

5-2017

Incorporating Caregivers into Adolescent Psychotherapy: A Systematic Review

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Recommended Citation

Taylor, Kelsey. (2017). Incorporating Caregivers into Adolescent Psychotherapy: A Systematic Review. Retrieved from Sophia, the St. Catherine University repository website: https://sophia.stkate.edu/msw_papers/796

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Incorporating Caregivers into Adolescent Psychotherapy: A Systematic Review

by

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MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work

St. Catherine University and the University of St. Thomas St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University - University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

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Abstract

This systematic review explores the therapeutic factors that influence how effectively caregivers are incorporated into various therapy models with their adolescents. The five therapeutic models investigated in this study are: individual therapy, cognitive behavioral therapy, dialectical behavioral therapy, ecologically-based family systems therapy, and attachment-based family therapy. Using the University of St. Thomas “Summons” search engine, 14 articles were selected for use in this study. The three predominant themes that emerged in the findings were a need for strong boundaries between clinicians and caregivers, sound clinical judgement in terms of when it is appropriate for caregivers to be involved, and the need for balanced therapeutic alliances between clinicians, caregivers, and adolescent clients.

Keywords: Adolescent Therapy, Caregiver Involvement, Attachment, Therapeutic Alliance, and Family Therapy

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Acknowledgements

I would like to thank my research chair, Renee Hepperlen, as well as my research committee members Brad Turner and Alea Johnson, for their guidance throughout this process. Your knowledge and feedback has been very much appreciated. I would also like to thank my family, friends, and fellow MSW students who have supported and encouraged me in this program for the past two years. I feel very fortunate to have been surrounded by such a positive and caring network of people.

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The involvement of parents or other caregivers in adolescent therapy is a common practice across many different types of settings. Adolescent therapies come in many forms and may serve different purposes. Whether the therapy takes place in a school, crisis program, outpatient clinic, or family-based program, it is common for adolescent therapy to focus on issues related to family interactions and the home environment. Mental health services encourage and often require adolescent caregivers to be involved in and consent to treatment for their children. While some treatment programs do not require caregiver involvement beyond a basic consent for participation, many programs may encourage involvement in the form of family therapy, groups, provider meetings, etc. The involvement of caregivers in adolescent treatment has been shown to be effective in securing treatment retention and reducing rates of attrition in community settings (Pravin, Thomsen, Langeviold, & Stormark, 2007).

This paper defines adolescent therapy as any therapeutic programming that specifically focuses on the treatment of adolescents. Some examples of this include, but are not limited to, family therapy, individual therapy, and residential treatment. The definition of caregivers should be understood as parents or other adults who maintain guardianship over an adolescent. This paper does not explore how other types of family relationships impact the adolescent in psychotherapy. Finally, it is important to understand the term “therapeutic alliance” and its importance to work with adolescents and their caregivers. The definition of therapeutic alliance (known in some literature as a “working” alliance) is “consisting of both a positive, supportive bond between client and therapist, and mutual collaboration and agreement between client and therapist on the tasks and goals of therapy” (Hawley & Garland, 2008, p.59). The therapeutic

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alliance will be discussed throughout this paper in terms of both the adolescent (client) relationship with the therapist, and the caregiver(s) relationship with the therapist.

The purpose of this systematic review is to analyze and consolidate themes in recent literature on the subject of caregiver participation in adolescent therapy. The effectiveness of caregiver involvement in treatment will be examined through the review of several treatment models: individual therapy, cognitive behavioral therapy, dialectical behavioral therapy, ecologically-based family systems therapy, and attachment-based family therapy. In order to achieve this, attachment theory was used as a conceptual model for understanding how caregiver involvement both contributes to, and detracts from the therapeutic process. This paper examines caregiver involvement in terms of quality of attachment between caregivers and adolescents, and the therapeutic alliance between the caregiver(s) and therapist. In order to understand the benefits of caregiver involvement in adolescent therapy, this systematic review seeks to answer the question: What treatment models most effectively incorporate caregivers in therapy with their adolescents?

Literature Review

The purpose of this literature review is to explore and illustrate how adult caregivers are involved with their adolescents in therapy settings. Before examining the effectiveness of caregiver involvement in various treatment modalities, it is necessary to understand the purpose of the involvement, potential barriers, factors related to adolescent age and gender, and what involvement looks like across different treatment settings. The significance of the “therapeutic alliance” and the role of attachment are explored in order to provide context for the different types of relationship dynamics that occur in psychotherapy settings. Additionally, an overview of the following treatment models is provided: individual therapy, cognitive behavioral therapy,

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dialectical behavioral therapy, ecologically-based family systems therapy, and attachment-based family therapy.

Purposes of Caregiver Involvement

Adolescence can be a vulnerable life-stage, in which teens strive to distance themselves emotionally from family members and more closely align themselves with peer groups. Though this is a normal and healthy transition to make, caregivers may perceive this period as a form of deviance. Caregivers may also discern their children's pulling away from them as decreased need for family involvement and support in their lives (Robinson, Power, & Allan, 2011). While developing independence and autonomy from the family are important developmental tasks associated with adolescence, it is also critical for caregivers to continue to provide emotional support. According to Kocayoruk, Altintas, and Icbay (2015), adolescents who received parental support for basic psychological needs (i.e. autonomy, competence, and relatedness) were more likely to experience positive adjustment and mental health. This assistance demonstrates that caregivers are able to have an important impact on their children in the ways that they both involve themselves and encourage independence. Similarly, high levels of parental involvement are also associated with higher levels of well-being and "autonomous-self" among adolescents (Kocayoruk, Altintas, & Icbay, 2015). Caregivers can extend these benefits from the home into their child's therapy. When treatment providers involve caregivers in their child's therapy, families experience more consistent patterns of interaction with their adolescents (Hardway, Pincus, Gallo, & Comer, 2015).

Caregivers can aid in the therapeutic process when they are able to adapt to their children's evolving needs. Caregivers need to demonstrate an awareness of their adolescent's

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growing need for autonomy, while continuing to respond to their attachment needs. Adolescents respond more positively to emotional support in the form of verbal reassurances, guidance, and open discussion. Caregivers that are able to adapt to these shifting needs are more likely to promote their adolescent's growth in a therapy setting (Ewing, Diamond, & Levy, 2015). While autonomy-granting is important, caregivers also serve as moderators for adolescent's decision-making capacities. In early adolescence, the parts of the brain that correlate to reward needs are more highly aroused, while the parts of the brain that control self-regulation and avoidance of harm are still relatively immature (Robinson, Power, & Allan, 2011). This developmental process requires adolescent caregivers to exert some control over matters of health and safety, while also modeling responsible decision-making processes.

The Therapeutic Alliance

Developing a strong therapeutic alliance is a crucial component of adolescent psychotherapy. Creating a strong partnership between the client and therapist can result in greater client motivation to work on problems, greater persistence in therapy, improved compliance with therapy tasks, and more positive therapeutic outcomes overall (Hawley & Garland, 2008). In adolescent therapies where caregivers become involved, the ability to create a therapeutic alliance becomes more challenging. The therapist's attempts to establish a therapeutic alliance are bidirectional, and may result in conflicting perceptions between adolescents and their caregivers. The therapeutic alliance is an emerging "core ingredient" to the retention of family members in treatment. Families that drop-out of therapy are typically characterized as having significantly discrepant relationships with their therapists (Robbins, Mayorga, Mitrani, Szapocznik, Turner, & Alexander, 2008). The differing needs and perceptions of adolescents and

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caregivers in therapy may further complicate the discrepancies that arise. The alliance between the adolescent and the therapist, and therapist's alliance with the adolescent caregivers influence different therapy goals and different aspects of the therapy process (Hawley & Garland, 2008). A unique challenge faced by therapists working with adolescents and their caregivers is the need to provide equal attention to the concerns of the caregiver and the perspectives of the child. This dual focus becomes further complicated by the fact that adolescents and caregivers in therapy rarely agree on, or perceive their problems in the same way (Sheridan, Peterson, & Rosen, 2010).

A strong therapeutic alliance between the therapist and caregiver(s) is important for several reasons. A therapeutic alliance with parents corresponds to higher quality family participation across the duration of the treatment. In cases where caregivers were involved in therapy, there was greater mutual agreement between the therapist, caregivers, and adolescent clients termination and treatment trajectory. Additionally, forming an early alliance with adolescent caregivers is shown to be a significant predictor of positive therapy outcomes (Pravin, Thomsen, Langeveld, & Stormark, 2007). Therapists can build a strong alliance with caregivers early on by recognizing that many caregivers feel that they have exhausted all other options and are unclear about what direction to take with their children. Additionally, therapists build stronger alliances with caregivers when they are sensitive to the fact that early on in therapy, caregivers may feel inadequate or exhibit a sense of failure (Sheridan, Peterson, & Rosen, 2010).

For adolescents, there is a strong association between the therapeutic alliance with the therapist and symptom improvement (Hawley & Garland, 2008). In developing a strong therapeutic alliance between the therapist and child or adolescent, trust constitutes one of the most important aspects of the relationship. Therapists can be successful in gaining the

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adolescent's trust by differentiating themselves as a neutral figure in the adolescent's life- apart from authority figures such as parents, teachers, and coaches (Campbell & Simmonds, 2011). Therapists can also strengthen their alliance with an adolescent client by observing increased needs for autonomy and privacy from family. Though therapists are still bound by strict mandated reporting policies, they can also acknowledge the adolescent's need for increased responsibility over their own care and provide a safe space for self-expression (Feinstein, Fielding, Udvari-Solner, & Joshi, 2009). While in some ways this may conflict with the interests of involving caregivers, it is also an important component of developing an alliance with adolescents.

Gender Roles and Differences

Some studies have suggested that mothers and fathers (or female and male caregivers) play different roles in the ways they emotionally support and aid in the development of children. According to one study profiling adolescent perceptions of support in a mother-high, father-low group (meaning mothers who were highly supportive, and fathers who demonstrated low support), the levels of perceived involvement, autonomous support, and warmth were systematically higher (or equal to) than father levels. Despite this, adolescents in the same sample perceived that their fathers still contributed substantially to these measures of support (Kocayoruk, Altintas, & Icbay, 2015).

In another study examining the alliances that formed during Brief Strategic Family Therapy (BSFT), maladaptive family interactional patterns were found to have an affect on the level of involvement parents had with adolescents. Mothers are more likely to become over-involved and embroiled in conflict with their adolescents, whereas fathers (if present) tended to

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be left out of the highly conflictual mother-child dyad (Robbins, Mayorga, Mitrani, Szapocznik, Turner, & Alexander, 2008). Esbjorn, Somhovd, Nielsen, Normann, Leth, and Reinholdt-Dunne, (2014), also address how higher levels of maternal involvement impact the course of therapy for adolescents. They argue that mothers tend to spend more time with children attending to aspects of everyday care, and therefore may be more attuned to their children's needs and have more specific concerns to address in therapy.

Family cultural factors are also important to understanding caregiver dynamics within the family system and the level of involvement caregivers have with adolescents. It is common in many cultures for fathers to assume the role of head-of-household and primary authority figure for the family. Likewise, it is common for mothers to assume responsibility for more of the day-to-day tasks of child management and development. This hierarchical structure of parenting roles is frequently seen in Hispanic families. It is important to note that while these roles are culturally gendered, there is typically some cross-over between mothers and fathers in exerting authority and management of the children (Robbins, Mayorga, et al., 2008).

The gender of the adolescent is also an important factor in understanding how caregivers involve themselves in psychotherapy settings. More specifically, the gender of the child impacts the level of discrepancy between adolescents and their caregivers in therapy settings. According to Guo and Slesnick (2013), differences in perceptions of family functioning are strongly related to the child's gender, but not to the caregiver's gender. Furthermore, Guo and Slesnick found that adolescent boys tended to hold more discrepant views of family functioning compared to teen girls. As a result, adolescent boys displayed a slower rate of improvement in their discrepancies with caregivers.

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Gender also plays a role in the ways that caregivers view or respond to their children's treatment. Caregivers were found to be more involved in the treatment of adolescent boys as opposed to girls. Pravin, Thomsen, Langeviold, and Stormark, (2007), identified adolescent boys as being more likely to develop early-onset psychiatric disorders, which may contribute to perceptions of greater vulnerability among adolescent boys. Similarly, adolescent boys have been found to be much less open to discussing emotional and relational issues compared with adolescent girls. Due to this, girls tend to show more rapid improvement in therapy settings across time (Guo & Slesnick, 2013).

Age of the Adolescent

The age of the adolescent has important implications for the caregiver's level of involvement in therapy. Younger adolescents are typically more dependent on their caregivers for a variety of needs, while older adolescents are developing more autonomy and independence from their caregivers. Younger adolescents tend to be dependent on their caregivers for the use of psychotherapy services as a means of transportation to appointments and providing information that is critical to the assessment and treatment process (Pravin, Thomsen, Langeviold, & Stormark, 2007). Therefore, it is understandable that younger adolescents are inherently more dependent on their caregivers to be physically present in their treatment. Given that young adolescents tend to be more dependent on caregivers, Hawley and Garland (2008) argue that caregiver behaviors and the quality of the child-caregiver relationship are given more explicit focus in therapy sessions. Despite evidence that younger adolescents tend to be more dependent on their caregivers in therapy settings, high levels of involvement may not be therapeutically beneficial. Younger adolescents tend to benefit more when their caregivers are less involved in

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therapy sessions. Younger adolescents (beginning at about age thirteen) are beginning to transition away from their caregivers and demonstrating an increased need for autonomy.

Younger adolescents are able to meet this need by participating in therapy without the presence of caregivers (Hardway, Pincus, Gallo, & Comer, 2015).

Involvement Across Settings

Therapeutic interventions look different across different types of adolescent treatment settings, and so too are the ways that caregivers may be involved. In residential treatment centers, where children and adolescents receive treatment on an in-patient basis, caregivers may come into the facility to participate in therapy with their child or attend caregiver specific programming. Family proximity to the residential facility is perhaps the greatest factor as to whether caregivers can visit and participate with their child in therapy. Caregivers are more likely to visit and participate regularly with younger children or adolescents as opposed to older adolescents (Nickerson, Brooks, Colby, Rickert, & Salamone, 2006). In school settings, caregivers are frequently invited to partake in therapy. Aside from caregivers, teachers are also commonly involved in the therapeutic processes. According to Feinstein, Fielding, Udvari-Solner, and Joshi (2009), parents, teachers, and therapists make up the three primary therapeutic relationships in school settings. Since teachers play a significant role within the child's school social environment, therapists and caregivers must often create space for teachers within the therapeutic process, and subsequently foster a dual alliance with teachers. While "individual" therapy with adolescents may still incorporate caregivers, family therapy is distinctly different in its approach to integrating family members. In Ecologically-Based Family Therapy (EBFT), the therapy utilizes family systems theory by attempting to create more positive connections among

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family members and interrupting negative feedback loops (Guo & Slesnick, 2013). This approach does not focus explicitly on the adolescent, but rather incorporates all relevant members of the family system.

Treatment Models

Therapists and treatment programs use several treatment models are frequently used in adolescent therapies. Family systems therapy requires the involvement of multiple family members, and may or may not focus on one specific client. This type of therapy model focuses on developing more adaptive social skill sets among each family member in an effort to break down maladaptive interaction patterns in families. “Family systems therapy aims to improve the communication among family members and enhance the functioning of the family and it’s individual members” (Guo & Slesnick, 2013, p.184).

Similarly, attachment-based family therapy employs family interventions to treat adolescents with depression. “ABFT relies on a transactional model that aims to transform the quality of adolescent-parent attachment, as a means of providing the adolescent with a more secure relationship that can support them during challenging times” (Ewing, Diamond, & Levy, 2015, p.136). The key difference here is that ABFT focuses explicitly on strengthening the attachment relationship between caregiver and child, while family systems therapy looks at family interactional patterns as a whole.

Individual therapy has an explicit focus on one patient, but may or may not utilize other family members in the process. In terms of adolescent therapy, caregiver involvement is critical for recognition of behavioral patterns and intervention of maladaptive behaviors (Hawley & Garland, 2008).

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Cognitive behavioral therapy (CBT) is a treatment model that is used primarily in the treatment of anxiety disorders. CBT specifically targets the treatment of broader negative emotional symptoms, such as depression (Hardway, Pincus, Gallo, & Comer, 2015). CBT may be considered a sub-category of individual therapy, but focuses on a very specific treatment need.

Finally, dialectical behavioral therapy (DBT) is a group treatment model that teaches social and coping skills aimed primarily at managing symptoms of depression and anxiety. DBT groups are segregated between adults and adolescents, and differences exist in the ways treatment is delivered to these two groups (Katz, Fotti, & Postl, 2009). Though caregiver involvement is not an explicit focus of DBT with adolescents, this treatment model does encourage family participation in a variety of ways.

Barriers to Effective Caregiver Involvement

Even with the best of intentions, the involvement of caregivers in therapy can sometimes come at a cost to the child. Regarding consistent participation in sessions, caregivers sometimes experience barriers in terms of transportation to programming, personal problems, legal issues, and conflicting parenting obligations with other children (Nickerson, Brooks, Colby, Rickert, & Salamone, 2006). These barriers are more physical in nature, in the sense that they may prevent caregivers from consistently showing up and participating in therapy. Even more complicated are the barriers that arise when caregivers are present with their children in therapy. “Family conflict is frequently a negative moderator of treatment outcome” (Ewing, Diamond, & Levy 2015, p. 137). Similarly, chaotic home or family environments may contribute to increased adolescent risk-taking behaviors. “Characteristics of such environments may include physical and sexual

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abuse, neglect, attachment problems, parental mental illness, and family conflict, stress, and breakdown” (Robinson, Power, & Allan, 2011, p.57).

Over-involvement or over-protection on the part of the caregiver may also constitute a barrier to effective treatment. According to Hoff-Esbjorn, Somhovd, Nielsen, Normann, Leth, and Reinholdt-Dunne, (2014), caregiver over-protection can result in increased anxiety in children, but the presence of anxiety and poor adjustment may also trigger overly protective responses in parents. “Over-involvement or over-intrusive behavior, where parents provide unsolicited help and do not encourage autonomy in the child, seems to be one of the most influential rearing behaviors associated with anxiety disorders” (Hoff-Esbjorn et. al, 2014). Caregivers who do not contribute to the psychological needs of their children may also create barriers to effective treatment. According to Ewing, Diamond, and Levy (2015) adolescents whose caregivers do not cultivate feelings of connectedness or belonging in the family system are at an increased risk for depression.

The Role of Attachment

The quality of attachment relationships between adolescents and their caregivers is an important factor to understanding how caregivers can be incorporated into the therapeutic process.

Attachment theory’s central premise is that children have a basic evolutionary instinct to seek out parents for care and protection. When these needs are not met, children are at risk for developing an insecure attachment. While insecure attachment predicts a range of maladaptive outcomes, including depression, secure attachment protects children and

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adolescents and is related to a variety of adaptive outcomes (Ewing, Diamond, & Levy, 2015, p.138).

While attachment theory often refers to a caregiver's ability to consistently meet basic needs (safety, nourishment, shelter, etc.), children and adolescents also require that a number of emotional and psychological needs be met in order to form and maintain healthy attachments.

A growing body of literature indicates that family-related protective factors--such as providing a secure base, being caring, providing a feeling of connectedness and being valued, providing support and giving a sense of belonging-- are linked to positive outcomes in adolescence and beyond (Robinson, Power, & Allan, 2011, p.57).

It is important to consider how adolescence creates changes in attachment relationships and general relationship dynamics with caregivers. As children age and enter adolescence, caregivers are confronted with challenging new behaviors and ideas that upset the established family dynamics. According to Sheridan, Peterson, and Rosen (2010), "Many parents find that familiar forms of encouragement, displays of affection, and rules of discipline no longer work. Their challenge is to delicately balance love and connection with monitoring and discipline during this phase of family life" (p.144). While maintaining this balance may be difficult, it is evident that parenting practices such as monitoring an adolescent's behavior and activities, and remaining involved in decision-making serve as protective factors against behaviors such as delinquency and drug use (Sheridan, Peterson, & Rosen, 2010). Aside from changing behaviors, caregivers must also learn to cope with the transitions that adolescents make from primary reliance on the family, to increasing reliance on peer groups (Robinson, Power, & Allan, 2011).

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Attachment theory is the theoretical lens that will be used to understand the effectiveness of caregiver involvement in the following types of treatment models: individual therapy, ecologically-based family systems therapy, cognitive behavioral therapy, attachment-based family therapy, and dialectical behavioral therapy. While the emphasis placed on attachment will differ between these therapy models, it is a practical lens for understanding caregiver-adolescent dynamics in therapy and evaluating the efficacy of each of these approaches. An analysis of these five therapy models will seek to answer the question: What treatment models most effectively incorporate caregivers in therapy with their adolescents?

Methods

Research Design

A systematic review was chosen as the method for this research study as a means of sampling the recent literature on the topic of caregiver involvement in adolescent psychotherapy, and to identify common themes and findings on the effectiveness of involving caregivers in various treatment models with adolescents. For the purposes of this study, the definition of “recent” literature is peer-reviewed journal articles published no later than the year 2003. The population that this paper focuses on are adolescents and their caregivers participating in psychotherapy services. More specifically, adolescents receiving therapy for depression and anxiety are focused on. Articles were utilized that focused on adolescent psychotherapy in a variety of settings, such as residential treatment, family therapy, intensive inpatient treatment, and adolescents involved in the juvenile justice system. It was important to sample articles focusing on different psychotherapy settings in order to understand similarities and differences in the ways that caregivers are utilized across these settings. Understanding the ways that

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adolescent caregivers strengthen or impact the therapeutic process was an important goal of this study.

Research Criteria and Selection Strategy

Research for the systematic review began with general searches of the University of St. Thomas Library's "Summons" search engine for full-text, peer-reviewed articles focusing on adolescent therapy, caregiver involvement, and attachment theory. The search terms included: Adolescent Therapy, Parental Involvement, and Adolescents and Attachment Theory. During the research process, the author reviewed article titles and abstracts to determine initial inclusion for the study. Articles including keywords for "Adolescent Therapy", "Parent Involvement", "Attachment", "Therapeutic Alliance", and "Family Therapy" met standards for initial inclusion. The author then reviewed each article more thoroughly to determine that there was sufficient discussion of the keywords listed above. Some articles containing the keywords listed above were found to be insufficient in addressing the roles of both the adolescent and caregiver, and were excluded from use in this study. For more information about excluded articles, see appendix A.

A total of fourteen articles were selected for use in the literature review. Detailed notes were taken to identify the overarching themes of each article in order to organize the literature review. The organizational themes identified in the articles used in the literature review are illustrated in appendix B. For the findings section of this study, fourteen separate articles were used. Articles that were published before the year 2003, or that did not explicitly discuss the keywords listed above, were excluded from the study. Of the fourteen articles incorporated, ten

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were published in the United States, two were published in the Netherlands, and two were published in Israel.

Findings

A total of fourteen articles were selected for use in the findings for the five practice models. Initially, eighteen articles were selected. Of these, four articles were later excluded from the study due to lack of connection or specificity of the adolescent-caregiver relationship in therapy. For a listing of articles that were excluded from this study, consult appendix A. During the article selection process, each article that was used in this study was labeled with the name of the practice model that it was intended to describe (i.e. CBT, DBT, etc). For a chart listing the articles associated with each practice model in the findings, see appendix C.

Individual Therapy

While this mode of treatment can be executed through a number of different theoretical approaches, the majority of the work takes place between one client and one therapist. In practice with adolescents, it is common for caregivers to be involved in therapy to a degree. Contact with caregivers is typically established at intake, where caregivers are likely to be initiating the child's therapy and providing a client history for the therapist (Ruberman, 2009). While this may be true of many children in out-patient settings, there are some important distinctions that therapists need to make when deciding what level of caregiver involvement is appropriate to maintain. According to Ruberman (2009):

The decision about with whom the practitioner chooses to consult initially is informed by the child's development and the urgency of the consultation request. Indeed, unless the

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child is an older teenager, parents are almost always included as a part of any consultation (2009, p.359).

It may be inevitable that therapists need to work closely with caregivers in situations where the family has initiated the treatment. After this point however, it is important for the therapist to set firm boundaries with adolescent caregivers. With regards to individual therapy, the therapist should be concerned about limiting the involvement of caregivers in order to establish a strong therapeutic alliance with the client. “Parental work often takes the form of guidance for the parents or information-gathering, and frequency of contact varies depending on the needs of the case” (Ruberman, 2009, p. 359). It is also worth noting the appeal for caregivers to enroll their children in individual versus family therapy. In general, children and adolescents tend to be enrolled more in individual therapy as opposed to family therapy (Graves, Shelton, & Kaslow, 2009). The authors argue that this is likely the case because it is far more challenging to coordinate and engage multiple family members in treatment.

Cognitive behavioral therapy.

Cognitive behavioral therapy (CBT) is a popular treatment model that is used with both adults and children with a variety of disorders. This model seeks to bring about emotional and behavioral change in clients by changing maladaptive thoughts, beliefs, and cognitive processes (Melnyk, Kelly, & Lusk, 2013). CBT can be delivered in a variety of formats, including individual, group, family, couples, and through computerized programs (Webb, Auerbach, & DeRubeis, 2012). CBT is a particularly useful approach to use with adolescents with depression and anxiety, given that it is rooted in changing harmful thoughts and beliefs about oneself. The content of CBT sessions and homework focus on being in the present, examining automatic

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negative thoughts, and learning to change the cognition to more realistic thoughts. With adolescents, this treatment model generally focuses on skill-building, goal-setting, mood monitoring, self-regulation, relaxation techniques, increasing enjoyable activities and social interaction, communication skills, and problem-solving (Melnyk, Kelly, & Lusk, 2013).

Caregiver involvement in adolescent CBT can be positive or negative, depending on the level of involvement and the setting. With regards to out-patient clinic settings, caregiver involvement is important because it allows caregivers to learn about specific skills and cognitive processes that they can use to support their child's change process. Caregivers who are involved in an adolescent CBT program may also be more attuned to their child's goals and dreams, which can improve family functioning and attachment relationships (Melnyk, Kelly, & Lusk, 2013). While the involvement and support of family can be very beneficial to the treatment process, Webb, Auerbach, and DeRubeis (2012) argue that caregiver involvement should be limited. The authors assert that adolescent clients may struggle to connect with and disclose sensitive issues with the therapist out of a fear of this information being shared with parents. If clients are fearful about their confidentiality and the involvement of family members, they are also more likely to engage in therapy-impeding behaviors such as lack of engagement with the therapist, failure to complete homework tasks, and sporadic attendance. The authors argue that therapy should be an opportunity for the adolescent to develop autonomy from caregivers and develop close, trusting relationships with adults outside of the family system. These sentiments are also echoed by Kendall and Peterman (2015) who explain:

Whereas the development of autonomy involves distancing oneself from one's parents, many adolescents seek and value relationships with non-familial adults, and the

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therapeutic relationship may be particularly helpful for the adolescent's psychological well-being, with therapy as a context in which he or she can process normative adolescent stressors and experience support during a time of identity development (p. 526).

These results indicate conflicting opinions about the role of caregivers in adolescent CBT.

Caregivers can be very essential to the process of helping their children adopt more positive ways of thinking, but care also needs to be taken to ensure that family members do not become so enmeshed in the treatment that adolescent clients cannot feel safe discussing sensitive material.

Dialectical behavioral therapy.

Dialectical Behavioral Therapy was originally created for use with adults, but was adapted for adolescents in the early 1990's. Commonly referred to as DBT-A (for adolescents), this therapeutic model is an effective treatment for adolescents experiencing suicidal ideation, depression, disordered eating, aggressive or impulsive behaviors, and borderline personality disorder symptomatology (Groves, Backer, Wies van der Bosch, & Miller, 2012). Like the original version, DBT-A employs a collaborative and non-judgemental approach to improve motivation for change, increase individual client capabilities, and generalization of new behaviors. These competencies are typically taught using a combination of individual therapy, multi-family skills training groups, traditional family therapy, telephone consultation, and therapist consultation meetings (Klein & Miller, 2011). Through these methods, DBT-A is designed to address five core problem areas: 1) Confusion about self, 2) Emotion Dysregulation,

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3) Impulsivity, 4) Interpersonal Problems, and 5) Parent-teen dilemmas. These core problem areas are addressed based on each client's hierarchy of needs.

-their life-threatening behaviors are addressed first, often utilizing a chain analysis as a way to better understand the problematic behavior. From there, behaviors that negatively impact therapy are addressed, followed by behaviors that negatively impact the adolescent's quality of life (Zervas, 2014, p.5).

While client needs within this program may vary, family members (specifically caregivers) play a very important role in the therapeutic process of DBT-A.

Overall, DBT-A is considered to be a fairly successful mode of treatment for adolescents. In self-evaluation, adolescents who have completed DBT-A report fewer symptoms related to depression and anxiety one year after completing treatment. Similarly, the caregivers of these adolescent clients report perceptions of improvement in quality of life and a reduction in symptoms of psychopathology one year after therapy (Fleischhaker, Bohme, Sixt, Bruck, Schneider, & Schulz, 2011). Though DBT-A is generally geared towards adolescents with borderline personality disorder traits and a history of suicidal gestures, this treatment model is recognized for its practicality across a wide range of psycho-social needs. "Expansions of DBT to the treatment of bi-polar disorder, externalizing behavior problems, and eating disorders suggest that DBT may improve functioning and reduce psychopathology across a range of problem areas and treatment settings" (Klein & Miller, 2011, p. 208). The key difference between the original DBT model and DBT-A is the level of involvement to which caregivers are incorporated into treatment. DBT-A requires a high degree of commitment from both adolescents and family members as a means of instilling skills and evaluating progress outside of the

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treatment setting. When both adolescents and caregivers are involved in DBT-A programming together, retention rates are higher and participants report “liking” the treatment more as well (Groves, Backer, Wies van der Bosch, & Miller, 2012).

Ecologically-based family systems therapy.

Family therapy requires therapists to attend to the individual needs of multiple family members, as well as to be attuned to the larger family dynamics governing their interactions. The systemic family therapy motto posits that “the whole is more than the sum of its parts” (Robins, Turner, Alexander, & Perez, 2003). Family systems therapy does not focus on a specific client, but rather targets maladaptive interactional patterns between family members. While family systems therapy may involve many family members of different generations (multisystemic), it is most common for this type of therapeutic model to be focused around caregivers and a child (Kaslow, Broth, Oyeshiku-Smith, & Collins, 2012).

Family systems therapy is a very effective treatment modality for adolescent problem behaviors and maladaptive family patterns, provided certain conditions are met. The primary factors found to influence the effectiveness of family-systems therapy are the frequency/consistency of the sessions, and the quality or types of therapeutic alliances that the therapist establishes with the participants. When sessions are scheduled irregularly or far-between, and therapeutic alliances create conflict between family members, there is a high likelihood of the family dropping out of treatment (Robins, Turner, Alexander, & Perez, 2003).

Family therapy poses a number of challenges in terms of treatment retention. This treatment model may be less attractive and sought after by families whose members whose schedules require more coordination. According to a comparison study of individual versus

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family therapy utilization among adolescents and their families, Graves, Shelton, & Kaslow (2009) found that as the number of therapy sessions increased, negative behaviors in adolescents decreased. The researchers cited that “in order to establish healthy patterns of relating while simultaneously decreasing problematic behavior, therapists should be consistent with the children they serve” (Graves, Shelton, & Kaslow, 2009). This claim asserts that both adolescents and their caregivers do better in therapy when sessions are scheduled on a routine basis and occur frequently.

Therapeutic alliances between the therapist and caregivers, and between the therapist and adolescent, are also a significant predictor of whether families will choose to stay in treatment. Early family therapy sessions tend to be characterized by high levels of conflict between family members. According to Robbins, Turner, Alexander, and Perez (2003):

This conflict is often manifested in subtle and overt attempts to pull the therapist into forming coalitions with one family member against another. How therapists respond to these appeals influences family members’ behaviors and their experience of their relationship with the therapist (p. 541).

Aside from avoiding coalitions with family members, Robbins, Turner, Alexander, and Perez (2003), assert that therapists must take extra care to create balanced alliances with family therapy participants in order to prevent conflicts and drop-outs. According to their study on the influences of drop-outs in family therapy, adolescent clients can become alienated if the therapist spends too much time during sessions inadvertently validating the views and concerns of the caregiver. This becomes especially problematic if the therapist has not adequately addressed the views and concerns of the adolescent as well. With regard to their findings, the authors state:

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The trend for parents in drop-out cases to have higher alliances than the completer cases supports this argument. In light of prior research findings, therapists in drop-out cases may have engaged in fewer positive relational interventions or statements directed toward the adolescent than did therapists in completer cases (p. 541).

These findings indicate that while it is important for therapists to establish a therapeutic alliance with caregivers in family therapy, it is equally important to establish a strong connection to the adolescent in order to retain the whole family in treatment.

Attachment-based family therapy.

This therapeutic model was designed specifically to repair rifts in the quality of attachment between children or adolescents and their caregivers. For the purposes of understanding this model, it should be noted that attachment disturbances can stem from specific adolescent psychopathology or external threats that contribute to the development and maintenance of adolescent symptoms, such as familial abuse, neglect, or loss (Kobak & Kerig, 2015). Attachment-based family therapy (ABFT) is a twelve to sixteen week long intervention program best suited to adolescents experiencing depression and suicidal behaviors. Informed by attachment theory and research on adolescent development, a core assumption of ABFT is that changing negative family processes reduces adolescent depression and suicidal gestures (Feder & Diamond, 2016). ABFT focuses on repairing the caregiver-adolescent attachment by improving trust and safety, which ultimately acts as a protective factor against depression and suicide. According to Shpigel, Diamond, and Diamond (2012):

For depressed adolescents, when parents empathetically and non-defensively listen to their pain or frustrations, adolescents begin to feel validated. This validation increases

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safety in the relationship and the sense of being cared for and important. Consequently, adolescents are more likely to seek protection and guidance from parents at times of distress, thus buffering against depression and suicide. Moreover, it is within the context of renewed close, intimate relationships with parents that adolescents learn important emotional regulation skills, such as perspective taking, negotiation, impulse control, and symbolizing and articulating feelings. These skills also buffer against depression and suicide (p.272).

In ABFT, parents or other caregivers are essential to the treatment process, and are explicitly woven into the therapeutic interventions that help adolescents recover from depression and suicidal behaviors.

Practitioners using the ABFT model with adolescents and their caregivers strive to implement five therapeutic tasks over the course of the treatment. The first task involves a relational re-frame, in which the adolescent and caregiver(s) choose to redefine the primary goal of therapy as repairing the relationship (Feder & Diamond, 2016). This task is very important because it shifts the adolescent problem from “interpersonal” to “relational”, and emphasizes collaboration between the adolescent and caregiver(s) in treatment. In the second and third therapeutic tasks, the practitioner seeks to build strong therapeutic alliances with the adolescent and caregivers. This is done through individual sessions (first with the adolescent, and then later on with the caregivers). The purpose of these sessions is to form connections with each the participants and prepare them to engage with each other towards rebuilding the relationship (Shpigel, Diamond, & Diamond, 2012). During the fourth task, conjoint sessions resume and the adolescent and caregiver(s) address maladaptive relationship dynamics head-on. This stage of

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ABFT is considered to be the primary mechanism of change (Feder & Diamond, 2016). In the fifth and final treatment task, caregivers provide (and adolescents accept) support and guidance through both normative and non-normative life challenges. When there is less conflict and more trust present in the relationship, adolescents are more likely to seek out caregivers as a source of support. This task begins when participants are engaged in ABFT, and ideally continues long after the therapy has ended (Feder & Diamond, 2016).

ABFT posits that both the adolescent and caregiver(s) are responsible for contributing to and maintaining the attachment bond. Caregivers reserve the right to express their own opinions, but are encouraged to do so in a way that validates the needs of the adolescent. “[the] caregiver’s capacity for maintaining a cooperative goal-correct partnership depends not only on monitoring their own emotions, but on caregiver’s ability to clearly assert their own positions while validating and supporting the adolescent’s attachment and autonomy needs” (Kobak & Kerig, 2015, p.113).

Discussion

The results of this study indicated that the level of structure in the therapy models, the ability to develop therapeutic alliances, and clinical judgement with regards to boundary-setting were most influential in determining the effectiveness of caregiver involvement in therapy. These factors are explored as they relate to each therapeutic model, and are also discussed individually as significant considerations for caregivers and adolescents in therapy.

Individual Therapy

In terms of individual therapy that takes place in out-patient settings, the findings on this therapeutic model indicate that caregivers are most heavily involved at the beginning of therapy.

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This involvement most frequently takes place in the form of therapy initiation on behalf of the adolescent, and participation in intake procedures and interviews. However once the adolescent is established in therapy, it is important for the clinician to begin setting firmer boundaries with caregivers. Ruberman (2009) asserts that clinicians need to use judgement with respect to the child client's age and developmental stage to determine what level of caregiver involvement is appropriate. Issues pertaining to the child's safety or wellbeing are also important factors for clinicians to consider when choosing to involve caregivers in the therapy. Aside from this, it is expected that caregivers or other important family members may be consulted with on some level regarding the child's progress or skill development in therapy. With adolescents, a higher level of discretion is advised in order to protect confidentiality and ensure that clients are able to maintain a strong therapeutic alliance with the clinician.

Cognitive Behavioral Therapy

The findings on this treatment model indicate that caregiver involvement with adolescents in CBT can be both positive and negative. Caregivers can be an asset to adolescents in CBT by helping them to practice and be mindful of therapeutic skills at home and out in community settings. Depending on the type of therapeutic setting, caregivers may be explicitly educated on strategies for supporting their adolescents and reinforcing the therapeutic goals. Caregiver interest and involvement in reinforcing CBT skills is beneficial for strengthening family attachment relationships, which also act as a protective factor for depression and anxiety in adolescents.

Similarly to individual therapy, excessive caregiver involvement in various CBT models can be also unhelpful to the process. Caregivers who are overly-present in therapy sessions or

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express too much interest in being involved can create a rift in the therapeutic alliance between the adolescent and clinician. Promoting the need for privacy with adolescent clients aids in the important developmental tasks of developing autonomy and identity formation. The findings on caregiver involvement in CBT with adolescents clearly identifies a need for boundaries, but nevertheless indicates that caregivers can play an important role in supporting and reinforcing CBT goals and skill development.

Dialectical Behavioral Therapy

DBT-A is a treatment model that explicitly incorporates family members into the treatment (if possible), and has been shown to be very effective for adolescents when caregivers can be successfully engaged. Unlike the traditional DBT model for adults, DBT-A encourages caregiver involvement through family therapy and family skills training groups. Similarly to CBT, this treatment model utilizes caregivers as an important tool in developing skills, practicing mindfulness, and focusing on treatment goals. Given that this treatment model provides space for caregivers to receive psycho-education alongside their children, both caregivers and adolescent clients tend to be highly engaged in terms of attendance and overall enthusiasm for the treatment. Caregiver involvement is important throughout the duration of DBT-A, but especially so when addressing the core problem area of “parent-teen dilemmas” (Zervas, 2014). Caregiver involvement during this phase of treatment is particularly beneficial in repairing rifts in the adolescent-caregiver attachment.

Ecologically-Based Family Systems Therapy

Family therapy can be a very effective intervention for adolescents (and other family members) when specific conditions are met. One of the most important factors in the success of

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family therapy is the clinician's ability to maintain balanced therapeutic alliances with participants, and avoid being pulled into "coalitions" with specific participants. In situations where caregivers and children are the participants, it is very important for clinicians to provide attention and validation of the concerns aired by all members. According to Robbins, Turner, Alexander, and Perez (2003), families are highly susceptible to dropping out of therapy if the therapeutic alliances are unbalanced. Adolescent clients are most likely to drop-out if they feel that their views and concerns are not being validated by the clinician. Therapists need to take extra care to be directing positive statements towards adolescents in family therapy settings. Failing to establish a therapeutic alliance with an adolescent child in family therapy is perhaps the most significant predictor of drop-out for the family as a whole.

Attachment-Based Family Therapy

ABFT is a more specific family-based treatment model that explicitly incorporates caregivers into therapy with children and adolescents. Unlike traditional family therapy (which may involve many types of family systems), ABFT is specifically focused on improving the quality of attachment relationships between caregivers and adolescents. In order to do so, both caregiver(s) and child assume responsibility for participating as fully as possible in order to repair the relationship. ABFT clinicians utilize a highly structured approach to building therapeutic alliances separately with caregivers and children, and then use these alliances to prepare all participants to engage effectively with one another. While validation and respect are important considerations for all participants in ABFT, this model places particular emphasis on the need for caregivers to validate and respect the feelings of the adolescent in therapy. ABFT

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assumes that children are the most vulnerable participants in treatment, and caregivers need to be very mindful in their interactions with them.

General Findings

The results of these findings indicate that there are several key factors that influence how successfully caregivers can be incorporated into different adolescent therapy models. For the purposes of understanding these results, success should be defined as a situation where adolescents are able to participate fully in therapy, and all parties (child client, caregivers, therapist) are using boundaries appropriate for their role in the therapeutic relationship.

One factor that was shown to be very influential in caregiver involvement was the level of structure in the therapy model. The cognitive behavioral, dialectical behavioral, and attachment-based family therapy models were perhaps the most structured treatment models discussed in this paper. A common theme among these treatment models is that they are designed to have very specific skills or competencies for clients to learn, and encourage caregivers to take ownership for learning the importance of these skills alongside the adolescent clients. Given the level of structure and psycho-educational curriculum involved in these treatment models, the boundaries and expectations for client caregivers are quite clearly laid out. The findings related to these treatment models indicate that more highly structured models strongly encourage caregiver participation. However, the treatment models create an environment where caregivers must function within appropriate therapeutic boundaries that ultimately help the child develop autonomy and a stronger sense of trust with the clinician.

On the note of trust between client and clinician, the findings on the five treatment models also indicate that a strong therapeutic alliance is also a critical factor for predicting the

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success of the therapy. In order for both the adolescent client and caregivers to be effectively engaged in therapy, it is pertinent that the clinician developed balanced therapeutic alliances between participants in therapy. The need for these balanced alliances is primarily associated with the the ecologically-based and attachment-based family therapy models, where caregivers and children are equally involved as participants in the therapy. In the individual, cognitive-behavioral, and dialectical behavioral treatment models, it is understood that the child is the client and the primary focus of the clinician.

Finally, clinical judgement emerged as a critical factor to the success of caregiver involvement in adolescent therapy. The need for clinicians to use sound judgement and set appropriate boundaries with caregivers appeared most crucial for the individual therapy model. This is likely due to the fact that the individual model is less structured in its capacity for involving caregivers or other types of participants. While clinical judgement regarding consultation and boundary-setting is undoubtedly important across all five of these treatment models, it is clear from the findings that it should be at the forefront of the clinician's mind in individual therapy settings with adolescents.

Limitations

One limitation to this study is the apparent lack of research related to caregiver involvement with adolescent clients in individual therapy. Only two articles were deemed relevant and explored this connection explicitly enough to be incorporated into this study. The lack of research on this topic is perhaps limited due to the fact that caregivers are expected to have little to no involvement. It is also possible that capacity for caregiver involvement in this treatment model is not uniform across treatment settings.

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Another limitation to this study is that the attachment theory lens was not clearly identified in some of the research on these practice models. Some articles made loose or no associations to the role of attachment between caregivers and children in therapy together. While attachment theory was the theoretical lens for this study, it is evident that attachment relationships were not an explicit interest of all the research that was incorporated into this study.

Implications for Future Practice and Research

Considering the limitations discussed above, it would be beneficial for future research to explore the role of caregivers whose children participate in individual therapy. More context is needed for how clinicians decide to involve caregivers, and how this type of involvement is negotiated among clients, family members, and clinicians. It would also be practical for future research to focus more on the role of attachment across each of these therapy models. While attachment is discussed quite explicitly with regards to the family models, it would be useful to explore the efficacy of the attachment theory lens with regards to the individual, cognitive behavioral, and dialectical behavioral therapy models. Similarly, the current literature on caregiver involvement in adolescent therapies does very little to explore the types of issues that may bring caregivers and children to therapy. Recent research primarily focuses on adolescent psychopathology, but not the family dynamics or environmental conditions that precipitate the psychopathology and maladaptive behavioral patterns. It would be very useful for future research to explore more specific relationship dynamics and environmental conditions in families in order to understand how caregivers can be successfully incorporated into therapies with their adolescent children.

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Conclusion

Caregiver involvement in adolescent psychotherapy can be beneficial, provided that caregivers are able to abide by boundaries that are appropriate for the treatment model. Certain therapeutic models (such as cognitive behavioral or dialectical behavioral) are more highly structured and allow for caregiver involvement in specific capacities. Other models (such as individual therapy) are more ambiguous in terms of the roles of caregivers or other family members. It is important for clinicians to use sound judgement regarding the child's age, developmental stage, and potential safety issues when deciding in what capacity caregivers should be involved. Finally, in therapeutic models where caregivers are incorporated into sessions with the child and clinician, it is imperative that clinicians establish balanced therapeutic alliances with all treatment participants.

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Appendix A- Excluded Articles

Article Title	Therapy Model	Reason for Exclusion
Depressed Youth: Treatment Outcome and Changes in Family Functioning in Individual and Family Therapy (2012)	Individual/Family Systems	Article failed to describe how/if caregivers can be incorporated into therapy.
Effectiveness and Cost Effectiveness of Cognitive Behavioral Therapy (CBT) in Clinically Depressed Adolescents: Individual CBT versus Treatment as Usual (TAU) (2013)	Individual/CBT	This article focused more on the overall efficacy of CBT as an adolescent treatment model- no connections to caregiver involvement.
The Experiences of Parents of Adolescents in Family Therapy: A Qualitative Investigation (2010)	Family Systems	This article focused more on parental perceptions of the therapy, not explicit involvement.
Preliminary Outcomes on the Use of Dialectical Behavioral Therapy to Reduce Hospitalization Among Adolescents in Residential Care (2008)	DBT	Article failed to describe how/if caregivers can be incorporated into therapy.

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Appendix B- Literature Review Articles Organized by Theme

Lit Review Theme	Associated Articles
<p>Purposes of Caregiver Involvement</p>	<p>Ewing, E., Diamond, G., & Levy, S. (2015). Attachment-Based Family Therapy for Depressed and Suicidal Adolescents: Theory, Clinical Model and Empirical Support. <i>Attachment and Human Development</i>, 17(2), 136-156. doi:10.1080/14616734.2015.1006384</p> <p>Hardway, C., Pincus, D., Gallo, K., & Comer, J. (2015). Parental Involvement in Intensive Treatment for Adolescent Panic Disorder and its Impact on Depression. <i>Journal of Child and Family Studies</i>, 24, 3306-3317. doi:10.1007/s10826-015-0133-7</p> <p>Kocayoruk, E., Altintas, E., & Icbay, M. (2015). The Perceived parental Support, Autonomous-Self and Well-Being of Adolescents: A Cluster Analysis Approach. <i>Journal of Child and Family Studies</i>, 24, 1819-1828. doi:10.1007/s10826-014-9985-5</p> <p>Robinson, E., Power, L., & Allan, D. (2011). What Works with Adolescents? Family Connections and Involvement in Interventions for Adolescent Problem Behaviours. <i>Family Matters</i>, 88, 57-66.</p>
<p>The Therapeutic Alliance</p>	<p>Campbell, A., & Simmonds, J. (2011). Therapist Perspectives on the Therapeutic Alliance with Children and Adolescents. <i>Counseling Psychology Quarterly</i>, 24(3), 195-209. doi:ISSN: 1469-3674</p> <p>Fienstein, N., Fielding, K., Udvari-Solner, A., & Joshi, S. (2009). The Supporting Alliance in Child and Adolescent Treatment: Enhancing Collaboration Among Therapists, Parents, and Teachers. <i>American Journal of Psychotherapy</i>, 63(4), 319-342.</p> <p>Hawley, K., & Garland, A. (2008). Working Alliance in Adolescent Outpatient Therapy: Youth, Parent, and Therapist reports and Associations with Therapy Outcomes. <i>Child Youth Care Forum</i>, 37, 59-74. doi:10.1007/s10566-008-9050-x</p> <p>Pravin, I., Thomsen, P., Langeveld, J., & Stormark, K. (2007). Child Factors Associated with Parent Involvement in Usual Clinical Care of Children and Adolescents: A National Register Study. <i>Nordic Journal of Psychiatry</i>, 61, 173-181. doi: 10.1080/08039480701352363</p> <p>Robbins, M., Mayorga, C., Mitrani, V., Szapocznik, J., Turner, C., & Alexander, J. (2008). Adolescent and Parent Alliances with Therapists in Brief Strategic Family Therapy with Drug-Using Hispanic Adolescents. <i>Journal of Marital and Family Therapy</i>, 34(3), 316-328.</p> <p>Sheridan, M., Peterson, B., & Rosen, K. (2010). The Experiences of Parents of Adolescents in Family Therapy: A Qualitative Investigation. <i>Journal of Marital and Family Therapy</i>, 36(2), 144-157. doi:10.1111/j.1752-0606.2010.00193.x</p>

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<p>Gender Roles and Differences</p>	<p>Esbjorn, B., Somhovd, M., Nielsen, S., Normann, N., Leth, I., & Reinholdt-Dunne, M. (2014). Parental Changes After Involvement in Their Anxious Child's Cognitive Behavior Therapy. <i>Journal of Anxiety Disorders</i>, 28, 664-670. doi:0887-6185</p> <p>Guo, X., & Slesnick, N. (2013). Family Versus Individual Therapy: Impact on Discrepancies Between Parents and Adolescents Perceptions Over Time. <i>Journal of Marital and Family Therapy</i>, 39(2), 182-194. doi:10.1111/j.1752-0606.20012.00301.x</p> <p>Pravin, I., Thomsen, P., Langeveld, J., & Stormark, K. (2007). Child Factors Associated with Parent Involvement in Usual Clinical Care of Children and Adolescents: A National Register Study. <i>Nordic Journal of Psychiatry</i>, 61, 173-181. doi: 10.1080/08039480701352363</p> <p>Kocayoruk, E., Altintas, E., & Icbay, M. (2015). The Perceived parental Support, Autonomous-Self and Well-Being of Adolescents: A Cluster Analysis Approach. <i>Journal of Child and Family Studies</i>, 24, 1819-1828. doi:10.1007/s10826-014-9985-5</p> <p>Robbins, M., Mayorga, C., Mitrani, V., Szapocznik, J., Turner, C., & Alexander, J. (2008). Adolescent and Parent Alliances with Therapists in Brief Strategic Family Therapy with Drug-Using Hispanic Adolescents. <i>Journal of Marital and Family Therapy</i>, 34(3), 316-328.</p>
<p>Age of the Adolescent</p>	<p>Hardway, C., Pincus, D., Gallo, K., & Comer, J. (2015). Parental Involvement in Intensive Treatment for Adolescent Panic Disorder and its Impact on Depression. <i>Journal of Child and Family Studies</i>, 24, 3306-3317. doi:10.1007/s10826-015-0133-7</p> <p>Hawley, K., & Garland, A. (2008). Working Alliance in Adolescent Outpatient Therapy: Youth, Parent, and Therapist reports and Associations with Therapy Outcomes. <i>Child Youth Care Forum</i>, 37, 59-74. doi:10.1007/s10566-008-9050-x</p> <p>Pravin, I., Thomsen, P., Langeveld, J., & Stormark, K. (2007). Child Factors Associated with Parent Involvement in Usual Clinical Care of Children and Adolescents: A National Register Study. <i>Nordic Journal of Psychiatry</i>, 61, 173-181. doi:10.1080/08039480701352363</p>
<p>Involvement Across Settings</p>	<p>Fienstein, N., Fielding, K., Udvari-Solner, A., & Joshi, S. (2009). The Supporting Alliance in Child and Adolescent Treatment: Enhancing Collaboration Among Therapists, Parents, and Teachers. <i>American Journal of Psychotherapy</i>, 63(4), 319-342.</p> <p>Guo, X., & Slesnick, N. (2013). Family Versus Individual Therapy: Impact on Discrepancies Between Parents and Adolescents Perceptions Over Time. <i>Journal of Marital and Family Therapy</i>, 39(2), 182-194. doi:10.1111/j.1752-0606.20012.00301.x</p> <p>Nickerson, A., Brooks, J., Colby, S., Rickert, J., & Salamone, F. (2006). Family Involvement in Residential Treatment: Staff, Parent, and Adolescent Perspectives. <i>Journal of Child and Family Studies</i>, 15(6), 681-694. doi:10.1007/s10826-006-9041-1</p>

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<p>Treatment Models</p>	<p>Ewing, E., Diamond, G., & Levy, S. (2015). Attachment-Based Family Therapy for Depressed and Suicidal Adolescents: Theory, Clinical Model and Empirical Support. <i>Attachment and Human Development</i>, 17(2), 136-156. doi:10.1080/14616734.2015.1006384</p> <p>Guo, X., & Slesnick, N. (2013). Family Versus Individual Therapy: Impact on Discrepancies Between Parents and Adolescents Perceptions Over Time. <i>Journal of Marital and Family Therapy</i>, 39(2), 182-194. doi:10.1111/j.1752-0606.20012.00301.x</p> <p>Hardway, C., Pincus, D., Gallo, K., & Comer, J. (2015). Parental Involvement in Intensive Treatment for Adolescent Panic Disorder and its Impact on Depression. <i>Journal of Child and Family Studies</i>, 24, 3306-3317. doi:10.1007/s10826-015-0133-7</p> <p>Hawley, K., & Garland, A. (2008). Working Alliance in Adolescent Outpatient Therapy: Youth, Parent, and Therapist reports and Associations with Therapy Outcomes. <i>Child Youth Care Forum</i>, 37, 59-74. doi:10.1007/s10566-008-9050-x</p> <p>Katz, L., Fotti, S., & Postl, L. (2009). Cognitive-Behavioral Therapy and Dialectical Behavior Therapy: Adaptations Required to Treat Adolescents. <i>Child and Adolescent Psychiatry for the General Psychiatrist</i>, 32(1), 95-109.</p>
<p>Barriers to Effective Caregiver Involvement</p>	<p>Ewing, E., Diamond, G., & Levy, S. (2015). Attachment-Based Family Therapy for Depressed and Suicidal Adolescents: Theory, Clinical Model and Empirical Support. <i>Attachment and Human Development</i>, 17(2), 136-156. doi:10.1080/14616734.2015.1006388</p> <p>Hoff-Esbjorn, B., Somhovd, M., Nielsen, S., Normann, N., Leth, I., & Reinholdt-Dunne, M. (2014). Parental Changes After Involvement in Their Anxious Child's Cognitive Behavior Therapy. <i>Journal of Anxiety Disorders</i>, 28, 664-670. doi:0887-6185</p> <p>Nickerson, A., Brooks, J., Colby, S., Rickert, J., & Salamone, F. (2006). Family Involvement in Residential Treatment: Staff, Parent, and Adolescent Perspectives. <i>Journal of Child and Family Studies</i>, 15(6), 681-694. doi:10.1007/s10826-006-9041-1</p> <p>Robinson, E., Power, L., & Allan, D. (2011). What Works with Adolescents? Family Connections and Involvement in Interventions for Adolescent Problem Behaviours. <i>Family Matters</i>, 88, 57-66.</p>
<p>The Role of Attachment</p>	<p>Ewing, E., Diamond, G., & Levy, S. (2015). Attachment-Based Family Therapy for Depressed and Suicidal Adolescents: Theory, Clinical Model and Empirical Support. <i>Attachment and Human Development</i>, 17(2), 136-156. doi:10.1080/14616734.2015.1006384</p> <p>Robinson, E., Power, L., & Allan, D. (2011). What Works with Adolescents? Family Connections and Involvement in Interventions for Adolescent Problem Behaviours. <i>Family Matters</i>, 88, 57-66.</p> <p>Sheridan, M., Peterson, B., & Rosen, K. (2010). The Experiences of Parents of Adolescents in Family Therapy: A Qualitative Investigation. <i>Journal of Marital and Family Therapy</i>, 36(2), 144-157. doi:10.1111/j.1752-0606.2010.00193.x</p>

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Appendix C- Findings Articles Organized by Practice Model

Practice Model	Findings Articles
Individual Therapy	<p>Graves, K., Shelton, T., & Kaslow, N. (2009). Utilization of Individual versus Family Therapy Among Disturbed Adolescents with Severe Emotional Disturbance. <i>The American Journal of Family Therapy, 37</i>(3), 227-238. doi:10.1080/01926180802403328</p> <p>Ruberman, L. (2009). Working with Parents: Implications for Individual Psychotherapeutic Work with Children and Adolescents. <i>American Journal of Psychotherapy, 63</i>(4), 345-362.</p>
Cognitive Behavioral Therapy	<p>Kendall, P., & Peterman, J. (2015). CBT for Adolescents with Anxiety: Mature Yet Still Developing. <i>American Journal of Psychiatry, 172</i>, 519-530. doi:10.1176/appi.ajp.2015.14081061</p> <p>Melnyk, B., Kelly, S., & Lusk, P. (2014). Outcomes and Feasibility of a Manualized Cognitive-Behavioral Skills Building Intervention: Group COPE for Depressed and Anxious Adolescents in School Settings. <i>Journal of Child and Adolescent Psychiatric Nursing, 27</i>, 3-13. doi:10.1111/jcap.12058</p> <p>Webb, C., Auerbach, R., & DeRubeis, R. (2012). Process of Change in CBT of Adolescent Depression: Review and Recommendations. <i>Journal of Clinical Child and Adolescent Psychology, 41</i>(4), 654-665. doi:10.1080/15374416.2012.704842</p>
Dialectical Behavioral Therapy	<p>Fleischhaker, C., Bohme, R., Sixt, B., Bruck, C., Schneider, C., & Schulz, E. (2011). Dialectical Behavioral Therapy for Adolescents (DBT-A): A Clinical Trial for Patients with Suicidal and Self-Injurious Behavior and Borderline Symptoms with a One-Year Follow-Up. <i>Child and Adolescent Psychiatry and Mental Health, 5</i>(3). doi:10.1186/1753-2000-5-3</p> <p>Groves, S., Backer, H., Van den Bosch, W., & Miller, A. (2012). Review: Dialectical Behaviour Therapy with Adolescents. <i>Child and Adolescent Mental Health, 17</i>(2), 65-75. doi: 10.1111/j.1475-3588.2011.00611.x</p> <p>Klein, D., & Miller, A. (2011). Dialectical Behavior Therapy for Suicidal Adolescents with Borderline Personality Disorder. <i>Child and Adolescent Psychiatric Clinics of North America, 20</i>(2), 205-216. doi: 10.1016/j.chc.2011.01.001</p> <p>Zervas, N. (2014). Demystifying DBT with Adolescents. <i>The Brown University Child and Adolescent Behavior Letter, 30</i>(12), 4-6.</p>
Ecologically-Based Family Systems Therapy	<p>Graves, K., Shelton, T., & Kaslow, N. (2009). Utilization of Individual versus Family Therapy Among Disturbed Adolescents with Severe Emotional Disturbance. <i>The American Journal of Family Therapy, 37</i>(3), 227-238. doi:10.1080/01926180802403328</p> <p>Kaslow, N., Broth, M., Oyeshiku-Smith, C., & Collins, M. (2012). Family -Based Interventions for Child and Adolescent Disorders . <i>Journal of Marital and Family Therapy, 38</i>(1), 82-100. doi:10.1111/j.1752-0606.2011.00257.x</p> <p>Robbins, M., Turner, C., Alexander, J., & Perez, G. (2003). Alliance and Dropout in Family Therapy for Adolescents with Behavior Problems: Individual and Systemic Effects. <i>Journal of Family Psychology, 17</i>(4), 534-544. doi:10.1037/0893-3200.17.4.534</p>

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Attachment-Based Family Therapy	<p>Feder, M., & Diamond, G. (2016). Parent-Therapist Alliance and Parent Attachment-Promoting Behavior in Attachment-Based Family Therapy for Suicidal and Depressed Adolescents. <i>Journal of Family Therapy</i>, 38, 82-101. doi:10.1111/1467-6427.12078</p> <p>Kobak, R., & Kerig, P. (2015). Introduction to the Special Issue: Attachment-Based Treatments for Adolescents. <i>Attachment and Human Development</i>, 17(2), 111-118. doi:10.1080/14616734.2015.1006382</p> <p>Shpigel, M., Diamond, G. M., & Diamond, G. S. (2012). Changes in Parenting Behaviors, Attachment, Depressive Symptoms, and Suicidal Ideation in Attachment-Based Family Therapy for Depressive and Suicidal Adolescents. <i>Journal of Marital and Family Therapy</i>, 38(1), 271-283. doi:10.1111/j.1752-0606.2012.00295.x</p>
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