Treating Troubled Adolescents

The Tools of Therapy:

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> Three umpires were having an argument about which of them was the best umpire. The first said, "I am the best because I calls 'em as I sees 'em." The second retorted, "I'm the best because I calls 'em the way they are." The third umpire, stepping back slightly from the other two, cried, "I'm the best umpire—because the balls, they ain't nothin' 'till I calls 'em."
>
> -ALAN MACKAY

THE BEST THERAPIST, like the third umpire in the anecdote, acts to distinguish problems and thus to help create a more functional reality for the family. Just as the balls "ain't nothin' " until they are called, so the clinician must distinguish the specific therapeutic problem out of an almost limitless number of possibilities. Moreover, it is the responsibility of the therapist to persuade the family to accept the different and hopefully more functional reality that leads to a quick amelioration of problems. When working with adolescents, brief therapy is preferred because adolescents, like saplings, are experiencing rapid growth. If a sapling's angle of growth is corrected in time, the tree will grow straighter and stronger. So it is with adolescents. It is essential, therefore, for the therapist to assess the family situation correctly and to move to create a 'therapeutic reality' that will lead to the fastest transformation of the system. The tools introduced in the following pages are designed to help the therapist transform the family system as rapidly as possible and enable the family to stabilize a new, more functional structure.

Assessment Tools

The family therapist uses assessment tools to understand the nature of the family's organization and process as well as its strengths and weaknesses. In addition, these tools should help the therapist specify therapeutic goals and strategies.

THE FOUR-DIMENSIONAL MODEL

The detailed assessment approach that I use I call the four-dimensional model. This tool can help

the therapist assess a family system from a number of different perspectives. The model is four-dimensional in several ways. First, there are four aspects of assessment for the therapist to consider: contemporary developmental pressures on the family, history, structure, and process. Furthermore, the process dimension is, as will be discussed later, an extra, or fourth, dimension that involves the subjective reaction of the therapist similar to the inclusion of a space-time perspective in physics or in painting.

The concept of four-dimensional space has, of course, been around for a long time. It revolutionized contemporary physics and has had profound effects in non-Euclidian mathematics and other fields such as painting. In cubist art, for example in Marcel Duchamp's famous *Nude Descending a Staircase,* the three dimensions of physical space are transformed by the fourth dimension of time, allowing the artist to portray the figure in motion from numerous angles. In my model, the transforming dimension is the therapist him- or herself. While the other therapeutic perspectives are linear and objective—the result of what the therapist observes in the treatment room—the fourth dimension is more subjective. It is determined both by the therapist's feelings when in the presence of the family and by the therapist's active participation in the very process of treatment.

The four-dimensional model should give the therapist, like the cubist painter, a kaleidoscopic view of his or her subject. It allows the therapist to look at a moving system from different perspectives. It also takes into consideration the therapist's position in the process as the therapist moves in and out of the system, sometimes as a neutral observer, other times as an involved protagonist who supports a particular family member or suddenly realizes the family's control. This emphasis on process and the therapist's active place in it is what helps define family therapy as a therapy of experience—with the therapy focusing first on the family's enactment of its dysfunctional patterns and then, later, on more functional, corrective ways of interacting. The four-dimensional model can help the therapist guide the family through this transformation.

Let us take a closer look now at the individual dimensions of the model. The first dimension is the *contemporary* developmental pressures that are destabilizing the family. Like all living systems, families have tendencies toward both equilibrium and evolution. During the course of a family's life, there are destabilizing developmental pressures that disrupt equilibrium and challenge the family to evolve. The therapist must be able to detect these points of instability, for these are times when the family's structural

rules do not hold and, as Ilya Prigogine (in Minuchin and Fishman 1971, 21) says, the fluctuations created by developmental pressures can result in a dissipative state that is formed and maintained by non-equilibrium conditions leading to a new structure.

Destabilizing events create stress to which family systems can react in different ways. Some systems respond by transforming the rules under which they operate, thereby allowing new, more functional behaviors. In other systems, rather than changing shape, a medical or psychological symptom emerges.

The work of Holmes and Rahe (1967), confirming the association between stressful life events and illness leading to hospitalization, supports the clinical observation that patients who present medical and presumably psychological problems are living in a system in which some destabilizing factor has increased the stress on the family. The destabilizing factor may be positive or negative—a new baby, for example, or the death of a parent. It may be predictable or unpredictable—an older child leaving home or a child killed in an accident. Whatever the nature of the precipitating factor, at the emergence of the symptom these families become stuck and organize around the symptom so that the family members cannot address their developmental needs.

A powerful example of a symptomatic status quo caused by contemporary premises is discussed in chapter 5. In the violent family that is described, there were developmental pressures among both generations. The parents, who were in their early thirties, had the pressure of raising four children, three of whom were adolescents, as well their own issues of trying to attain educational and job skills they had missed as young parents. The teenagers, for their part, were struggling to develop their own competence and to function on their own. These pressures coalesced to produce behavior problems—drinking, violence, and poor performance in school and work—which became the focus of the family disruption. The result was a dysfunctional but stable situation in which the causative stress was not effectively dealt with.

The importance of this first dimension is that it informs the therapist of the developmental tasks with which the family is struggling. With this knowledge the therapist can design and direct the treatment necessary to help the family achieve its developmental goals.

The second dimension in the model involves the history of the system, the individual and family

background that may contribute essential information regarding options to the therapy. The therapist must take the history of important events such as the death of a parent, the loss of a child, divorce, illness, a financial reversal, and so forth. The therapist must try to understand the history of the problem presented, the steps the family has taken to attempt its resolution, and the involvement of any other therapists, past and present. In addition, the therapist must try to ascertain biological processes such as organic brain syndrome or any other medical conditions.

The historical dimension is essential to the therapy because it provides information regarding the chronicity and severity of the family system's dysfunction. The family described in the clinical chapter on couples therapy (chapter 10) illustrates how significant the historical dimension can be. In this couple, the wife had been anorexic for more than twenty years. She abused laxatives, often taking a box at a time, and had been rushed to the hospital in a coma on several occasions. With historical data such as this, the therapist knows the necessity of working even more intensively than usual, as well as the importance of consulting closely with medical colleagues. A history is also important because it allows the therapist to garner vital information about the current concerns of the family. We should keep in mind, however, that the history that a family reports reflects only a partial reality, a selective chronicle edited by present concerns. Families scan their collective reflections, remembering and retelling what they are concerned about at the present.

The third assessment dimension is structure. Structural considerations for the therapist concern the organization and demarcation of the therapeutic system, including important relationships outside as well as within the family. The therapist must decide what, in effect, constitutes "the family"—the structure of important relationships that should be included in the treatment. The therapist must consider the relationship of the defined family system not only with extended family members but also with external systems affecting individual family members—school, social agencies, friends, and other therapists.

Later in this book we shall see how structure was a key dimension in the chapter on treating an incestuous family (chapter 6). In this case, a number of social systems were involved: the mother's therapist, the father's therapist, the children's therapists, and the court. On inquiry, all of these helpers differed on what should be done. The only point each of them agreed on, it seemed, was that the other

agencies knew less. (I felt myself falling into the same divisive morass when I entered the therapy room to consult.)

The other important structural consideration for the therapist involves the issue of proximity and distance between the important figures in the system. The therapist assesses a family system on the basis of the appropriateness of the proximity and distance between members of the system at a given point in time of the family's development. The appropriateness is determined by considering the family life cycle and the resulting changes that have taken place in the family structure.

It is, of course, axiomatic in psychology that the family structure changes with the passage of time and that these changes tend to follow regular patterns. What is less widely recognized is that these changes are the result of the concurrent development of the children and the adults within the family system (Carter and McGoldrick 1980). As therapists we are aware of individual life cycles and look for the classic transitional stages of adolescence, courtship, marriage, having children, children leaving home, old age, and so forth. But we must also factor in those specific points of adult developmental crisis that are likely to occur within this classic life cycle—breaking away from parents, the age-forty crisis (which tends to occur in the thirties for blue-collar families), middle-age, and retirement. As pointed out by Gail Sheehy (1976) and Daniel J. Levinson and associates (1978), these adult crises tend to occur with the same regularity as do the developmental stages in children. The overlapping of individual child development, individual adult development with its attendant crises, and the development of the family as a unit can result in a shifting structural context. And in evaluating a family, the therapist must be aware of this shifting structure and be able to make the correct distinctions regarding appropriate proximity and distance. For example, a mother and son are only appropriately or inappropriately close in accordance with the developmental stages of child, adult, and family. A mother and three-day-old son who are inseparable are appropriately close. But if a mother and her seventeen-year-old son are inseparable, there is very likely a problem of inappropriate proximity.

Structure, then, is a key dimension in any therapeutic assessment of a family system. Its exploration can reveal to the therapist not only what the operant therapeutic unit is but also what is appropriate interaction within the unit according to the stages of development reached by individuals and by the family as a whole.

The fourth dimension is process. In assessment it is useful to keep in mind that descriptions of a system by family therapists are different from those done by anthropologists or novelists. Unlike our colleagues in these other fields, family clinicians do not maintain a fixed distance from the family. At times we may in fact become part of the system through techniques such as unbalancing, where the therapist acts as a protagonist in the family drama. During the session the therapist must be able to distance him- or herself from the events and describe the subjective experience of the system.

The process dimension involves the search for interactional patterns in the system. There are two types of patterns that must be assessed: patterns the therapist sees operating within the system and the therapist's own patterns of response. The first of these refers to transactional patterns, such as enmeshment or conflict diffusion, which the therapist can observe taking place in the treatment room. The second involves the more difficult area of the therapist's own subjective responses as one both intervenes within and withdraws from the system.

In the process of interaction with and disengagement from the family, the therapist will both act and be acted upon. In assessing the system, the therapist must be aware of interactional patterns of which he or she becomes a part. In addition, the therapist must recognize that to some extent one's reactions will be affected by one's own professional and personal contexts. For example, does the therapist have two supervisors who fervently espouse conflicting models? The therapist's assessments may also be affected by the therapist's own family context—family of origin, contemporary family system, spouse, children, and extended family.

Therapists bring into the treatment room, then, a number of subjective factors that can affect the assessment of family systems. By recognizing, and if necessary resisting, the pressures of their own contexts, by keeping in mind this "fourth dimension," therapists are both enlightened about the system and better prepared to evaluate the information they receive from and about families.

IDENTIFICATION OF THE HOMEOSTATIC MAINTAINER

I believe that one of the most useful assessment tools available to the family therapist is the concept of the homeostatic maintainer, the individuals or social forces that are maintaining a given problem and

must therefore be included in the treatment.

The term *homeostatic maintainer* derives from the word *homeostasis* or *same state.* As used in biology or physiology, homeostasis refers to a process of maintaining sameness by restoring a system to a state from which it periodically departs. A classic example of a homeostatic mechanism is the thermotactic system in the human body. This system acts like a regulator to maintain body heat at a constant temperature to maximize efficiency both in cell reproduction and in interaction with the environment. As we know, however, there are times of crisis, such as infection or injury, when the critical function of the thermotactic system is to *raise* body temperature. During these periods, increased temperatures act to enhance the production of white blood cells and to destroy infecting agents. While the overall goal of the higher temperature is to improve bodily protection, if this excess heat is maintained for too long a period —if it becomes a new status quo—there can be deleterious side effects. The homeostatic system, then, can prove either a positive or a negative force.

With a family in crisis, there can be forces at work that act to maintain the status quo in a way that is detrimental to the system, by keeping the system from changing in the face of developmental pressures. It is this negative characteristic of homeostasis that makes it an important concept for family therapy. Like the body, the family system can include forces that keep it in a steady state that proves harmful because it prevents the family from adapting to developmental changes. The system either cannot allow a necessary increase in social "temperature" to deal with crisis, or it persists in crisis and cannot return to "normal"—to an everyday productive functioning.

A few years ago, the newspapers reported a story of a nineteen-year-old man who had committed an armed robbery in a rural community. When his court-appointed attorney went to see him, the man pulled a knife and held the young woman prisoner for three days. Finally the man was apprehended and had his day in court. When, just before sentencing, the judge asked, "Is there anything you would like to say in your own behalf?" the man remained silent but gestured to his mother. The middle-aged mother then stood, pointed to the judge, and said, "How dare you treat my son like this! It's not fair. He's done nothing wrong."

With just this brief story to go on, one can only guess about the true nature of the forces in the young

man's life that had buffered him from facing the consequences of his actions. But it is clear that even at this eleventh hour, in the face of overwhelming evidence of culpability, the mother refused to hold her son responsible and instead acted to maintain the status quo. This was a family system held fast in negative homeostasis, where productive change had not been allowed and where terrible dysfunction had come to be accepted as the norm.

The family therapist uses the concept of the homeostatic maintainer by attempting to render ineffective the family's stereotyped, stable ways of responding. The first step for the therapist is to discover what is maintaining the problem—that is, the person or persons who are encouraging the homeostasis—then distinguish a therapeutic unit that includes the homeostatic maintainer. The therapist must obviously demarcate the extent of the forces to be worked with—mother, father, grandparents, neighbors, teachers. As Francisco Varela (1976) points out, family systems can be like Chinese boxes: individuals are part of a family, which is part of an extended family, which is part of a community, and so forth. The job of the therapist is to identify and focus on the "box" that may hold the homeostatic maintainer and then treat this unit as the family system. The second step in the treatment process is for the therapist to disrupt the system and observe who attempts to return the system to its status quo. That person or social force is the homeostatic maintainer.

A very clear example of a family member functioning as a homeostatic maintainer is the father described in the chapter on delinquency (chapter 3). Early in the session, when his wife was confronting their delinquent youngster (who had been caught the night before with some of her jewelry and an empty vial of cocaine), the father, by his passivity and solicitous concern for his son, continually undermined his wife's efforts to have the boy respond to parental authority. He sat passively and stared at his son while his wife confronted the adolescent. By not joining with his wife in the confrontation, the father was implying approval and thus maintaining the dysfunctional pattern of the boy's illegal behavior.

IDENTIFICATION OF KEY TRANSACTIONAL PATTERNS

Once the therapist has assessed the individuals or forces maintaining the problem, the next step is to identify the patterns that are contributing to dysfunction in the system. The therapist's goal here is to

make use of these patterns to map out a strategy for brief therapy, a treatment that will produce the fastest possible change. Other therapies—such as psychoanalysis, cognitive therapies, and behaviorism—provide a tremendous array of possible descriptions of individual and family problems. But our interest here is not to describe the family in all of its complexity. After all, therapy is neither anthropology nor literature; it is changing systems. And to do this with the greatest efficiency we must look for the most parsimonious description, the identification of the patterns that will allow for the most rapid change.

There are a number of key patterns that the therapist should look for. One is certainly conflict avoidance. Dysfunctional families often take steps to bypass confrontation and avoid acknowledging conflict. For example, a therapist may bring up a difficult issue and ask the parents to discuss it with each other, only to find that they are so persistent in avoiding confrontation between themselves that instead they direct their response entirely to the therapist or to their children, retreating to safe ground whenever possible.

For example, in the chapter on runaways (chapter 4) the parents in the case study allowed their 15-year-old daughter to leave home rather than enforcing their rules. At the time of the session the girl was living with an 18-year-old boy in a very tough neighborhood. In the therapy room the parents seemed like two magnetic poles, repelling each other as I challenged them to resolve their differences and take some action to retrieve their daughter from potential danger.

Other patterns that therapists may well encounter in dysfunctional families include complementary and symmetrical schizmogenesis. (Bateson 1972). The term *schizmogenesis* refers to escalating sequences of interaction leading to a schism. In its complementary form, this pattern can be observed as a series of reciprocal-fitting behaviors. For example, a therapist might encounter a wife who is angry and a husband who complains of stomachaches. When the pattern escalates, the wife becomes angrier and the husband has escalated to the point where he has a bleeding ulcer. In the symmetrical form, the individuals act in concert. For example, there may be a heated argument in which neither party can back down. When this pattern escalates, violence may erupt on both sides.

There are additional patterns that may be observed in certain families, such as psychosomatic families (Minuchin, Rosman, and Baker 1978). Here the therapist is likely to encounter patterns like

enmeshment. This is an extreme form of proximity and intensity in family interactions, resulting in both poorly differentiated boundaries between family members and a lack of proper distinctions in the perceptions those family members have of one another and of themselves. I remember seeing Salvador Minuchin at work with a psychosomatic family in which the lack of boundaries of the enmeshed family was very evident. In the therapy room are father, mother, and 12-year-old diabetic daughter. Minuchin walks into the room and squeezes the girl's arm, asking the father, "Can you feel that?" The father replies, "You know, it's odd, I can feel that!" Minuchin then asks the mother the same question. Mother: "I can't feel that, but I have poor circulation."

Another pattern often encountered in psychosomatic families is rigidity. This refers to the inability of families to depart from the status quo when circumstances would seem to necessitate change. Such families remain committed to accustomed patterns of interaction and resist change. This is especially problematic for families with adolescents, where issues of the adolescent's autonomy are apt to stress the usual rules of family interaction. The chapter in this book on the suicidal adolescent (chapter 7) deals in depth with this type of rigid family. The suicidal child is living in a family where there is such severe rigidity that the only way to be heard, to communicate that things need to change, is to commit the ultimate act of desperation. Frequently these families are ones that make fixed demands on the child; their message is: "You are valued for what you *do,* not for *being* you." Another frequently seen pattern is a rigid stance that communicates a message to the adolescent that says, "No matter how hard you try, the family does not want you."

Overprotectiveness is yet another pattern that may be found in psychosomatic and other families. The degree of concern family members have for one another is exaggerated, often preventing a child from developing autonomy and competence. An interesting case of overprotectiveness is discussed in the chapter on disability (chapter 8). In this family a 19-year-old, mildly retarded Swedish girl was living in a system that was organized to provide for her every need. This system was possible because the family lived in a social environment where there was a great abundance of services to assist them. The family and the outside helpers would not allow the young woman to try to become more independent. When seen after her cautious suicide attempt, the girl confided that she desperately wanted to try to get a job, live away from home, and manage her own money. These might have been simple and attainable needs, but the overprotective system would not let her attempt to stretch her abilities and grow to achieve her

goals.

Many families that exhibit patterns of enmeshment, rigidity, and overprotectiveness also demonstrate an inability to cope directly with conflict. As a result, a pattern of conflict diffusion is common in such families. Conflict is diffused through the activation and complementary focusing of a family member, often the symptomatic adolescent. The result is an inability to confront differences and negotiate satisfactory resolutions.

Conflict avoidance and conflict diffusion differ only in that the latter is a term used to describe what can actually happen during a family therapy session. When tension begins to build between two people, a third person attempts to reduce the tension. For example, in the case study in chapter 5, when the father and the eldest son began to argue during the session, the next eldest son chimed in and complained that he wanted to be heard. What made it clear that this was a pattern of conflict diffusion and not just the boy's spontaneous need to be heard was the fact that at virtually every time conflict seemed about to emerge, one or another family member would interrupt, and the net effect was that the conflict would be forgotten.

These patterns of psychosomatic family organization are frequently seen, in part or entirely, in families that present problems other than psychosomatic ones. Patterns such as these, as well as the others mentioned, must be addressed for the therapy to be brief. These are pivotal patterns that can be observed and changed in the therapy room. And as long as therapy is directed toward these fundamental patterns, the treatment can move forward rapidly. Conversely, if these patterns are not being altered in the therapy, the clinician should conclude that it is time to change strategies.

Essential Techniques

The family therapy orientation of this book is based on the specific techniques described in much greater depth in *Family Therapy Techniques,* by Minuchin and Fishman (1981). There are many therapeutic techniques in structural family therapy that are useful in working with adolescents and their families. Those discussed in the following paragraphs, however, are some of the therapeutic tools that I have found most helpful in transforming dysfunctional adolescent family systems.

BOUNDARY MAKING

Boundary making is the cornerstone of family therapy with adolescents. The central issue of achieving a separate identity in preparation for leaving home depends on how well a family deals with boundaries. When the therapist works with boundary making, to either attenuate or bolster existing boundaries around subsystems, he/she is working with the pivotal interactional process. A definition of boundary making includes the process by which the therapist helps to control membership of family members in subsystems. The therapist may encourage participation of subsystem members with other family members as well as with the extra-familial system or the therapist may also exclude members. The therapist may do this by increasing proximity and experimentation among the subsystem members.

Of course, interpersonal boundaries do not exist, visually speaking. They are a construction to help the therapist describe patterned transactions among family members with the exclusion of other family members. Boundaries define both the members that are included as well as those that are excluded. And they are described from a continuum of enmeshed to disengaged. How functional a given boundary is depends on the developmental stage of a youngster, as mentioned earlier.

ENACTMENT

Enactment involves the therapist's encouraging interpersonal scenarios during the treatment session in which the dysfunctional transactions among family members are played out. The effective use of enactment usually consists of three steps. In step one the therapist observes the spontaneous transactions of the family and decides which dysfunctional areas to highlight. In the second step the therapist organizes the scenarios and allows the dysfunctional process to be played out, perturbing the system when necessary to increase intensity. In the third step the therapist challenges ways of transacting till more functional transactional patterns emerge, and the process of therapeutic change begins. *For enactment to occur the therapist must assume a decentralized position.*

This technique of enactment distinguishes family therapy from other therapies. Its focus is on the provocation, assessment, and amelioration of interactional patterns between significant people in the adolescent's life that can be observed in the actual process of therapy. Such techniques are normally not used in psychoanalysis, cognitive therapy, or behaviorism. And while in gestalt therapy the clinician may

indeed focus on patterns, the patterns emerge between relative strangers, not between actual family members who go home and live their lives in some proximity.

The enactment technique is a powerful tool for family therapists. It allows the therapist to see the problem in operation as well as to see change. This is especially useful in cases such as those involving patterns of violence. The logicians tell us that one cannot prove a negative. One cannot prove that violence will not recur. But if one follows the progression of new family patterns in therapy and sees new, more functional transactions taking place in the treatment room, then one can be reasonably sure that the old patterns will not recur. It is this insistence on "show me," that makes the technique so effective. A fundamental principle of this therapy is that if the therapist cannot see changes, there is no way of assuring that they have in fact occurred. Reports of people "feeling better" are evanescent; enactment of change and seeing new family interactional patterns stabilize make a far better gauge of successful therapy.

UNBALANCING

Unbalancing is a technique in which the therapist challenges and changes the family organization. When using this technique the therapist, rather than presenting a balanced, "firm but fair" point of view, joins the family system and acts to support only one individual or subsystem. For example, the therapist may affiliate with a family member low in hierarchy and help empower that person; or the therapist may form coalitions with certain family members to confront another member of the system. The object is to change the usual signals that direct the interpersonal behavior within the family. With new signals provoked by the therapist's affiliation, family members may act in unaccustomed ways and may feel free to explore unfamiliar possibilities for personal and interpersonal functioning.

The unbalancing technique can be quite effective in altering power alliances within a system. However, unbalancing makes unique, at times uncomfortable, demands on the therapist. For one thing, it calls upon the therapist to break with tradition and take sides. With unbalancing, the therapist uses an accrued position within the system in an unexpected way that may produce stress for both family and therapist alike. In addition, the therapist must be careful not to be inducted into the family's dysfunctional pattern, suddenly becoming a kind of henchman who reinforces instead of disrupts old

behaviors. This technique can be especially difficult when working with adolescents because the therapist may frequently have to "work both sides of the street," alternately supporting child and parents in a shifting pattern of coalitions.

REFRAMING

The technique of reframing involves the therapeutic introduction of alternative realities that provide family members with a different framework for experiencing themselves and one another. The therapist offers a different reality and the therapy then evolves from a clash of old and new realities. The family's framing is designed for the continuity and maintenance of its current system. The therapeutic framing is intended to move the family toward a reworking of the dysfunctional reality. Out of this clash of realities, then, the therapist looks not only for changed cognition but also for the *emergence of different interactional patterns.* The emphasis is on changed interaction leading to new understanding as well as to changed experience, both in the treatment room and at home.

SEARCH FOR COMPETENCE

Another key technique for the therapist is the search for competence in all family members, the object being to expand alternatives and help individuals discover new, more positive selves. As mentioned in the preceding chapter, one of the underlying rules of family therapy is its insistence on the multifaceted self—on the great potential for functional possibilities within dysfunctional individuals and systems. The goal in the search for competence, then, is both to confirm the individual and to challenge the system that is preventing the emergence of more positive, more functional behavior.

INTENSITY

In order to produce change in a family system the therapist must, of course, first be able to get his or her message across. In even the most highly motivated of troubled families the therapist's message may never register. There is, in a sense, a family threshold of deafness that must be overcome. In order to make a family "hear," the therapist uses intensity, the technique of selectively regulating the degree of feeling in the room in order to amplify the therapeutic message. The variations in intensity can be wide, from

simple, low-key communications to high-intensity crises. The appropriate level will depend on the family's readiness for response and on the level of the homeostatic threshold. Below this threshold the family may simply deflect or assimilate information without really getting the message. As therapists we should always remember that information sent is not necessarily information received. The therapist can be sure that the family has received only when different patterns begin to emerge in the room. It is the therapist's job to constantly monitor the intensity, increasing the level until the family's threshold is surpassed and new behavior becomes evident.

These are some of the tools, both assessment and therapeutic, that I have found most useful in addressing the problems of families with troubled adolescents. In the clinical chapters that follow I show how these tools can be used to evaluate dysfunction and stimulate change in actual families in treatment.