like the light in here.

**Th:** This is the kind of thing that happens at home, right? You would like him to do this thing, and the two of you get into it back and forth. Then do you give up, or what?

**Mo:** It just don’t look right.

**Adol:** It just don’t look right to her.

**Th:** So there are some things—you have your own style of dress.

**Adol:** Yeah. If she would have bought it, I’d be happy to take it off.

**Th:** So I think there are some bigger issues, and there are some smaller ones, and I think there are some things you have more control over than others, like his clothes.

**Mo:** But his clothes—I’ve gotten to the point where I don’t care what he wears. He wears what he wants to wear, ’cause he don’t go out nowhere with me. So he don’t have to wear nothing at all if he’s not going to be around me with it.

**Th:** Because you don’t like what he wears.

**Mo:** No I don’t, and I’m not going to pretend.

In an MDFT process study we referred to this pattern of spiraling negativity as the therapeutic impasse (Diamond & Liddle, 1999). In-session impasses often centered on current behavioral concerns such as household chores, parental supervision, and peer associations. If joint arguments over these sorts of issues were to begin, they could dominate the session. If the impasse was not addressed and resolved, the session would break down and therapeutic progress would stop, as it did in the above example. Successful impasse resolution was achieved by a shift intervention. The shift intervention involved three therapist-initiated changes in response to the negativity. First, the focus of conversation is changed from a behavioral to an emotional realm. Although it has cognitive and behavioral aspects, attachment is closely intertwined with emotion, such that secure attachment is unlikely in the absence of warmth and closeness (Maio et al., 2000). The negative feelings underlying the impasse need to be exposed and examined before the family’s attachment system can become more secure. Helping parents and adolescents understand each person’s experience of the other, particularly in terms of relationship problems, is the first step toward healing the relationship hurts, reframing the family’s relationship history, and developing a practical, developmentally appropriate plan to move ahead in positive ways, despite all that has come before. The following excerpt provides an example:

**Th:** So it’s not so much about what Mom did, but you got disappointed a lot, and sometimes now, when you get disappointed, you think about those things. I’m not saying you’re not angry about it, and I think that is sitting there between you and your mom. But when it comes out, it’s difficult for your mom to hear you saying, “You did this, you did that.” Doesn’t it go better when you say, “Look, I was let down sometimes; back then I didn’t trust you?”

**Adol:** It does.

Second, the focus of conversation is changed temporarily from the present to the past. Since negative family emotional states are associated with a history of conflict and traumatic events (Allen & Hauser, 1996), part of impasse resolution
involves bringing the history of the problem up for discussion. The following case example exemplifies the shift from present to past. Sixteen-year old Rita and her mother have been arguing about the fact that Rita is not working and has not been looking for a job. The therapist seizes an opportunity, in the form of a statement made by the mother, to explore why Rita is unwilling to seek help.

**Th:** Your mom wants you to get a job. I know it’s hard—you haven’t gotten a job before.

**Mo:** You can ask for help. [to therapist] Rita doesn’t ask for help with anything.

**Th:** Is there anything in the past, between the two of you, that would keep Rita from asking for help?

**Adol:** Yeah, there is.

**Th:** Tell me about it.

**Adol:** When I was younger, I used to ask for help, and no one would help me.

**Th:** So you figure it’s pointless. You’re not going to get the help, so why bother asking?

**Adol:** A lot of things that I do are connected with things that happened in the past.

**Th:** What do you mean?

**Adol:** I’m just scared I’m not going to be helped. Maybe I just need to be trusted for once. And I need to be loved, for once.

**Th:** What Rita said was powerful. She wants to be trusted. We should talk about that.

**Mo:** I agree. It was powerful.

**Th:** Can you respond to Rita?

**Mo:** I do love you, Rita. I’m sorry I haven’t been able to show you that like I should. I’ve just been under a lot of stress lately. But I always want you to know that I love you, and I will work on the trust thing.

**Adol:** Okay, and I promise to get a job and start helping you trust me. If you’re going to be a better mother, then I’m going to be a better daughter.

Formation of a secure base is facilitated if parents and adolescents understand each other’s perceptions of what happened. This is a shared task in which parents and adolescents, along with the therapist, collaborate in formulating a mutual account of the family’s history. This history details the attachment disruptions that occurred in the past, from everyone’s point of view, and how those disruptions have contributed to the current situation. Through arriving at a shared understanding of past events and how they have shaped the family’s history, parents and adolescents learn to live together in new ways. Empathy and acceptance are important ingredients in this process.

Third, the focus is shifted from aggressive emotions (e.g., anger and hostility) to an inquiry and sharing about other aspects of the relationship experiences—aspects that involve vulnerable and “soft” emotions (e.g., disappointment, regret, and abandonment). Research indicates that attachment problems are more strongly related to tender emotions than to aggressive ones (Dekovic, 1999; Palmer & Hollin, 2001). Therefore, addressing attachment problems is accomplished by attending to feelings of hurt, fear, and disillusionment. Dominant emotions such as aggression and rage are more distally associated with attachment problems, and they obscure other, more vulnerable feelings. Family members are supported in their joint expression and exploration of the events and experiences that have led to their current estrangement.
**Th:** [to Fa] Dad, what do you feel about what your son just said?

**Fa:** That was deep. It’s hard to put into words what I’m feeling right now. I know in my heart that a lot of things you’ve gotten into were because of me. Not because I did this or I didn’t do that, but mainly because I wasn’t there for you when I should have been. I don’t fault you. You’ve done the things that you felt—you got this big barrier up in front of you, and you don’t want nobody to knock that barrier down, you’ve put up this big wall. And then you’re like, “Damn, where’s my daddy at? My daddy ain’t there.” I know what you’re going through because I went through the same thing with my dad. I didn’t even know who my father was. The only way I knew who my father was was by how many kids he had, how many women he had, and how much of a player he was. That was the only thing I could tell you about your granddaddy.

**Th:** So you know how your son feels.

**Fa:** Yeah. Believe me, I know how he feels. It’s like a tape recorder—I could have sat down thirty years ago, and the same thing my son is telling me, I could have sat down and told my father. Because I know what he’s feeling—he’s feeling betrayed, he’s hurt, because there was a time when I was [stiffening] him. One minute I was there, and the next minute, “Where’s he at?” As your father, that’s my fault. I know what you feel, and I respect what you feel. I can’t change what I should have done, I can’t change what I could have done, I can’t change what I didn’t do. All I can do is to try to make things better for you from this point on, in any way that I possibly can. I know you’ve been through a lot, and I know that a lot of what you’re going through is because of me. The main thing is, I haven’t been there to listen to you. But the only thing I can tell you, son, is I love you, and I’ll be there for you.

One of our MDFT process studies teased apart this kind of in-session event. We determined the interactional characteristics, including therapist behaviors, that were associated with impasse resolution. Compared to cases of unsuccessful in-session impasse resolution, cases of successful resolution were characterized by significantly less parental power assertiveness and greater levels of openness, collaborative negotiation, and assumption of responsibility (Diamond & Liddle, 1999). When the shift intervention was successful, parents and adolescents, initially engaged in intense conflict, were now working together, respecting one another, open to suggestions from one another and from the therapist, and willing to claim responsibility for their respective roles in creating the impasse. In attachment terms, the parents and adolescents were displaying autonomous relatedness and were behaving in ways characteristic of securely attached families (cf. Allen & Hauser, 1996). Warmth, trust, and concern between parents and adolescents, all significant correlates of attachment security (Allen et al., 1998), were increasingly present in families who had successfully navigated the impasse.

In summary, MDFT addresses attachment problems in three ways. First, specialized engagement and alliance building strategies help both teenagers and parents to become securely attached to the therapist so that they are in position to play significant roles in the treatment process. Second, particular techniques and an overarching therapeutic protocol help to build attachment relationships between physically or emotionally estranged parents and adolescents, such that dis-
connection can be transformed into autonomous relatedness. Finally, shift interventions are used to access the “softer,” and at first, inaccessible feelings associated with parent-adolescent conflict and disconnection. The intervention facilitates a new process between parent and teen, one aim of which is to help them formulate a shared and coherent story about the past (part of the process of creating a platform from which participants encounter a new relationship future). Taken together, these strategies are part of a treatment protocol that aims to repair damaged attachment relationships and promote the development of a secure family base.

SUMMARY AND CONCLUSION

We sought to illustrate the clinical relevance of attachment research for treating families with adolescents. The attachment research literature was used to identify some ways in which parent-adolescent distance and conflict can be framed as attachment problems. We discussed the clinical implications of attachment research and discussed them within multidimensional family therapy, an established treatment designed to incorporate developmental research findings. We illustrated specific MDFT interventions, targeting each of the three adolescent attachment dimensions that we discussed. Finally, we presented empirical and clinical evidence that these interventions target attachment processes associated with a secure family base.

The ability of developmental psychology and developmental psychopathology to inform clinical practice relies on therapists’ knowledge of normative and non-normative processes in adolescence. Specifically, if therapists understand how attachment relationships unravel or stay healthy, their interventions can target specific mechanisms linked to positive and negative developmental outcomes.

The furor in the field about the non-interaction of research and practice has subsided. One sign of progress on this front has been in the realm addressed in this article—changes in clinical practice brought about by the incorporation of knowledge about normative and nonnormative developmental transitions. Substantive progress since Hoffman’s challenge (see epigraph of this article) is well underway.

1 In Multidimensional Family Therapy, attachment relations within the family are targeted as are relations between family members and other social institutions that have developmental influence (Liddle, 2002). A parent’s and or adolescent’s relationships with school or juvenile justice systems are routinely assessed and targeted for change. This article focuses mostly on intrafamilial attachment relations.

2 Adolescent Engagement Interventions (AEI) and Parental Reconnection Interventions (PRI) are vital parts of MDFT. This approach has defined key therapeutic operations and established them at the level of therapeutic module—protocols are written for how to engage in each aspect of work. The AEI and PRI are done simultaneously, and they are begun in the first stage of therapy. Both of these modules begin by working with the teen (AEI) and parent (PRI) alone. Although composition of the session for each of these modules is important, it is the therapeutic goals (beginning the process of reconnecting the parent and teen in a developmentally appropriate relationship, for example) that drives the therapeutic operations and decisions about session composition. Work within the AEI and PRI modules are interconnected. Work in one subsystem do-
main is used to shore up, create new opportunities, and potentiate clinical focus and work in other subsystems (see Liddle, 1995). In this regard, grandparents and siblings, as the therapeutic focus, specifics, and goals of the case dictate, are routinely included in the second stage of AEI and PRI interventions.

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