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A Qualitative Investigation of Therapists' Practices for Addressing the Parent-Adolescent Relationship

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A Qualitative Investigation of Therapists' Practices for Addressing the

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STRENGTHENING THE PARENT-ADOLESCENT RELATIONSHIP

Abstract

The parent-adolescent relationship appears to have a significant impact on the mental health of adolescents. Previous literature has identified poor attachments to be associated with adolescent mental health concerns as well as delinquent behaviors. In order to address these concerns, practitioners have utilized practices of providing safety within the therapeutic relationship as well as enhancing communication and encouraging attunement within the parent-adolescent relationship. The purpose of the study is to identify theories and approaches that practitioners find most effective when working with adolescents and their families. This was a qualitative study in which data was collected through interviews with eight family and mental health practitioners. Six major themes emerged from the data analysis: systems approach, safety and trust, respect, cultural awareness and responsiveness, emotional bond, and positive interactions. These findings highlight some of the vital approaches utilized by therapists when working with parents and adolescents. This study supports previous literature, which indicates the importance of therapists joining with the family to create safety as well as modeling healthy interactions. Implications for future research and social work practice are explored to offer therapists continued insight into practices for strengthening the parent-adolescent relationship, so as to reduce mental health concerns in adolescents.

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There are four million children and adolescents in America who have serious

mental disorders (National Alliance on Mental Illness, 2013). Among those four million,

approximately 20 percent of them receive mental health services (National Alliance on

Mental Illness, 2013). The pervasiveness of this issue is evident. These mental health

issues impair and impact the child's academic and social functioning (National Alliance

on Mental Illness, 2013). Mental health issues are affecting adolescents in numerous

ways. Poor mental health appears to be associated with delinquent behaviors and

negative relationships for adolescents (Aseltine, Gore, & Colten, 1994; Bloch & Guillory,

2011; Green, Myrick, & Crenshaw, 2013; Hair, Moore, Garret et. al, 2008; Scharf &

Mayseless, 2008; Sheridan, Peterson, & Rosen, 2010; Videon, 2002). Furthermore,

studies have indicated that poor quality parent-child relationships may cause future

substance abuse and/or domestic abuse (Green et. al, 2013; Scharf & Mayseless, 2008).

If adolescents do not receive the necessary treatment, their mental health will be in

jeopardy.

Adolescence appears to be a difficult, yet important developmental stage for

individuals and their families. Many parents struggle with how to properly parent their

adolescents, while adolescents struggle with their identity formation (Barber, Ball, &

Armistead, 2003; DeHart, Pelham, & Tennen, 2006; Videon, 2002). Moreover, poor

attachment with parents is associated with mental health problems (Bloch & Guillory,

2011; Green et. al, 2013; Lee & Hankin, 2009), which may lead to poor relational choices

with romantic partners (Scharf & Mayseless, 2008). The struggles in parent-child

relationships have been found to impact the mental health of adolescents (Aseltine et. al, 1994; Barber et. al, 2003; Green et. al, 2013; Hair et. al, 2008; Lee & Hankin, 2009; Maurizi, Gershoff & Aber, 2012; Schilling et. al, 2008; Videon, 2002).

Early bonds between parents and children are crucial for childhood development. The lack of healthy, loving, nurturing, and responsive parenting is likely to negatively impact a child (Capps, 2012; Green et. al, 2013; Hair et. al, 2008; Steinberg, 2001). Parental neglect or abuse is a prevalent issue in which there could be long-term negative effects (Hahm, Lee, Ozonoff, & Wert, 2010; Schilling, Aseltine, & Gore, 2008). A significant link was found between child maltreatment and depression (Schilling et. al, 2008). Such negative experiences are likely to affect adolescents' mental and social health. The impact of the problem is seemingly widespread. Ultimately, a child's response to poor parenting has been associated with behavioral issues (Aseltine et. al, 1994; Bloch & Guillory, 2011; Green et. al, 2013; Hair et. al, 2008; Sheridan et. al, 2010; Videon, 2002), negative peer relationships (Green et. al, 2013; Scharf & Mayseless, 2008;), and substance abuse (Van Ryzin & Norwicka, 2013) among a variety of other issues.

Mental health practitioners need to become more informed of best practices when working with families in order to improve adolescent mental health. Social work plays an important role in this discussion. Practice needs to be better informed around the issues of significant relationships in an adolescent's life as social workers need to be competent in their area of practice. It is the duty of social workers to respond to the needs of their clients in practice. Practitioners should recognize the value of the relationship: the therapeutic relationship is more important than the actual treatments (Green et. al, 2013).

Furthermore, practitioners should be attentive to both the child and the parent(s)' needs (Hawley & Weisz, 2003). In aligning with the principles of social work, practitioners should be competent and value the 'importance of human relationships' (National Association of Social Workers, 2008). Competence refers to *"Social workers practice within their areas of competence and develop and enhance their professional expertise"* (National Association of Social Workers, 2008). In addition, social workers are to "recognize the central importance of human relationships" (National Association of Social Workers, 2008). Therefore, those who practice with families and adolescents should understand the parent-child relationship dynamics, so as to better address the issues that may be impacting adolescents. By working towards improving the parent-child relational outcomes, practitioners will be able to respond and improve the mental health of adolescents. Working toward this end requires an understanding of how different approaches strengthen the parent-adolescent bond. For example, Sheridan et. al (2010) found that family therapy involving parents and adolescents was found to enhance communication (Sheridan et. al, 2010). This problem should be addressed early on so as to reduce the risk of pervasive mental health disorders in adolescents.

In order to improve parent-adolescent outcomes in practice, it is essential to study what approaches are utilized by practitioners who work directly with adolescents and families. The purpose of this research is to explore and better understand mental health practitioners' best practices for working with parents and their adolescent children. What do mental health practitioners do to improve parent-child relational outcomes to respond to adolescents' mental health needs? What specific theories and practices do they use and how do they implement these practices?

Literature Review

Defining Healthy Parent-Child Relationships

The style of parenting that is utilized has been shown to impact adolescents' behaviors and psychological state (Capps, 2012; Hair et. al, 2008; Steinberg, 2001). There are many theories discussed within that literature that focus on the importance of healthy parent-child relationships (Capps, 2012; Green et. al, 2013; Hair et. al, 2008; Steinberg, 2001; Van Ryzin & Nowicka, 2013). When defining a healthy parent-child relationship, there are a number of theoretical viewpoints; however, there appears to be consistency among the essential components. The quality of parent-child relationships can be assessed in numerous ways and have been widely examined throughout previous research. Previous literature has examined parenting styles (Hair et. al, 2008; Steinberg, 2001) by assessing attachment (Bloch & Guillory, 2011; Green et. al, 2013; Lee & Hankin, 2009), strictness (Hair et. al, 2008; Steinberg, 2001), warmth and supportiveness (Capps, 2012; Hair et. al, 2008).

Attachment. The attachment framework has been widely utilized to discuss the parent-child relationship (Bloch & Guillory, 2011; Green et. al, 2013; Lee & Hankin, 2009). It is applied to address the importance of emotional support, engagement, and responsiveness within parent-child relationships (Bloch & Guillory, 2011). Similarly, Green et al. (2013) defined attachment as "a dynamic pattern of cognitions, affect, and associated behaviors that result from a caregivers' ability to meet infants' needs for warmth, nurturance, and safe physical closeness" (p. 91).

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Attachment is typically on a continuum from secure to insecure. A secure attachment is characterized by a close, loving, and trusting relationship, whereas an insecure attachment is characterized by a lack of trust, inability to feel loved, and unpredictability. Secure attachments are formed by parents' attunement and responsiveness to their child. Such attachments are shaped when caregivers are able to attune to their children's cries and reassure their children that they can rely on them to respond to their needs (Green et. al, 2013). Insecure attachment has been broken down into three styles: anxious ambivalent (resistant), avoidant (Lee & Hankin, 2009) and disorganized (Green et. al, 2013). These styles help to explain children's early experiences with their caregivers and are found to be exhibited in future relationships. Anxious-ambivalent individuals display fear and anxiety, while avoidant individuals avoid closeness with others (Lee & Hankin, 2009). Disorganized attachment encompasses both avoidance and resistance, with the child changing patterns of connection with every new reunion with his or her caregiver (Green et. al, 2013).

Parenting Styles. Parenting styles have also been observed in attempts to discover the most effective approach (Steinberg, 2001; Vignoli, Croity-Belz, Chapeland et. al, 2005). The term "authoritative" parenting has been coined by many psychologists to describe a parenting style in which the parents are "warm and involved, but firm and consistent in establishing and enforcing guidelines, limits, and developmentally appropriate expectations" (Steinberg, 2001, p. 7). Additionally, Steinberg (2001) found consistent parenting to be an important aspect of authoritative parenting. Similarly, authoritative parenting was hypothesized to contribute to lower levels of anxiety in adolescents. Neglectful parenting (which can be viewed in opposition to authoritative

parenting) was also observed. It was shown to impact the amount adolescents sought out their parent for information (in regards to careers): the more neglectful the families were, the less likely the adolescent utilized his or her family as a resource. The results did indicate that an authoritative parenting style was positively related to "psychological adjustment" (Vignoli et. al, 2005). Overall, this firm, but involved style of parenting appears to be beneficial for adolescents and their mental health.

Measuring Parent-Child Relationships. When elaborating on parenting styles, researchers have measured parental involvement (Bloch & Guillory, 2011; Green et. al, 2013; Hair et. al, 2008; Steinberg, 2001). Attachment theory has been used to measure parental involvement (Bloch & Guillory, 2011; Green et. al, 2013; Steinberg, 2001). Four important interventions utilizing this theory include validation, empathetic attunement, reframing, and enactments (Bloch & Guillory, 2011). Furthermore, Hair et. al (2008) assessed the parent-adolescent relationship in regards to parental awareness, strictness, and supportiveness. An eight-item questionnaire was completed by adolescents in regards to their perception of the relationship. The questions sought out their feelings about spending time with their parent, admiration for their parents, their perceived appraisal of parents, their perception of parental criticism, their perception of blame from parents, and how much the adolescent thinks their parent(s) cancel their plans with them (Hair et. al, 2008). This questionnaire demonstrates the importance of parental time and positive parental attention toward adolescents.

Parental support, perceived parental awareness, and parental strictness are other concepts that have been measured to assess the parent-adolescent relationship. Parental support is described as the mid-level of parental strictness: not overly strict, but also not

overly permissive (Hair et. al, 2008), which bears close resemblance to authoritative parenting (Steinberg, 2001). Parental supportiveness has been examined and measured by asking adolescents about how supportive their parents are (Hair et. al, 2008). Green et. al (2013) noted how secure adolescents tend to rely more on their parents as supports as opposed to insecure adolescents. Additionally, the perceived higher quality parent-child relationships were found to be associated with higher levels of parental supportiveness and parental awareness (Hair et. al, 2008).

Perceived parental awareness also was an important measure in assessing a healthy parent-child relationship. It was measured by responses from adolescents about how much their parents know about their friends, their close friends' parents, the people the adolescent spends time with when he or she is not home, and the adolescent's academic activities and teachers (Hair et. al, 2008). Many other studies recognized this as attunement, in which parents are aware of their child's needs (Bloch & Guillory, 2011; Green et. al, 2013; Lee & Hankin, 2009). Parental strictness was measured by adolescents' responses of how strict they felt their parents were. "Adolescents with mothers they thought were strict reported lower levels of mental well-being" (Hair et. al, 2008, p. 195). In contrast to authoritative parenting, which encourages the child to become autonomous, 'psychological control' refers to exerting a level of intrusiveness, indicating overprotectiveness in which the parent's strictness is detrimental (Steinberg, 2001). Ultimately, the relationship between a parent and child appears to be crucial for developmental capacities, especially as recognized during the period of adolescence.

Overall, unhealthy adolescent behaviors appear to be examined in relation to the lack of healthy parent-child relationships (Hair et. al, 2008; Sexton & Turner, 2010; Van

Ryzin & Norwicka, 2013). For example, Hair et. al (2008) assessed adolescents' delinquent behaviors in association to parent-child relationships. Delinquency was measured in this study through self-reports of delinquent behaviors. Delinquency was associated with poor parent-adolescent relationships (Hair et. al, 2008).

Adolescent Mental Health Symptoms in the Context of the Parent-Child Relationship

There are a number of adolescent mental health problems that have been assessed in the literature, including depression, anxiety, and self-esteem (Aseltine et. al, 1994; Barber et. al, 2003; DeHart et. al; Hair et. al, 2008; Lee & Hankin, 2009;Videon, 2002). Although mental health issues cannot generally be predicted or understood, there is a vast amount of literature that discusses the possible factors impacting mental health. When observing parent-child relationships, previous research has found a link between poor parenting and poor mental health (Aseltine et. al, 1994; Barber et. al, 2003; Green et. al, 2013; Hair et. al, 2008; Lee & Hankin, 2009; Maurizi et. al, 2012; Schilling et. al, 2008; Videon, 2002). Parental support was found to be associated with lower risks of mental health concerns in adolescents, including depression, psychological disorders, externalizing behaviors, and behavior in youth (Hair et. al, 2008). These findings appear to be consistent throughout the literature (Aseltine et. al, 1994; Barber et. al, 2003; Hair et. al, 2008; Schilling et. al, 2008; Videon, 2002). Barber et. al (2003) found that there was less psychological distress present when the relationship quality between parent and adolescent was higher. Using the Brief Symptoms Inventory (BSI), Barber et al. (2003) found a direct relationship between the quality of the parent-adolescent relationship and adolescent psychological distress in a study of African American adolescent females;

quality parent-child relationships were associated with less psychological stress (Barber et. al, 2003).

The literature indicates that depression is widespread among adolescents (Kandel & Davies, 1982; Lee & Hankin, 2009; Maurizi et. al, 2012; Videon, 2002), and that the quality of parent-adolescent relationship is frequently associated with depression. Videon (2002) and Aseltine et. al (1994) measured depression with the Center for Epidemiologic Studies Depression Scale (CES-D). Adolescents in the Videon's study responded to 19 questions designed to measure their affect; the questions incorporated frequency of sadness, tiredness, loneliness and depressed mood from the past week. Findings indicated that the adolescent's relationship with his or her opposite-sex parent impacted his or her depression. The boy's satisfaction in his relationship with his mother indicated fewer symptoms of depression and similarly, the higher the girl's rating was in regards to her relationship with her father, the fewer depressive symptoms she reported (Videon, 2002). Correspondingly, the lack of a strong family and peer connections were found to predict depression (Kandel & Davies, 1982). Furthermore, there appear to be long-term effects: "chronic family turmoil" was shown to shape long-term mental health in individuals (Aseltine et. al, 1994).

The attachment frame helps to understand depression and anxiety in children (Bloch & Guillory, 2011; Green et. al, 2013; Lee & Hankin, 2009). Using the Experience in Close Relationships (ECR) Questionnaire as a measure of attachment and the Children's Depression Inventory (CDI) as a measure of depression, Lee & Hankin (2009) found that insecure attachments were found to be linked to depressive symptoms and later emotional distress. Without the security of a parent, an adolescent may have a lack

of trust and begin to exhibit internalizing symptoms, including anxiety and depression (Green et. al, 2013). An insecure attachment can cause an adolescent to believe he or she has no parental support or comfort, which results in their lacking proper coping skills (Bloch & Guillory, 2011). In relation, adolescents' reports of parental affection were associated with depression; the higher the rating of parental affection, the lesser the adolescent's rating of depression was (Maurizi et. al, 2012). Similarly, using the Mood and Anxiety Symptom Questionnaire (MASQ), Lee & Hankin, (2009) found some support for insecure attachment predicting anxiety symptoms. Adolescents in another study responded to a 61-item measure to assess their stress; it was examined in two ways: direct effects from their nuclear family and events that directly affected them (Aseltine et. al, 1994). These measures helped to interpret the direct impact the family has on the adolescent. It was found that when adolescents detach from their family during stressful times, it helps to alleviate stress (Alestine et. al, 1994). Therefore, it appears as though anxiety is impacted by parenting and family relationships.

Self-esteem was another critically assessed component of adolescents' mental health (Barber et. al, 2003; DeHart et. al, 2006). A ten-item, self-report questionnaire (devised by Rosenberg, 1965) was utilized with a Likert- type scale ranging from "strongly disagree" to "strongly agree" to measure self-esteem (Barber et. al, 2003). Higher levels of self-esteem were found to be related to more positive relationships between the parent and adolescent (Barber et. al, 2003). The positive parent-adolescent relationship also indicated better overall psychological functioning (Barber et. al, 2003). DeHart et. al (2006) utilized the same ten-item questionnaire. The self-evaluation included the statement "I feel that I have a number of good qualities", in which the

participants were to rate themselves on the scale from one (completely true) to seven (not at all true) (DeHart et. al, 2006). DeHart et. al (2006) also found that children had a higher level of self-esteem when they reported a nurturing response from their parents as opposed to the children who experienced a lack of nurturance from their parents. Self-esteem is thought to be formed through interactions with others (Leary, Tambor, Terdal, & Downs, 1995). "Individuals with low self-esteem have repeatedly experienced perceived interpersonal rejection. Conversely, most people with high self- esteem have experienced many subjectively successful or non-rejecting interpersonal relationships" (DeHart et. al, 2006, p. 2). Therefore, parent-child relationships would be important for increasing self-esteem. Implicit and explicit self-esteem were used to assess the results (DeHart et. al, 2006). Implicit self-esteem is understood as an unconscious and uncontrolled evaluation of one's self (Greenwald & Banajai, 1995), whereas explicit self-esteem is a conscious and controlled self-evaluation. Explicit self-esteem was related to permissive parenting, while implicit self-esteem was associated with overprotectiveness. Furthermore, explicit and implicit self-esteem were found to be positively related to parental nurturance as reported by children (DeHart et. al, 2006).

The level of parental involvement has been found to affect the behaviors and self-esteem of adolescents (Hair et. al, 2008; Steinberg, 2001). "Positive relationships between adolescents and their mother and/or father figures significantly predicted lower levels of delinquency and higher levels of mental well-being" (Hair et. al, 2008, p. 192). Similarly, adolescents in authoritative homes have been found to have higher levels of self-esteem (Steinberg, 2001). In addition, family rituals were found to enhance an adolescent's self-esteem and identity due to familial cohesiveness. Family rituals also

help to better prepare families to handle difficult situations (Hair et. al, 2008).

Ultimately, the role of parenting and family does appear to play a significant role in a

child's self-esteem and other mental health issues.

Unhealthy parenting results in negative outcomes; child maltreatment clearly

affects children and adolescent outcomes (Hahm, Ozonoff, & Wert, 2010; Schilling et. al,

2008). One study pointed out the impact of child maltreatment (which indicates poor

parenting) on adolescents' mental health. Child maltreatment variables included sexual

abuse/assault, physical assault, physical abuse and serious neglect. Males and females

were found to exhibit depressive symptoms following child maltreatment (Schilling et. al,

2008). Correspondingly, the experience of child maltreatment was found to lead to

internalizations, externalizations, self-harm behaviors, and depressive symptoms (Hahm

et. al, 2010). Severe "childhood adversities" were shown to affect adolescents' mental

and social health and continue into adulthood. On the contrary, those who experienced

lesser-impact childhood events had a greater chance of social success and opportunities

(Schilling et. al, 2008). Adolescent mental health is clearly impacted by parenting.

Mental health issues also appear to lead to poor behaviors.

Impact on Adolescents' Behaviors and Interactions

Adolescents' behaviors have been found to be linked to their relationship with

their parents (Bloch & Guillory, 2011; Green et. al, 2013; Hair et. al, 2008; Sheridan et.

al, 2010; Videon, 2002). Videon (2002) stated: **"**Alterations in behavior may be

adolescents' way of demonstrating their displeasure or satisfaction with changes in the

family environment". (p. 500). There is a heightened level of externalizing behaviors

during adolescence, which may include drug and alcohol use, self-injurious behaviors, and relationship conflicts (Green et. al, 2013).

Several phenomena related to parenting have been associated with adolescent behavior problems. Adolescents who are not able to rely on their parents during stressful times in their lives may endorse symptomatic behaviors (Bloch & Guillory, 2011). Additionally, externalizing behaviors were suggested to be a possible plea for attention from the adolescent to caregivers who were not engaged with their child (Green et. al, 2013). Similar to such findings, disorganized attachment between a parent and child was found to be related to ADHD symptoms in children (Thorell, Rydell, & Bohlin, 2012). Therefore, the development of ADHD could potentially be better understood through an attachment lens in some cases. In comparison, adolescents who were involved in family rituals were found to have reduced levels of conduct disorder (Hair et, al, 2008). Again, there was a lower level of delinquency found when an adolescent and his or her mother/father figure had a positive relationship (Hair et. al, 2008). There are a number of theories that predict and help improve behavioral issues in adolescents (Bloch & Guillory, 2011; Sexton & Turner, 2010; Van Ryzin & Norwicka, 2013).

Bloch & Guillory (2011) found that externalizing issues were found to be linked to Oppositional Defiant Disorder and Conduct Disorder. Another study found behaviors and weight to be impacted by parenting; poor parenting was shown to increase poor eating habits and other behaviors (Van Ryzin & Norwicka, 2013). Antisocial behaviors and substance abuse may also be impacted by the parent-child relationship (Van Ryzin & Norwicka, 2013).

Adolescents' peer and future relationships, another manifestation of adolescent behavior, also appear to be affected by the quality of the relationship with their parents (Aseltine et. al, 1994; Green et. al, 2013; Scharf & Mayseless, 2008). One study noted that adolescents who were experiencing family stress turned to their peers for support (Aseltine et. al, 1994); therefore future research could also investigate the impact of friendships on adolescent mental health. A potential reason for this is that adolescence marks a heightened level of peer influence (Aseltine et. al ,1994; Green et. al 2013). They clearly rely more on their peers during this time (Green et. al, 2013). Aseltine et. al (1994) noted the possible detriments of adolescents relying on their peers; when there is an absence of family ties, strong peers ties can supplement depressive symptoms (Aseltine et. al, 1994). Consequently, peer relationships also appear to impact adolescents' mental health.

The quality of parent-child relationships also impact adolescents' romantic relationships (Green et. al, 2013; Scharf & Mayseless, 2008). A general finding indicated that positive relations with parents were a resilience factor for future romantic relationships (Scharf & Mayseless, 2008). However, adolescent romantic relationships did not appear to be as influenced by this, because of the typical short term relationships that occur. Therefore, romantic relationships are more impacted by parental bonds later in life (Scharf & Mayseless, 2008). Subsequently, attachment styles were found to be linked to adolescent peer and romantic relationships. Insecure attachment was seen to be related to "relationship stress". Additionally, insecure attachment was associated with physical violence in some romantic relationships (Green et. al, 2013).

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Socio-cultural Impacts on Families

Mental health concerns also appear to be a result of socio-cultural factors negatively affecting families. Economic status (Ennis & Bunting, 2013; Lee, Wickrama, & Simons, 2013; Miller & Taylor, 2012; Stern, Smith, & Jang, 1999), education (Ennis & Bunting, 2013), race (Miller & Taylor, 2012; Wickrama & Bryant, 2003), gender (Ennis & Bunting, 2013; Lee, Wickrama, & Simons, 2013), and social resources (Wickrama & Bryant, 2003) have all been found to be factors related to the mental health of families. Consequently, those of a lower socioeconomic status, those with less education and resources, and those of a minority status appear to experience more mental health concerns, which indicates problematic factors for adolescents beyond parenting.

Families with a low economic status appear to be more susceptible to mental health problems (Ennis & Bunting, 2013; Lee et al., 2013; Miller & Taylor, 2012; Stern et al., 1999). Financial burdens within families are shown to be associated with increased vulnerability for individual mental health concerns (Ennis & Bunting, 2013). Correspondingly, Ennis and Bunting (2013) found that individuals with more than 16 years of education were less vulnerable to mental health issues than those with less than 16 years of education. Another study explored the mental health of adolescents in urban families and found that poverty was related to externalizing and internalizing mental health problems in adolescents (Stern et al., 1999). Similarly, youth from lower socioeconomic families displayed more depressive symptoms than youth from families of higher socioeconomic status (Miller & Taylor, 2012). Lee et al. (2013) found that persistent "economic hardship" in families influenced adolescent's mental and physical

health; financial struggles increased health problems. There is seemingly a significant correlation between low economic status and poor mental health.

Social experiences in communities may also influence adolescents and contribute to their mental health (Wickrama & Bryant, 2003). "Adverse structural conditions erode community social resources, which, in turn, diminish family social resources. Diminished family social resources contribute to adolescent depressive symptoms" (Wickrama & Bryant, 2003, p. 861). Therefore, community resources appear to influence family resources, which affect the adolescent. The lack of social resources causes adolescents to feel frustrated and hopeless, which directly relate to depressive mood (Wickrama & Bryant, 2003). The context of the community is yet another indicator of adolescents' mental health.

Race and gender appear to play significant roles in this discussion (Ennis & Bunting, 2013; Lee et al., 2013; Miller & Taylor, 2012; Wickrama & Bryant, 2003). Miller and Taylor (2012) explored the differences in depressive symptoms between black and white youths. They found that black youth exhibit more depressive symptoms than white youth. Similarly, "being a minority (in the case of this particular study, African American) increases adolescent depressive symptoms even after controlling for community and family adversities as well as other individual characteristics" (Wickrama & Bryant, 2003, p. 862). Gender is also seen to contribute to differences in mental health concerns (Ennis & Bunting, 2013; Lee et al., 2013). Females reported experiencing a higher level of mental health struggles than males (Ennis & Bunting, 2013). Likewise, Lee et al. (2013) found that females showed more consistent depressive symptoms than males. These factors of identity are seemingly challenging for adolescents to mediate.

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There appears to be numerous socio-cultural factors impacting adolescents' mental health. However, these issues have been found to be reduced or managed with support and intervention (Lee et al., 2013; Miller & Taylor, 2012; Stern et al., 1999). Economic hardships in families have been seen to be mediated with supportive parenting (Lee et al., 2013). Similarly, useful strategies of family management, such as supportive and warm parenting, help to lessen the risks of mental health problems for adolescents (Stern, et al., 1999). Miller and Taylor (2012) also discuss the importance of discovering strengths in families to enhance the psychological well-being of youth and to instill coping strategies for difficult times. Therefore, effective and strategic interventions in therapy are vital.

Theories and Therapeutic Approaches Incorporating the Parent-Child Relationship

Research has explored many theories and has discovered some effective approaches for working with parents and adolescents (Bloch & Guillory, 2011; Capps, 2012; Rivett, 2008; Sheridan et. al, 2010; Spring, Rosen, & Matheson, 2002; Steinberg, 2001). Each theory has a different focus, but there are clearly some parallels in the literature about healthy parent-child relationships. Research has indicated some useful therapeutic approaches that have been found to be effective when working with families (Bloch & Guillory, 2011; Capps, 2012; Sexton & Turner, 2010; Van Ryzin & Norwicka, 2013).

Firstly, a child's feeling of safety is essential (Capps, 2012; Rivett, 2008). When assessing the developments in family therapy approaches, Rivett (2008) found safety to be of the utmost importance within the therapeutic environment with families. If a family feels safe in therapy, they will better able to discuss the difficult issue (Rivett, 2008).

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Capps (2012) also found safety to be important. Filial Therapy was utilized to enhance

the safety within a parent-child relationship. It was derived from play therapy and

educates parents on how to utilize play therapy skills. The approach emphasizes the

benefits of building strong parent-child relationships in order to provide that safety for a

child (Capps, 2012). This was also noted by Sheridan et al. (2010); the study indicated

the benefits of "creating a therapeutic climate".

Communication was recognized as an essential aspect of healthy parent-child

relationships, as it was repeatedly mentioned in the literature (Bloch & Guillory, 2011;

Capps, 2012; Sheridan et al., 2010). Again, Bloch and Guillory (2011) used an

attachment frame to improve the interactions between parents and their children. The

importance of parents being open and regularly communicating with their children was

pointed out (Capps, 2012). Empathetic responses during communication were found to

strengthen the parent-adolescent relationship (Capps, 2012; Spring et al., 2002).

Moreover, simply using family therapy involving parents and adolescents was found to

enhance communication (Sheridan et. al, 2010). Families noted progress from family

therapy when they began communicating better; instead of avoiding an issue, it was

discussed (Sheridan et al., 2010). Emotion-Focused Family Therapy (EFFT) promotes

family interaction dynamics to improve psychological and emotional health (Bloch &

Guillory, 2011). Additionally, Capps (2012) noted how beneficial this communication

was when parents and their children needed to problem solve. Filial Therapy is an

approach that addresses the need for communication between parents and their child,

with a particular focus on foster children. "Filial therapy is an open and empathetic

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communication…and increased thoughtful communication and problem solving between foster parents and the adolescent" (Capps, 2012, p. 429).

In addition to communication, attunement and responsiveness have been found to be essential for creating a healthy parent-child relationship (Bloch & Guillory, 2011; Green et. al, 2013). Literature revealed the importance of warm and involved parenting (Bloch & Guillory, 2011; Capps, 2012; Steinberg, 2001), which indicates a high level of attunement and responsiveness from parents. Capps (2012) found that teenagers in foster homes greatly valued "parental warmth" and the presence of it enhanced the likelihood of continued contact with their foster families. The research clearly indicates the advantages of warm, supportive care-giving. Steinberg (2001) also addresses parental warmth in regards to essential aspects of the authoritative parenting style. When parents readily respond to their child's needs, as previously discussed in regards to attachment, children are more likely to seek their parent's support during adolescence (Bloch & Guillory, 2011).

There were a number of benefits found when utilizing the authoritative parenting style, including more school success, less anxiety and depression, higher self-esteem, and less delinquent behaviors and drug use. Additionally, it promotes self-reliance, motivation, self-control, confidence, cheerfulness, and prosocial behavior in children (Steinberg, 2001). In comparison, neglectful parenting was found to be related to heightened anxiety in adolescents (Vignoli et. al, 2005). Additionally, a lack of warmth and consistency as well as controlling parenting is associated with anger and hostility (Muris, Meesters, Morren, & Moorman, 2004). Ultimately, warm, consistent parenting appears to be advantageous for children and their emotional health.

There are a number of family therapies that incorporate these key ingredients for improving parent-adolescent relationships. Family Check-Up (FCU) is a family-based intervention used to treat adolescents with depression, unhealthy eating behaviors, and other unhealthy behaviors (Van Ryzin & Norwicka, 2013). It addresses concerns of trust, parental involvement, and communication by indicating the importance of family in reducing these unhealthy behaviors (Van Ryzin & Norwicka, 2013). Sexton and Turner (2010) also address behavioral concerns through Functional Family Therapy (FFT). Essentially, 12 sessions of family therapy are utilized to help reduce delinquent behaviors in youth (Sexton & Turner, 2010). In addition, Multisystemic Family Therapy (MST) has been shown to consistently reduce behavioral and mental health concerns in adolescents (Henggeler, Schoenwald, Borduln, Rowland, & Cunningham, 1998). It is an intensive treatment intervention that has primarily been utilized to help treat youths with serious antisocial and criminal behaviors by observing all systems in the young person's life, including peers, family, and school networks. Some of the goals and values of MST include improving the adolescent's academic performance, eliminating antisocial peer groups, fostering resilient and strong families, and forming positive social support systems (Henggeler et al., 1998). These approaches in family therapy demonstrate ways to reduce emotional and behavioral issues in adolescents through family interventions, which ultimately result in improved parent-adolescent relationships.

Clinical Suggestions for Family Therapists

There are many practitioners who work with adolescents, adults, and families who encounter issues within the parent-child dynamics. This has impacted research and has encouraged practitioners to explore best practices for working with these groups (Barber

et. al, 2003; Green et. al, 2013; Hawley & Weisz, 2003; Rivett, 2008; Sheridan et. al, 2010; Walker, 1999; Windows, Richards, & Vostanis, 2004). These studies have offered many techniques as suggestions for such work. For example, Rivett (2008) suggested integrating Cognitive-Behavioral Therapy with a systemic approach. Barber et. al (2003) indicated the importance of mental health professionals assessing the parent-child relationship when measuring self-esteem in adolescents. This idea appears to be applicable to many interventions with adolescents due to the seen effects of this relationship as noted above.

The value of the therapeutic relationship is important for positive outcomes (Green et. al, 2013; Hawley & Weisz, 2003; Sheridan et. al, 2010). "Therapists should work to create a supportive and collaborative therapeutic climate that will likely contribute to parental and adolescent behavior change, as well as lead to an overall positive therapy experience for the parents" (Sheridan et. al 2010, p. 155). This appears to be a consistent thought throughout the literature. Green et. al (2013) noted the value of the therapeutic relationship is more important than the actual treatments. Through empathy (Walker & Gillian, 1999) and attunement to the child (Green et. al, 2013), the therapist may then act as a model for the parent.

In addition, parents and children should all have a voice in family therapy (Hawley & Weisz, 2003; Windows et. al, 2004). Children do wish to be involved in the process (Windows et. al, 2004). It is important that the therapist does not take one side. One study found that parents and children were not in agreement about their relationship problems: more than half disagreed on the main problem. This clearly makes it difficult for the therapist to identify and treat the problem. Mental health professionals have found

it best to incorporate some of the parents' input and some of the adolescents' input into the intervention. However, they do seem to find parents' definitions of the problem more accurate (Hawley & Weisz, 2003).

The basic needs of families must also be met before attempting reparative work. The therapy process should be framed to the client's (family's) needs (Windows et. al, 2004). Furthermore, the needs of the separate family member should be taken into account (Hawley & Weisz, 2003; Bowley & Bratley, 2005). Although adolescents may feel the need to be creative and independent, it is important for therapists to encourage parents to recognize their role in providing a "secure base" for the family (Bowley & Bratley, 2005). This may be better understood through the communication process in therapy when discussing the presenting family problems (Hawley & Weisz, 2003). Overall, it appears to be the therapist's role to mediate the parents and children by enhancing communication and support, so as to improve the quality of the parent-child relationship (Bowley & Bratley, 2005; Green et. al, 2013; Hawley & Weisz, 2003; Sheridan et. al, 2010). "Family therapists are in a unique position to actively repair problematic parent-child relationships and in so doing, to create long-lasting change in other relationships" (Walker, 1999, p.43).

This literature review has clearly illustrated the importance of high quality parent-child relationships for adolescents' social, emotional and mental health, as well as the importance of therapists providing the kind of environment in which such relationships can flourish. Communication (Bloch & Guillory, 2011; Capps, 2012; Sheridan et. al, 2010) and responsiveness (Bloch & Guillory, 2011; Green et. al, 2013) are among many components that are beneficial for building strong parent-child relationships. Having

identified the problem, it is important to address clinical implications for continued work with this population. It is essential for therapists to learn how to provide this environment for families. Safety was found to be of great importance to enhance the therapeutic environment (Capps, 2012; Rivett, 2008), but the way in which safety is implemented remains unclear. Clinicians will be interviewed in this study to find out what effective approaches are being used in practice with adolescents and families. The data from this research will supplement the literature by demonstrating just how these principles are incorporated into therapy. Ultimately, this study is designed to benefit research and offer clinicians insight into effective practices.

Conceptual Framework

Attachment Theory

The development of the Attachment Theory began in the 1930's by John Bowlby (Bretherton, 1992). Bowlby was interested in the impacts of motherhood (or lack thereof) on personality development (Bretherton, 1992). He later joined Mary Ainsworth, whose interest was in the theory of security, to collaborate and contribute to attachment research (Bretherton, 1992). Ainsworth was the first researcher to conduct a study observing the attachment of an infant to his or her mother: "The Strange Situation" (Bretherton, 1992). This experiment observed infants' responses when their mother left the room, when a stranger entered the room, and when the mother returned (Bretheron, 1992). Ultimately, the theory of attachment offers insight to the impact of the parent-child relationship.

The attachment bond that a child forms with his or her primary caregiver can either be secure or insecure. The three types of insecure attachments have been labeled

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avoidant, ambivalent, and disorganized (Ainsworth, Blehar, Waters & Wall, 1978). The theory of attachment points out how an infant turns to his or her caregiver for comfort when he or she is in need. The responsiveness of the caregiver is what shapes the attachment and teaches the infant what he or she can expect (Turney & Tanner, 2001). The more responsive and nurturing the caregiver is, the more secure the infant feels (Berger, Jodl, Allen, MecElhaney, & Kupermine, 2005). A child with a secure attachment forms a close, loving, and trusting relationship, whereas a child with insecure attachment lacks trust, ability to feel loved, and predictability (Bowlby, 1982). In The Strange Situation, if the infant was comforted by the mother, but also able to explore and play, Ainsworth concluded that there was a secure relationship (Bretheron, 1992). Attachment experiences also help to understand one's internal working model, which "is a mental representation of self, other people and the relationships between self and others, and is constructed through and by an individual's experiences of the care-giver-child relationship". (Turney & Tanner, 2001, p. 196).

When observing the relationships between a parent and an adolescent, attachment can be very prevalent. This framework offers an approach for understanding and treating such a dyad. Early experiences with parent(s) appear to impact a child's social and emotional development. Attachment has become a more widely utilized lens for therapeutic work with families (Turney & Tanner, 2001). If practitioners are able to explore the early relationship between a caregiver and infant, they may be better prepared to work with the dyad on restructuring their relationship so as to create a secure attachment.

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In addition to the Attachment Theory, the lens in which this research was viewed also included practitioner's competency in practice. Competency is a core value of social work (National Association of Social Workers, 2008). In order to be a competent practitioner, one must understand the importance of the therapeutic relationship (Green et. al, 2013; Hawley & Weisz, 2003; Sheridan et. al, 2010). Strong rapport within such a relationship is essential for successful treatment (Green et. al, 2013). The literature has reiterated this when observing family therapy approaches; therefore it is necessary for family therapists to be competent and demonstrate expertise in their practice (National Association of Social Workers, 2008). Ultimately, it is necessary for practitioners to ensure a positive therapeutic relationship when working with parents and adolescents.

Methods

Research Design

The design that was utilized in this clinical research study was a qualitative research design. The purpose of this research study was to gain a better understanding of how mental health/family clinicians incorporate approaches that address adolescent mental health issues in the context of adolescent-parent relationships. The researcher planned to obtain eight respondents to partake in a semi-structured interview. The respondents answered twelve open-ended questions (See Appendix B).

Sample

The sample population included mental health/family clinicians who either currently work or previously worked with adolescents and families. In order to participate, clinicians had to meet criteria of working directly with adolescents and/or

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families for a minimum of two years. The participants were obtained through a convenience sampling method. (Snowball sampling was also attempted, but the researcher was unable to recruit additional participants through this method.) The researcher's committee members assisted in recruiting participants through their agency or community connections, all of which incorporated family work with adolescents.

The sample was comprised of eight clinicians who have experience working with children and/or adolescents and their families. Out of the eight, five were licensed Marriage and Family Therapists (LMFT), two were licensed Independent Clinical Social Workers (LICSW), and one received his master's degree in child and family counseling (MA) and is working towards becoming fully licensed as a Marriage and Family Therapist (LMFT). Three of the participants were males and five were females. All clinicians had at least two years of experience with the population.

Protection of Human Subjects

Protection of the participants was ensured throughout this process. The respondents were asked to participate on a volunteer basis, in which their participation was left confidential. This population, as social service professionals, would not be considered vulnerable. The Institutional Review Board (IRB) of St. Thomas was consulted to ensure safety and protection of the sample. The IRB approved the research study. In order to ensure their protection, confidentiality was maintained through following several steps that were provided on the informed consent form. First off, the participants names were not included in the any of the research data. Additionally, any research notes were locked up and secured in the researcher's house. The data was only used for the purpose of this research and will be destroyed afterwards. The participants

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were provided with an informed consent form (See Appendix A), which informed them of their right to withdraw from the study at any time without a penalty.

Data Collection

Participants were collected through convenience sampling. The committee members supplied the researcher with names and contact information of therapists who qualified and may be interested. The researcher then emailed the potential participants to provide detailed information about the research study. If/when the potential participants responded, the researcher inquired about convenient times to meet the therapist at his or her agency to conduct the interview. The researcher had participants sign a consent form (Appendix A) prior to beginning the interview. After conducting the interview, the researcher inquired about the participant providing name(s) of other clinicians for potential participation. However, there were no participants recruited through this attempt.

The researcher scheduled and carried out eight semi-structured interviews to obtain qualitative data. Prior to the interview, a set of twelve questions were formulated (See Appendix B) and approved by the researcher's chair, Lance Peterson, Ph.D., LICSW. This process was carried out to ensure that the questions met the guidelines for the UST IRB and the Protection of Human Subjects. The respondents were asked twelve open-ended questions, as well as follow-up questions when the researcher found it necessary. The questions were associated with the research question and avoided personal information. They were open-ended in nature and were relevant to previous literature on family therapy practices (Bloch & Guillory, 2011; Capps, 2012; Sexton & Turner, 2010; Van Ryzin & Norwicka, 2013). The interviews were approximately 30-45

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minutes each. They were audio-taped for the purpose of later transcribing and coding the

data.

In order to ensure confidentiality, crucial measures were taken. First, the hard

copies of data were locked up in a cabinet at the residence of the researcher. Moreover,

they only included the participant's initials on them, rather than full names. Additionally,

the electronic data was kept safe in a password-protected computer.   All data will be

destroyed after the completion of the study on June 1, 2014.

Data Analysis

The analytic strategy that was utilized in this study was derived from grounded

theory. This is the process in which raw data is analyzed and themes emerge (Padgett,

1998). The methodology of this study was based on a grounded theory approach, which

assesses the reliability of the codes in accordance to raw data. Grounded Theory utilizes

raw data to derive a theory (Padgett, 1998). After collecting the data, it was repeatedly

examined and read in order to obtain codes; these were phrases or words directly taken

from the transcription of the interview to avoid interpretation. There were numerous

codes that were drawn from quotes, but in order to condense the data, similar codes were

combined into themes. Ultimately, the researcher had the ability to find themes through a

process of transcribing the data, coding the data, and finally, identifying themes in the

data.

<div align="center">

Findings

</div>

Eight family and mental health therapists were interviewed for the study. Their

experience practicing with adolescents and families ranged from three to 20 years. There

was also varied experience with direct family practice and individual practice with adolescents, including a wide range of ages. Six themes emerged from the qualitative data in this study. They include: systems approach, safety and trust, respect, cultural awareness and responsiveness, emotional bond, and positive interactions.

Systems Approach

The first theme that was found was that of a systems approach. Seven out of the eight participants reported using a systems approach or analyzing the adolescent within a systemic context when doing therapy. By recognizing the family system, therapists were better able to respond to their needs. When asked of the primary theoretical approach utilized, one participant promptly stated *systems. Family systems*. Similarly, another response was *definitely a contextual, common factors, systemic approach*. Another participant elaborated on the importance of using a systems perspective.

> *As systemic therapists, we are strong believers in problems and solutions and always being attached to the systemic, systems piece. It is not just about this one individual person with an individual problem, but it is connected. The healing and the problem are connected to the broader context.*

Many participants reported working with parents, teachers, and other family members to address the adolescent's needs. One participant described *using external, or informal supports, extended family, environmental, you know, neighborhood, coaches, clergy* when working with adolescents. It was also evident that many child and adolescent therapists work closely with the parents/guardians, as many participants reported

incorporating family work. One participant reported using a *family functioning approach* and described incorporating a *family modality* to therapy with adolescent clients. This participant further discussed how *our agency does MST- Multi-Systemic Therapy.* Another participant strongly stated:

> *I think that what I firmly believe in is family systems. So, even when we*
>
> *are doing individual therapy, it's not the adolescent sitting in the room;*
>
> *we interact with the parents, the parents are involved. You spend time with*
>
> *the parents, you spend time with the adolescents and you work with them.*
>
> *My belief system is, we believe here, that you can't do good therapy if*
>
> *you're not involved with the whole family, and so that is the cornerstone of*
>
> *what we do here.*

It appears as though many therapists incorporate a family piece into therapy with adolescents, even when treatment was meant for the individual. The adolescents' presenting issues are reportedly linked to some environmental factors, which cannot be addressed without utilizing a systemic approach.

Safety and Trust

A reoccurring theme within this study was safety and trust, which consisted of two subthemes: confidentiality and therapeutic relationship.

Confidentiality. Five participants used the word "confidential" or "confidentiality" when discussing safety practices within therapy. One participant simply stated, *we talk a lot upfront about confidentiality*. Another participant expressed the importance of discussing confidentiality:

I think at the intake I sort of set the tone at the beginning. When I do the informed consent piece, I go over what confidentiality is. I talk about the legal requirements of confidentiality and what might be more useful to know in terms of family confidentiality. So, if I am working with a 14-year-old, here is what I have to report to mom or the police by law and let's talk about having some freedom in this room to talk about things without feeling like I am telling mom. So I really set myself apart from other teachers, adults, or authority figures in the kid's life and kind of lay the groundwork out ahead of time.

Similarly, another participant emphasized the confidentiality piece as*: …then confidentiality and clarifying how I am going to protect what they say to me and what's not protected. And then I think it comes to the relationship piece again of building that trust.* One participant expanded upon this by discussing mandated reporting.

One of the things I would do, is I would say I am a mandated reporter. 'Do you know that that means?' I would explain it to them. So if somebody, if I reasonable believe, based on what I see, think that somebody is being hurt or harmed, or neglected, I am obligated by law to break confidentiality. And the way that I usually work with this is, 90-95% of the time, you're going to know when I make that phone call, because I am going to let you know. I don't like surprises, you don't like surprises, because that breaks that trust. And if I am calling, and I am keeping that a secret, how icky is that?

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Ultimately, confidentiality appeared to be an essential aspect of therapists' approaches for building trust.

> *So it takes more time to build that level of trust, to let them know that I am*
> *there to help them achieve what their needs and their goals are. And, that*
> *what we are working on is sacred and is confidential.*

Many participants described the particular importance of clarifying confidentiality with adolescents when meeting with them individually. For example, one participant explained, *oftentimes with the safety piece, it might just be the safety about the information being presented. With adolescents, some of that might just be going through my spiel on confidentiality*. Additionally, several participants reported using individual assessment approaches prior to family work in order to discuss confidentiality and build safety.   One participant explained discussing the therapeutic environment to adolescents stating *this is where you get to have your big emotions. This is where you get to have a safe place to feel all of this; this is not punishing behavior*. This quote alludes to the greater significance of confidentiality in the context of therapy. It describes how confidentiality should be explained at the beginning of therapy as a way to engage adolescents in being more open, rather than just being presented for identifying exclusions to confidentiality.

Therapeutic Relationship. Some additional words that frequently appeared in the data, which were related to safety in the relationship were: trust, joining, and rapport. One participant described it as *building that relationship with the family.* Another participant stated: *I am slow to be directive in order to gain trust and therapeutic rapport.*

This quote denotes the efficacy of therapists being patient and not rushing the process. Another participant also emphasized this by stating:

> *And the relationship is really what it is all about. If you have a relationship, you can do some good work. If you don't have that trust and you don't have a relationship, it's not likely you are going to have very much success.*

Ultimately, building a trusting therapeutic relationship appears to be crucial for obtaining effective outcomes when working with adolescents and their families.

Respect

Respect was identified as a critical aspect of work with adolescents and their families. Four of the eight participants directly stated respect as a core value for therapeutic work with adolescents and families. One participant stated that respect is of utmost importance: *I think families have to feel like you respect them at a certain level. Whether it is respect their time or their…it is as little as returning calls…so it's just respect.* Another participant simply stated: *so it's about respect; it's about honoring that person.* Likewise, a participant expressed *…And communicating with the family that every family has some strengths and that families know their kids so much better than I ever will. So honoring and respecting that piece.* These note the variety of ways in which respect can be shown to families. It can mean something more concrete, such as respecting clients' time or it can be more valued-oriented, such as respecting the strengths of each family.

When discussing respect as a critical value, there were a number of additional ways the participants spoke of respect. The words and phrases 'non-judgmental', 'honest', 'transparent', 'listening', being heard', 'meet the client where she/he is at', and 'including everyone's voice' were repeatedly found. One participant encompassed this by saying:

> *And respect. A lot of people who might be making choices that are not ideal, already don't feel respected, already feel judged or already defensive and aggressive. They don't need one more person telling them what they should and shouldn't do or how they did this right or wrong.*

Non-judgmental. Furthermore, five participants specifically mentioned using a non-judgmental approach. J*ust kind of being connected and non-judgmental being where they are at.* Refraining from judgment appeared to be an important way of showing respect to families. One participant simply stated *non-judgment* and *acceptance of where they are, where they're at* when asked what values were most important when working with adolescents and their families. Another therapist discussed how non-judgment is central to accepting family differences. *And I think a lack of judgment, because all families act differently; all families are different…I can't just go in there and blankly say this is what the problem is…not being judgmental.*

The same participant elaborated on this by later saying,

> *… and huge, non-judgmental stance. That's a DBT skill, non-judgmental stance. And my core belief about people, no matter what happens in my office- that they are doing the best they can. This is really the best they*

> *can do in that moment. There is something about them or where they are*
>
> *at or what their experiences have been that, yes, that is the best they can*
>
> *do… so making sure my judgments do not impact my work and that I am*
>
> *really seeing them for where they are at and just that this is the best they*
>
> *can do right now.*

By taking on a non-judgmental stance, therapists reported recognizing more trust and respect within the therapeutic relationship. The notion that respect within the therapeutic relationship offers advancements in the therapy were continuously presented by therapists. One participant described *and then I think it comes back to the relationship piece again of building that trust, so that they don't feel like I am judging them.* In accordance with non-judgment, many participants discussed meeting the client where they are at. One participant incorporated the value of cultural respect when working with families.

> *I also try to be respectful of them, you know, culturally, their family*
>
> *values…try not to be too judgmental in terms of my own values or trying*
>
> *to assert my own beliefs on them. And meet them where they are at.*

Honesty. There were also five participants who directly spoke of the importance of honesty. Participants spoke about honesty in regards to mandated reporting, reasons for mandated therapy, as well as transparency throughout the therapeutic process. It appears to be common practice for therapists to convey honesty from the beginning of treatment.

Just being very clear, very open, very honest, and very transparent with what I am doing.

I think honesty. I think it is really hard, particularly with teenagers; you cannot lie to them. You cannot sort of omit truths or information. So, just having that disclosure of what rules are, what is going to happen.

Honesty is a big one. I think it's really important that when you are doing family work that you are clear that 'I am not taking anyone's side'.

So kind of open and honest and really transparent about what our relationship is and just really try to work together. And I think meeting them where they are at is the most important.

I think some of this is transparency with families as part of early engagement about here is why I'm here. I tend to be pretty up front with families.

Incorporating everyone's voice. An additional form of respect that was mentioned by participants when doing family therapy was making sure to include everyone's voice. Many participants talked about managing all the voices within a family, whether they are big voices or there is someone who seemingly does not have a voice; it is important to allow each family member *to* have a voice. This was repeatedly discussed by the participants.

Trying to validate everybody and allow everyone to have a voice and their

voice is important.

It is incorporating everyone's point of view.

I want them both to feel as though they are being heard.

There is that balance of being respectful of both opinions.

Cultural Awareness and Responsiveness

This theme emerged in every participant's data. Each participant presented different views and approaches for being aware and responsive to the culture of clients. However, all eight addressed it in some way. One participant powerfully stated *culture is not something that one can be competent at. It is not something that one can be perfect at.* When discussing responsiveness to culture, one participant explained some ways to practice cultural sensitivity.

As a group, we are always talking about how we can be culturally

sensitive and culturally responsive. And so, I think what I've come to at

this point is really creating a safe place, context, so relationship, that they

can just share their stories and tell what their experience is. I think that's

the only way to really know, truly, what culturally their experience is; you

can't get that from a book.

Similarly, a participant discussed the necessity of recognizing culture when working with families.

> *There is no middle ground [with culture]. You are either on the side of really respecting client and family culture, or, unfortunately, you fall into the category of not being responsive to culture. I think culture is one of those things that gets so downplayed, so minimized. But it is so ever present. You cannot not have culture…the meaning of culture is that as a human being I come with my own culture and as I enter into these relationships with these human beings, these families, they have their own cultures.*

An additional perspective and approach was to allow families to teach their culture.

> *We look at it as an opportunity to learn and let them be teachers. I work with a Somali family and I have absolutely no clue. And they have taught me about their culture and I have had to have an interpreter.*

This data alludes to the fact that cultural competency is not achieved by taking classes and reading textbooks. Rather, culture is individualized with each family; it appears to be the therapist's role to encourage and allow families to simply share their own culture. The therapist can then begin to understand patterns and influences in families' lives so as to better help them.

Meeting Basic Needs. One of the reoccurring phrases within this theme was 'meet basic needs'. In accordance with social work values, it was evident that many therapists found it imperative to ensure that their clients' basis needs were met before

therapeutic interventions could be effective. One participant summed this up by stating:

If there are economic barriers, I think about Maslow's hierarchy, if you don't have food

or you don't have a house, how are you going to do therapy? Similarly, a participant

spoke of therapists' duty to address cultural barriers.

> *I think some of it is just realizing that people are trying to meet basic*
>
> *needs… A lot of times- and this is the one risk with doing work with high*
>
> *needs kids and families- you don't want to become the case manager per-*
>
> *say, but a lot of times you have to do the case management-y things in*
>
> *order to move therapy forward.*

Therefore, the role of the therapist should be evaluated due to the presenting

circumstances. At times, this may mean connecting families to resources and assisting in

meeting their basic needs prior to beginning a therapeutic intervention.

This theme was further illustrated by participants who also discussed the

therapist's responsibility to address needs. They explained their approaches for

addressing barriers that clients may encounter.

> *I think of families that, for instance, live in extreme poverty. I don't ever*
>
> *take for granted some of that case manager role. Stuff like, if I notice they*
>
> *don't have any food in their cupboard, I make sure to at least connect*
>
> *them to a food shelf or something like that. And I don't tend to just blow*
>
> *that off as 'oh that is someone else's' job to do that', because maybe they*
>
> *do not have a case worker at the county who would do that. But, even as I*
>
> *am entering their lives as a therapist, I want to make sure I don't overlook*
>
> *those things.*

For myself, I do a lot of connecting families to resources trying to find

places to get food where they can and if they celebrate Christmas, where

they can get gifts. And helping them find clothing, helping with

transportation, getting insurance if they don't have insurance at the time.

I often waive co-pays or waive deductibles or see people if...I tell families

if you are invested in coming and you are invested in this process, then the

financial piece will not be a barrier. So, not a great business move, but I

think the right move, in terms of why I got into this field.

These quotes allude to how essential it is for therapists to be culturally

responsive. Therapists must recognize the needs of families and address any

barriers that will prevent them from achieving positive outcomes in therapy. For

instance, if basic needs are not being met, the therapist should assist the family in

meeting those needs. Ultimately, according to respondents in this sample,

therapists cannot comprehensively do effective therapeutic work without

incorporating this piece into their approach.

Emotional Bond

All of the participants spoke of the importance of healthy emotional bonds

between parents and children/adolescents. Participants each mentioned different ideas

and approaches in regards to the significance of emotional bonds in the relationship. One

participant summed up the role of a family therapist by stating: *It's really about building*

those moments of connection, communication, and validation. This was similar to many other responses.

Attachment. There were five participants who spoke of the importance of healthy attachment and connection within the parent-child relationship. One participant illustrated the significance by repeatedly mentioning attachment.

It's part of attunement and engagement and building attachment and bonding.

Maybe it's grounded in attachment theory, but my gut tells that that is where it starts.

I think if families have had successful attachment and successful interactions in the past, it is easier to go back to.

Similarly, the notion to connect and bond on an emotional level reoccurred in the data. One participant discussed addressing the bond: *One of the things I address often is the emotional bond between the parent and child.* Participants also discussed this by talking about the connection that therapists can help to encourage between parents and adolescents. *Just connect on that intimate level* and *so really encouraging the connection.* One participant spoke of the inconsistencies of parenting an adolescent; it is still encouraged to maintain closeness when the adolescent is non-compliant. *So just letting the parents know that their kids do still need them and they are going to go back and forth between not wanting to have anything to do with you and cuddling on the*

couch with you. It can simply be helpful to share this information with parents, so that they can understand inconsistency is normal with adolescents. Ultimately, c*hildren generally, they want to be loved. They want to be appreciated. They want to be respected and validated.* One participant discussed how the relationship (established attachment) between the parent and adolescent can play a role in the adolescent's behavior. Therefore, it is useful for therapists to inform parents of such an association.

> *And oftentimes, you know, with kids who are particularly acting up, acting*
>
> *out, the parent-child relationship is strained. So, you introduce the idea*
>
> *that there is work needing to be done- not only about the structure or kind*
>
> *of reinforcement, so to speak, of the kid, but also the relationship piece….*
>
> *You can't discipline a kid if there is no relationship behind that.*

Essentially, the therapist can do some work on strengthening the relationship in order to aid in alleviating some of the stressors of dealing with oppositional adolescents.

Softening. Three participants mentioned the importance of encouraging parents to soften in order to build a healthy relationship with their adolescent. By doing so, it is recognized that parents are more able to respond to their child's needs in a positive manner. This was also discussed to help reduce tension and conflict within the relationship. *To be attuned to the softening piece when there is so much conflict in that relationship.* Another participant bluntly stated *a softening affect* when discussing the signs of a healthy parent-adolescent relationship. It was common for the participants to speak about the parent's duty or role in the relationship. *I like to get [parents] to that place where you're soft again and you remember kind of that they are still that little kid*

you love to death. Not an evil teen. Likewise, respondents discussed getting to a place where the parent can become more aware in order to recognize what their child is going through. *Encouraging parents to have, maybe, to cultivate a little more sympathy or empathy for their kid. That they are going through tough times too.* Thus, parents can begin to soften by feeling more empathetic toward their kids. Another participant discussed a similar approach.

> *I find that adolescents in particular, almost all of the communication, when they are coming to therapy, not always, but almost all of the communication is the parents telling the children what to do or what they did wrong or what they need to do better. So, 'you need to do your homework', 'why didn't you clean your room', 'you never do this', 'you need to do that'. Why the heck would a kid want to come or talk with a parent or share anything? So I feel like part of my job is reminding parents how much responsibility and pressure and stress there is on adolescents…If you look at how many hours kids are spending doing all of the requirements of being a teenager, for many kids, its more than what parents are doing. And they have no control over their time or their freedom. So, just having parents be more aware of that and compassionate about that.*

By informing parents of the challenges of being a teen, it is indicated that they will be able to find more empathy for their child. This is intended to bring about softer responses from the parent, which will help to lessen some of the conflict within the relationship.

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Communication. Another key message that was presented from the data was the necessity for parents and adolescents to communicate. The poor relationship and disconnection between parent-child relationships appeared to be related to poor communication. Participants spoke of their role, as therapists, to help foster communication between the dyad. This was directly stated by two participants: *They don't know how to communicate,* and o*pening up more, direct communication.* When doing therapy with families, it is useful to encourage taking turns speaking and truly listening to one another…*talking to be able to hear and listen and to be able to help strengthen that.* Communication within therapy was discussed to hopefully transfer over into the everyday life of these families. *I think progress is when people can talk. It's when they can understand the communication and have the safety-ness to be able to say that with each other.* Finally, a participant illustrated an effective approach of using psychoeducation when working with parents who have difficulties communicating in a calm manner with their adolescent.

> *I do a lot of brain education on how our brains act during stress.   I do a*
> *lot on how parents' brain state and how can they stay calm and collected*
> *to have this conversation with the kid. If the parent can't self-regulate,*
> *they are never going to get their kid to self-regulate.*

Positive Interactions

The final theme presented in this study was that of the benefits of positive interactions between parents and adolescents. Participants spoke about effective approaches in therapy for fostering them. All eight participants recognized how positive interactions can assist in improving the parent-adolescent relationship. When discussing

progress in the parent-adolescent relationship, one participant stated: *Less chaos in the home and less conflict, and more positive interactions.* Similarly, one participant spoke about the practice of using education: *Educating parents about building healthy engagement.*

Spending time together. Spending more time together as a family appeared to be a key factor for developing healthy relationships. Participants' responses ranged in regards to the activity; however, there was great consistency about how crucial the time spent together was. One participant alluded to the value of this due to it being re-emphasized throughout the interview.

I encourage parents to make sure that there are undivided minutes [with their kids].

It's more about daily interactions.

Spending time together, not talking about chores.

It seemed to be a frequent practice among therapists to convey the importance of this to the parents during therapy. Participants discussed suggestions they gave parents about small things they can do with their adolescent(s) and ways to incorporate family time into their everyday lives. One participant suggested *taking a walk together or going out to get a doughnut, little things like that.* Two participants spoke of spending time together at dinner.

Family time together. Building rituals. As little as…it could be the family meal.

> *Eating dinner together more often, you know, and they are watching TV*
>
> *and going to a movie together…it's just all the little nuances that for me,*
>
> *are just as important as the likert scale.*

These quotes explain the little things that therapists observe that indicate more closeness between a parent and adolescent. They illustrate how meaningful it can be for parents and children to simply have dinner together; time spent together does not have to include major outings and activities.

Use of Modeling. Many of the participants spoke about doing activities and playing games during sessions with families to model the importance of parents bonding with their adolescent to encourage further engagement at home. Additionally, this appeared to be an effective use of skill-building. One participant discussed an activity done in therapy to facilitate positive interactions. *One intervention I will use is modeling that. So, one example is with teenage girls, will have teenage girls and mom paint each other's nails in session.*

Two participants spoke about parents using post-it notes to point out strengths in their adolescent. This gesture can be a powerful way to enhance the parent-adolescent relationship. By using such a technique, parents can model the importance of positive interactions for their kids.

> *I have parents who will, for 30 days, write little post-it notes and they have*
>
> *to write positive things.*

Putting it up in the kid's room for 30 days in a row and on the post-it note

is just some strength or behavior. Either some quality about the kid that

they appreciate or a behavior from the kid that they have seen that they

appreciate.

This is suggested by the therapist in hopes that this family will learn to have consistent positive interactions following this task. Participants spoke of the effectiveness; they found that some adolescents began responding to their parent(s) with a post-it note as well. These positive interactions can potentially foster a stronger relationship.

Shared Laughter. Three participants mentioned laughter and smiling as signs that the parent-adolescent relationship is being repaired. When there is playfulness between the dyad, it can be assumed that the relationship is at a good place. Though they may appear to be small signs, the participants spoke of the impact these small interactions had on family relationships; they were reported to be an indicator that there is improvement in the parent-adolescent relationship**.**

When you see a kid and parent joking around more, or smiling

more…more playful.

Laughing together in a session or sitting close together in the room.

More laughing. More playing, for sure more playing. Just being playful

with each other.

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When I can see the parent and that child laughing.

The frequency of participants mentioning laughter indicates the positive influence it has on the parent-adolescent relationship.

Discussion

The research question in this study was: What do mental health practitioners do to improve parent-child relational outcomes to respond to adolescents' mental health needs? Supplementally, what specific theories and practices do they use and how do they implement these practices? This study sought to obtain theories and approaches utilized by therapists who work with adolescents and families. Eight family therapists provided insight about effective practices. "Family therapists are in a unique position to actively repair problematic parent-child relationships and in so doing, to create long-lasting change in other relationships" (Walker, 1999, p.43). Therefore, this study aimed at understanding specific values and techniques that are utilized by family clinicians to repair parent-child relationships. The findings from this study illustrate many parallels with previous literature.

Findings Related to Previous Literature

Five of the six themes presented in this study support previous findings from the literature review, including systems approach, trust and safety, cultural awareness and responsiveness, emotional bond, and positive interactions. However, there was no emphasis directly on respect in the literature; only the subtheme of the importance of incorporating everyone's voice when working with families into therapy *was* discussed in previous research (Hawley & Weisz, 2003; Windows et. al, 2004). The discrepancy is

likely due to the researcher's sectioning of the literature review; there was more literature reviewed on adolescent mental health in relation to the parent-child relationship than the clinical practices with families. If the review would have encompassed more findings on the values of practicing with families, respect may have been found. It does appear to be crucial and relevant to practice as it is included in the National Association of Social Workers Code of Ethics (National Association of Social Workers, 2008).

Honesty was another subtheme that emerged within the theme of respect. Although it was not revealed in the literature review, respondents in this study frequently emphasized its value; however, there was not much explanation on how to specifically convey honesty. What does it mean to be honest with clients? How are therapists to achieve transparency with adolescents when they would *like* to encourage adolescents to be open and talk to their parents about things? This is especially challenging with adolescents who are involved in harmful behaviors. Ultimately, it would have been beneficial to elaborate on this topic to better understand therapists' approaches for maintaining honesty. Further discrepancies between previous findings and findings in this study may be due to the emphasis on mental health in the literature review, which was not discussed at length in this study. The parallels between previous findings and findings in this study will be further discussed.

Systems Approach. The first theme, systems approach, was discussed by seven out of the eight participants. It was directly presented in the data. These results are rather significant and indicate that using a systemic perspective is common when practicing with families. Rivett (2008) suggested integrating Cognitive-Behavioral Therapy with a systemic approach when practicing with families. In addition, one participant in this

study specifically discussed how *our agency does MST- Multi-Systemic Therapy,* which relates to previous research that has shown MST to be an effective family intervention when working with adolescents with behavioral and emotional issues (Henggeler, Schoenwald, Borduln, Rowland, & Cunningham, 1998), and which incorporates elements of cognitive-behavioral therapy. Ultimately, it seems to be beneficial to utilize a systemic approach when working with adolescents. As a number of participants in this study discussed, incorporating the family into treatment with an adolescent is especially vital. However, this can prompt issues related to third-party billing. Unfortunately, these issues can inhibit the utilization a systems approach when it is crucial to the adolescent's treatment outcomes. Largely, this theme relates to the other themes; family systems appears to be the umbrella approach that encompasses the approaches presented in the following themes.

Safety and Trust. The second theme, safety and trust, was found due to the overwhelming amount of data related to it. It is clearly of great importance when doing therapy with any family as previous research stated; when assessing the developments in family therapy approaches, Rivett (2008) found safety to be of the utmost importance within the therapeutic environment with families. If a family feels safe in therapy, they will better able to discuss difficult issues. In addition, previous research discussed how "Therapists should work to create a supportive and collaborative therapeutic climate that will likely contribute to parental and adolescent behavior change, as well as lead to an overall positive therapy experience for the parents" (Sheridan et. al 2010, p. 155)

This theme was found in every participant's data; however, it manifested itself in different forms. Some of the subthemes that emerged within this safety and trust were

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confidentiality and the significance of the therapeutic relationship. Confidentiality was

mentioned by five of the eight participants, indicating how crucial it is. One therapist

talked about it as clarifying what is protected and what is not protected. Similarly,

another therapist spoke of informing families about their role as a mandated reporter.

Ultimately, building a trusting therapeutic relationship appears to be crucial for obtaining

effective outcomes when working with adolescents and their families. In accordance with

previous findings from Green et. al (2013), which indicated that the therapeutic

relationship is more important than the actual treatments, many participants referenced

the vital impact the relationship has on treatment. The relationship piece was noted by

one therapist as the foundation of doing good work, without which success is highly

unlikely.

Cultural Awareness and Responsiveness. This theme is not directly related to

the research question, but is evidenced as an essential component of clinical practice with

families. All eight participants stated their efforts for being culturally competent.

Although some previous research alluded to this theme, it was more strongly emphasized

among these participants. A previous study explored the mental health of adolescents in

urban families and found that poverty was related to externalizing and internalizing

mental health problems in adolescents (Stern et al., 1999). This finding indicates the

frequency in which families in such situations may significantly benefit from therapy,

although the economic barriers may stand in the way.   Several participants in this study

reported waiving co-pays and offering a sliding fee scale in order to accommodate those

in need. It was discussed as a duty to respond to the socioeconomic barriers of families.

One major subtheme that emerged from this theme was that of meeting basic needs. Many participants spoke of holding off on their intervention to connect families to resources; it was critical to have basic needs met before therapeutic interventions could be effective. Previous research also indicates this is the case. The basic needs of families must also be met before attempting reparative work. The therapy process should be framed to the client's (family's) needs (Windows et. al, 2004). The reoccurrence of this theme conveys clinical significance even though it is not directly related to the research question. It is essential for therapists to be aware of this component in therapy. Every family will enter therapy at a different place. It is the therapist's job to meet each family where they are and address any barriers that may be in the way of achieving positive outcomes in therapy. This may mean that the therapy process will take longer. However, it will likely help the positive outcomes to endure after therapy has ended. As this theme illustrates, cultural awareness and responsiveness will aid in understanding and addressing *all* the needs of a family, which speaks to generalist social work practice.

This theme draws on macro-level issues that may be impacting families. The large economic gaps that continue to grow between the upper class and lower class in our society likely play a role in generational patterns of poverty. Many lower class families face economic struggles that make it difficult for them meet their basic needs. Theses impoverished families struggle to get ahead and obtain resources. Without finances and resources, these families mental health needs will likely go unaided. Therefore, the use of macro-level advocacy would be useful for addressing such issues that are impacting micro-level practice.

Emotional Bond. The theme of the emotional bond [between the parent and child] was referenced by all eight participants in a variety of ways. It was discussed as an indicator of the quality of the parent-child relationship: the stronger the bond, the better quality the relationship. This theme encompassed subthemes of attachment/attunement, softening, and communication, which were all directly stated by therapists as things to encourage parents to strengthen in their relationship with their adolescent. The first subtheme, attachment, was present throughout the majority of the literature review as well as in some of the data in this study. This also identifies with the contextual framework of this study. One participant referenced attunement and engagement when referencing the parent's responsibility in the relationship. This finding aligns with previous research. Attunement and responsiveness have been found to be essential for creating a healthy parent-child relationship (Bloch & Guillory, 2011; Green et. al, 2013). This leads to further emphasis on strengthening the parent child-relationship.

Many participants spoke of aspects that they believe strengthen the parent-adolescent relationship. They discussed softening as a useful way for parents to connect with their adolescent. Additionally, the use of encouragement and affirmation were portrayed as positive parenting techniques. However, little was discussed about how to encourage parents to build the relationship without shaming the parent or making them feel like an inadequate parent. It would have been useful to better understand the role of the therapist in the instance when parents are not in tune with these approaches.

The last subtheme, communication was also a significant finding in both previous research and this study. The emphasis on building communication between the parent-child dyad has repeatedly existed in findings from other studies. When discussing

indicators of positive therapeutic outcomes between parents and adolescents, one participant conveyed the importance of good communication providing safety for the adolescent and parent to talk to each other. Congruently, another participant spoke of the therapist's role of *opening up more direct communication.* Previous literature consists of similar findings. Capps (2012) discussed the importance of parents being open and regularly communicating with their children. Furthermore, prior research has supported the benefits of positive communication. Empathetic responses during communication were found to strengthen the parent-adolescent relationship (Capps, 2012; Spring et al., 2002). Overall, communication appears to be a key aspect within this theme of the emotional bond.

Positive Interactions. The final theme that arose from the data in this research was that of positive interactions. This encompassed an array of examples, but some of the more prominent ones discussed by participants were families spending more time together, laughing together, and playing together. Additionally, participants spoke about ways to build these interactions into family therapy sessions, so as to model it for the parents. This theme is significantly related to the topic in this research as well as previous literature findings about simply being together. Spending family time together was a reoccurring subtheme in this study. *It's more about daily interactions,* one participant explained. Certain therapy models emphasize the value of family interactions. Emotion-Focused Family Therapy (EFFT) promotes family interaction dynamics to improve psychological and emotional health (Bloch & Guillory, 2011). The benefits of family rituals were discussed by a participant, which had also been noted in previous research. *Family time together. Building rituals. As little as…it could be the family meal.*

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Hair et. al (2008) also found family rituals to enhance an adolescent's self-esteem and identity due to familial cohesiveness. Family rituals also help to better prepare families to handle difficult situations (Hair et. al, 2008).

Many participants in this study spoke of how family bonds appear to be strengthened when the parents and adolescents can laugh and smile together. They discussed how this was an indicator that therapy was effective in improving the parent-adolescent relationship. While this repeatedly occurred in the data from this study, the literature review did not reveal such findings. A similar and final subtheme, playing together, was mentioned by many participants. It described as a form of modeling healthy interactions for parents while in therapy by many participants. Previous research has examined Filial Therapy as a form of educating and modeling for parents through play. It was derived from play therapy and educates parents on how to utilize play therapy skills. The approach emphasizes the benefits of building strong parent-child relationships in order to provide that safety for a child (Capps, 2012). Additional studies showed that through empathy (Walker & Gillian, 1999) and attunement to the child (Green et. al, 2013), the therapist may then act as a model for the parent. These findings imply that the role of the therapist is to model and educate parents and families of the benefits of regular positive interactions.

Strengths and Limitations

It is useful to note the strengths and limitations of this study. The strengths are that it provides useful practice implications for clinicians. The data in this study includes approaches as well as specific techniques for implementing them. Additionally, the consistency of results among the different professional backgrounds of the participants

was a strong point of this study. Though there may be differences in training and experience, there were several common themes among the variety of clinicians, which strengthens these findings. This research has added to previous research by providing more specified information and guidance for practitioners. There were also several limitations in this study.

Firstly, the sample size was relatively small, with eight participants, which does not allow the results to be generalized. The use of convenience sampling also limits the generalizability of this study. The differences in theoretical lens of the participants also limit the results. Some of the participants work for agencies that require them to adhere to a specific treatment model, which likely influenced their approaches. The participants who had more clinical experience working with adolescents and families were able to provide more information and specific examples, whereas those early in their practice did not have as many specific examples to offer.

Furthermore, the age of adolescents was not specified by the researcher; therefore, some of the participants responded in reference to younger children. Finally, deciphering the effectiveness of family interventions for strengthening the parent-adolescent relationship did not result in overly consistent findings among the participants. It was simply difficult to quantify as a therapist. Some participants discussed it in regards to overall family interactions, whereas some participants spoke about it in regards to the emotional connection. While both appear to be relevant, this study left more to be examined. These limitations could be addressed in future research.

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Implications for Future Research

This qualitative research project has investigated the topic of parent-adolescent relationships and therapeutic practices for working with families from the perspective of clinicians. It highlighted the importance of strengthening the parent-child bond through connection, communication, and togetherness. Furthermore, it examined specific approaches for implementing these values into therapy practices. Future research would benefit from gaining further understanding about what specific aspects help strengthen the quality of the parent-adolescent relationship.

Some of the practices mentioned in this study could be expanded upon in future research. For instance, the method of informing parents of the benefits of softening when parenting adolescents could be studied. A future study would help to understand how practitioners can encourage parents to soften their approach without making them feel as though they are inadequate parents. What specific things should be said to aid in alleviating judgment when discussing this with parents? Additionally, a future study expanding on the significance of families laughing and smiling together would be beneficial to add to social work research. Future research could investigate the significance of this finding as well as provide specific approaches and implications for incorporating fun and laughter into family therapy.

It would be also useful to obtain a qualitative study from the perspectives of families after receiving therapy. This would aid in answering the question: what aspects of therapy were most helpful for strengthening the parent-child relationship? In addition, what steps were taken to strengthen the relationship and what are the most important values within that relationship? By obtaining perspectives from both the parent(s) and

adolescent, a qualitative research study would more accurately capture the outcomes of interventions once treatment has been completed. Future studies should aim to inform and educate clinicians about interventions that have been successful. The research gathered from potential future studies could further improve the practices used by family clinicians.

Implications for Social Work Practice

The findings from this study highlight some of the approaches utilized by family and mental health practitioners when working with parents and adolescents. The practices emphasized in this study are applicable to social work practice. Many findings from this study are exemplary of the National Association of Social Workers' Code of Ethics. This study offers effective approaches to assist practitioners in becoming more competent in their practice, which is a principle of social work. It also highlights the importance of human relationships, which is identified in the code of ethics. The cultural piece of the study is strongly related to social work values; cultural competency is valued by social workers to gain understanding of their clients without discriminating. Finally, the theme of respect found in this study is a core value of social work (National Association of Social Workers, 2008). In addition to the adherence of social work values, the parallels between previous research and this study indicate the effectiveness of these practices.

The findings on the use of a systems approach with families that derived from this study illustrate implications for practice. They imply that there are a number of benefits that therapists discover from approaching therapy with a systemic perspective. Additionally, it was also emphasized as a useful one when working individually with

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adolescents; they are involved in numerous systems that impact their functioning. This study also suggested central theories and values when working with families. This is imperative information for clinical social work practitioners to be cognizant of when doing therapy.

The importance of safety for families was found to be crucial. The ways in which a therapist can create safety was explored. Some specific methods of doing so included discussing confidentiality at the beginning of treatment, joining with the family, and slowly building rapport by conveying non-judgment. Similarly, this alludes to the finding of cultural awareness and response. If practitioners culturally respond to families, they are more likely to achieve positive outcomes in therapy. More specifically, social work practice may need to incorporate more training to focus on addressing the basic needs of clients. Furthermore, policy implications could be useful to support advocating for policies to help meet everyone's basic needs. These are all practices that are useful for family therapists to keep in mind.

Significant to this study, the practices used to strengthen the parent-adolescent relationship help inform clinical social work practice. Firstly, participants spoke of how crucial it was for parents and adolescents to communicate with one another. It was further noted that it is important to encourage *positive* communication, rather than participating in arguments. As previously mentioned, in order to strengthen the communication within the relationship, it was suggested that practitioners assist parents in softening their approach. This practice implication is related to Gottman's work in couple's therapy. His method has informed practitioners of the benefits of partners utilizing soft responses, when discussing issues, in order to build emotional connection (Gurman, 2008). This

practice could also be applied to therapy with parents and adolescents. Practitioners could model and inform parents of using soft responses to regulate negative affect. The use of modeling in therapy was also found to be constructive for additional practices of strengthening the parent-adolescent relationship.

Practitioners in this study indicated the importance of parents and adolescents spending time together. In order to encourage that, some practitioners spoke of modeling it by playing games in session or talking about family rituals. Additional methods suggested by practitioners were to simply motivate parents to dedicate moments each day to their adolescent. For instance, therapists can give homework to parents and adolescents to spend 15 minutes a day together. Additionally, the importance of laughter between parents and adolescents could prompt practitioners to be clinically intentional to encourage this between the dyad. The practice of promoting/modeling enjoyable interactions could be one way to implement this into therapy. By utilizing this method of modeling and encouraging family time, practitioners are thereby assisting to strengthen the family bond. Consequently, this is a seemingly beneficial implication for practice with families.

Ultimately, these findings assist in training practitioners on what specific techniques are effective in practice, especially new family practitioners. The findings in this study do have clear benefits for the practice of social work. Nevertheless, this study does not comprehensively identify all of the implications for practice with parents and adolescents. Further analysis of therapeutic interventions with families would be advantageous.

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Appendix A

CONSENT FORM

UNIVERSITY OF ST. THOMAS

[The Impact of Parent-Child Relationships on Adolescent Mental Health]

[544144-1]

I am conducting a study about the skills clinicians use in session to address the parent-child relationship. I invite you to participate in this research. You were selected as a possible participant because you specialize in this area of practice. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Michelle Justen, student of the School of Social Work: University of St. Thomas/St. Catherine University.

Background Information:

The purpose of this study is: to explore and better understand mental health practitioners' best practices for working with parents and their adolescent children.

Procedures:

If you agree to be in this study, I will ask you to do the following things: Meet with me to partake in one interview that will last approximately 45 minutes. You will be asked to respond to 12 questions with detail and any additional questions prompted during the interview. Additionally, you will be asked if you know any other clinicians that would like to participate and offer.

Risks and Benefits of Being in the Study:

The study has some minor risks. Discussing intervention practices could potentially induce uncomfortable feelings about "not doing enough" for clients. Additionally, the clinician may feel uncomfortable disclosing some information related to his/her practice.

There are no benefits to participating in this study; no monetary rewards will be given for participation.

Confidentiality:

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. The types of records I will create include consent forms, audio recordings, and written notes, which will be locked up at the residence of the researcher. Any transcribed information from the interview will be kept on a password-protected computer. The researcher will be the only person with access to these records. These records, including the audio recording, will be destroyed after the study is complete on June 1, 2014.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with or the University of St. Thomas or St. Catherine University. If you decide to participate, you are free to withdraw at any time up to and until one day after the interview. Should you decide to withdraw data collected about you will not be used. You are also free to skip any questions I may ask.

Contacts and Questions

My name is Michelle Justen. You may ask any questions you have now. If you have questions later, you may contact me at via email at just9515@stthomas.edu or via phone at 763-923-5777. My advisor, Lance Peterson may also be contacted at 651-962-5811. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

STRENGTHENING THE PARENT-ADOLESCENT RELATIONSHIP

I have read the above information. My questions have been answered to my satisfaction.
I consent to participate in the study. I am at least 18 years of age. I also give permission
to be audio recorded during the interview.

_____   _____

Signature of Study Participant   **Date**

_____

Print Name of Study Participant

_____   _____

Signature of Parent or Guardian   **Date**

> **(If applicable)**

_____

Print Name of Parent or Guardian

> **(If Applicable)**

_____   _____

Signature of Researcher   **Date**

STRENGTHENING THE PARENT-ADOLESCENT RELATIONSHIP

Appendix B

Qualitative Interview Questions

1. What is your educational/professional background?

2. What is your current position/role?

3. How frequently do you work with adolescents and their parents?

4. What is the primary theoretical approach you use?

    a. What supplemental theoretical approaches do you use?

5. What do you do to provide a safe therapeutic environment for families? Please provide specific examples.

6. Do you find any socio-cultural factors that impact your work with families? If so, please explain.

7. Does your approach change when families have significant socioeconomic struggles?

8. How do you decide what to focus on in therapy? Do you focus more on the parents' needs or the adolescent's needs?

9. What are some theories/values you find of great importance when working with families?

10. What specific approaches do you use with adolescents and their parents to strengthen the adolescent/parent relationship?

    a. When you use these approaches, how do you implement them?

11. What approaches do you use that are not clearly articulated in theories, but you believe encourage positive therapeutic outcomes with adolescents and their parents?

    a.   Any specific examples?

12. What are the signs that progress is being made with parents and adolescents?