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Treatment Engagement: Building Therapeutic Alliance in Home-Based Treatment with Adolescents and their Families

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Abstract

Client engagement is an essential yet challenging ingredient in effective therapy. Engaged clients are more likely to bond with therapists and counselors, endorse treatment goals, participate to a greater degree, remain in treatment longer, and report higher levels of satisfaction. This study explored the process of engaging high-risk youth and their parents in a unique home-based family therapy intervention. Qualitative interviews were conducted with 19 families who completed family therapy sessions that included a core component aimed at increasing treatment engagement. Parents' and youths' perceptions of engagement suggest the importance of developing therapeutic alliance with therapists, who facilitated building a shared alliance among family members. Implications for improving client engagement are discussed within the context of alliance building with the therapist and among family members.

Keywords

High-risk youth; Family based treatment; Therapeutic alliance; Treatment engagement

Introduction

One of the key components of success in family therapy is attributed to the therapist's capacity to engage and retain the family in treatment (Stanton & Shadish, 1997; Wang et al., 2006). Research on clients' perceptions of family therapy suggests that therapists' rapport, warmth, optimism, humor, and commitment are crucial aspects of effective treatment (Beck, Friedlander, & Escudero, 2006). Expectations concerning treatment, the alliance formed between client and therapist, session attendance, and client satisfaction also contribute to or influence treatment engagement (Dearing, Barrick, Dermen, & Walitzer, 2005). Tensions

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created during family therapy sessions often lead families to blame problems on external rather than internal causes, which induces denial of the need to be involved in the change process (Digiuseppe, Linscott, & Jilton, 1996). Consequently, engagement and commitment to treatment must be emphasized if family members are to continue in therapy until completion and successful outcomes are achieved (Broome, Joe, & Simpson, 2001).

Therapeutic Alliance

The process of engagement requires client and therapist to construct a therapeutic relationship or alliance. This essential component of effective treatment reflects the quality of the interaction, the collaborative nature of developing tasks and goals of treatment, and the personal bond between client and therapist (Digiuseppe et al., 1996; Horvath & Symonds, 1991). Conducting therapy devoid of a positive alliance is likely to result in a treatment interruption or termination (Pinsof, Horvath & Greenberg, 1994). Decades ago Bordin (1979) noted that therapeutic alliance included three features—agreement on goals, establishing tasks, and building a bond. Research has continued to extend understanding concerning this phenomenon by examining the nature of the client-therapist relationship, the collaborative nature of agreeing on tasks and goals, and the personal attachment that emerges in treatment (Kazdin, Marciano, & Whitley, 2005). Recently, alliance has been conceptualized into two organizing concepts: task-based alliance and relationship-focused alliance (Hougaard, 1994; Pinsof et al., 1994). *Task alliance* is an agreement between client and therapist regarding the purpose, goals, and tasks needed for positive change in the client's life (Hougaard, 1994). This pseudo contract serves to empower clients, putting them in control of their treatment. *Relationship alliance* serves to bond the client and therapist by establishing trust and rapport. Building this connection has been associated with underlying attachment theory wherein building the alliance relieves attachment anxiety and allows a relationship to form that empowers the client to make changes. These two parts are mutual and complimentary; without one, the other is difficult to develop (Pinsof et al., 1994). However, it is the strength of the alliance, rather than the type of alliance, that results in positive treatment outcomes (Bordin, 1979).

Several randomized controlled trials of family therapy have demonstrated the effectiveness of this treatment approach for engaging and retaining clients and improving positive outcomes for youth and their families (Cunningham & Henneggler, 1999; Liddle et al., 2001; Waldron, 1997). Family therapy requires building a therapeutic alliance with each member of the family; thus, considering family system factors and family interaction patterns is critical for improving therapy attendance and engagement (Coatsworth, Santisteban, McBride & Szapocznik, 2001). Family disorganization, inadequate support for family members, and low cohesion among family members interferes with treatment engagement (Spoth, Redmond, Hockaday, & Shin, 1996). In a recent meta-analysis, the strongest predictors of positive treatment outcomes were therapists' interpersonal skills, direct influence skills, and the willingness and actual participation of clients in treatment (Karver, Handelsman, Fields & Bickman, 2006). Alliance formation is needed to bond with each family member in a way that increases their commitment to the therapeutic interaction and enhances outcomes (Diamond, Liddle, Hogue & Dakof, 1999; Thomas, 2006).

Youth are particularly difficult to engage. It has been estimated that 50–75% of young people referred to treatment do not initiate or complete the full course of treatment (Kazdin, Siegel & Bass, 1990), resulting in poorer outcomes in individual, school, home, and community functioning (Kazdin, Holland & Crowley, 1997). Creating a therapeutic alliance with adolescents is particularly challenging due to youths' inherent demand for developing independence and constant striving to differentiate themselves from authority (Eltz, Shirk & Sarlin, 1995). Adolescents often are involuntarily referred by parents and other caregivers and see limited value and need for treatment (Digiuseppe et al., 1996). Transforming adolescent

resistance and reluctance into investment in treatment requires development of a collaborative relationship with therapists that encourages youths to cultivate their own solutions (Diamond & Liddle, 1999). Some research has shown that the perception of the therapist as warm is especially important in increasing relationships with adolescents (Shirk, & Karver, 2003) as is respect, time shared, openness, role differentiation, guidance, identification, and familiarity with the therapist, trust, and taking responsibility (Martin, Romas, Medford, Leffert & Hatcher, 2006).

Intra-Family Alliance

A major difficulty in understanding therapeutic alliance in multi-person and multi-generational systems is that no single alliance can be considered separately. Interpreting alliance simply in dyads between each family member and the therapist ignores the complex intra-familial dynamics that make family therapy unique (Beck et al., 2006; Friedlander et al., 2006). The process of engaging with the therapist aids in developing insights and improvements in parent/youth relationships; increased engagement occurs when the therapist empowers family members to improve their relationships with one another (Bachelor, 1995). Through therapists' modeling of appropriate interpersonal behaviors, parents and youth are exposed to positive exemplars and are better equipped to develop skills that build family relationships.

Despite a growing body of research aimed at understanding the role of therapeutic alliance in engagement, there are several areas requiring further research. Few studies have been conducted that draw on clients' perspectives, especially those of adolescents. Thus, research focusing on the engagement process in family therapy requires inclusion of separate perspectives from youths and parents regarding the client-therapist relationship (Pinsof et al., 1994). Furthermore, research in naturalistic, real-world practice settings is needed if there is intent to move research into practice (Kazdin & Nock, 2003).

To address gaps in the literature, the current study explored the perception of treatment engagement among high-risk youth and their parents who participated in a family therapy intervention intended to increase treatment engagement. Specifically, this study aimed to understand parents' and youths' perceptions of their engagement in treatment through identifying both components of the therapeutic alliance developed between family members and the therapist and treatment elements associated with building relationships among family members.

Methods

Sample and Recruitment

Participants in the present study were recruited from among families participating in a larger family therapy intervention study. The purpose of the primary study was to evaluate engagement and retention among families receiving in-home family therapy with a focus on engagement versus family therapy services as usual. Families were recruited during the intake process at a large social service agency in central Texas. Families were recruited for the primary intervention study if: (a) the identified child was 12–18 years of age at the time services were sought and reported difficulties with delinquency, truancy, family conflict or running away; (b) parents were willing to provide permission for the child to participate in the intervention and data collection; and (c) at least one parent was willing to participate. Families were randomly assigned to either the experimental or control condition. The experimental group received up to 12 sessions of in-home, strength-based family therapy that included multiple activities designed to increase engagement ("Engagement Activities"), while the control group received services as usual, typically family therapy delivered in an office setting for up to 12 sessions.

For the current study, families who had been participants in the primary study and assigned to the experimental group were contacted ~3 months after completion of family therapy sessions to seek volunteers for this secondary investigation. The 3-month time period was chosen as post-tests also were conducted following termination of family therapy sessions and 3 months is a follow-up time frame often used in family based intervention studies (e.g., Waldron, Slesnick, Brody, Turner & Peterson, 2001). An interviewer provided youths and parents with a detailed description of the project, described the voluntary nature of participation in the follow-up interviews, and requested both parental consent and youth assent. From among the 40 families who participated in the experimental condition, a convenience sample of 19 families was recruited to complete qualitative follow-up interviews focused on perceptions of engagement. All follow-up interviews took place in the families' homes and were audio-recorded. Methods for the primary and follow-up study were reviewed and approved by the affiliated university's Institutional Review Board.

Intervention

The intervention delivered to the experimental group, on which this engagement study is focused, included 12 sessions of strength-based family therapy delivered to families in their homes rather than in a traditional office setting. A family therapist visited each family in their home for approximately an hour to an hour and a half. At the beginning of each session, one of 19 individual "Engagement Activities" was conducted. These activities were developed from a variety of sources and their key aim was to engage the youth and family in the treatment process by providing a novel approach to therapy. "Engagement Activities" involved experiential interactions and skill building exercises that elicited active participation from all family members and led to further discussions of relevant family issues. It was often necessary for the therapists to explain the use of the "Engagement Activities" to the families as they typically were not familiar with this type of creative, even playful, encounter with a therapist. Table 1 provides a brief description of some of the "Engagement Activities" (a full description of the family based intervention is described elsewhere).

Data Collection

Parents' and youths' perceptions of their engagement in treatment and other factors associated with engagement were queried through a semi-structured interview following methods used in qualitative research (Miles & Huberman, 1994; Thompson, Pollio, Eyrich, Bradbury & North, 2004). Guided by prior research that finds youth and parents give significantly different descriptions of services (Leaf, et al., 1996), interviews were initially attempted with youth and parents separately. During the initial pilot testing, however, youth provided very limited responses and appeared unmotivated to share their experiences in any depth or detail. To elicit more information from youth, therefore, interviews were conducted with youth and parent(s) together. Parents prompting and encouraging their child to describe their perspectives led to much more interactive and informative interviews with the youth. This interview format closely mirrored the family based intervention itself, and resulted in youth and parents sharing detailed information about their distinct impressions.

Interview questions were designed to query information concerning factors associated with the "Engagement Activities" and the family's perceptions of in-home services. A series of open-ended questions invited parents and youth to describe their overall impression of the "Engagement Activities," how well they engaged their interest, and whether they taught them something useful/helpful. Additional questions sought to understand the families' experiences with the treatment process, such as how family members initially felt about participating in treatment, how these feelings changed over the course of treatment, what features made it more comfortable to discuss sensitive topics as a family, and what aspects of the treatment enhanced their willingness to participate. Although none of the interview questions specifically queried

issues associated with building a therapeutic alliance with their therapist or other family members, the interview's qualitative nature and open format allowed family members to talk about topics they felt were important to them. During the interview process, it became apparent that though interviewers were not asking specifically for descriptions of how alliances formed with therapists and among family members, these topics were identified by family members as particularly significant. These responses are the focus of the following analysis and discussion.

Data Analysis

The analysis was developed through an iterative process using transcript-based, content analysis procedures (Miles & Huberman, 1994; Patton, 2001) and involved all members of the research team. First, separate team members examined complete transcripts to identify major themes. Major categories were identified and subcategories were developed to specifically illustrate components of the broad categories. Coders compared categories/subcategories to reach consensus on the categories and their definitions. Coders then separately examined each transcript and identified all distinct statements (any word, phrase, sentence or response that pertained to a single concept and stated by one individual), and differences in identifying these statements were reconciled through consensus. The categories/subcategories, definitions, and number of respondents reporting in each major category are included in Table 2.

Once categories/subcategories were identified and defined, reliability was evaluated. Two coders independently coded statements into the identified categories, and differences were resolved by further category definition. Inter-coder agreement was established by examining the proportion of agreement out of the total coded for each category (#agreement/# of statements coded into each category). Inter-rater agreement ranged from 68 to 100% across the various categories (see Table 2). Differences in coding were then resolved through discussion and by reaching consensus among the raters. Once each statement had been coded into a category/subcategory, QSR Nudist.6 Software was used to organize the coded statements into nodes containing similar concepts and hierarchies of categories and subcategories. Printed reports of each category and subcategory then were reviewed by the research team and specific statements were identified that demonstrated "typical" participant responses.

Findings

Of the 19 families completing the follow-up interviews, most caregiver participants were mothers ($n = 12$), fathers ($n = 3$), or other family members, such as grandmothers ($n = 2$), aunts ($n = 1$), and uncles ($n = 1$). Caregivers were primarily Latino (52.6%, $n = 10$); the remainder were White (31.5%, $n = 6$) or Black (15.8%, $n = 3$) and ranged in age from 29 to 63 years of age. Youth participants were predominately female (68.4%, $n = 13$) and Latino (52.6%, $n = 10$), White (31.5%, $n = 6$) or Black (15.8%, $n = 3$). Youths' ages ranged from 12 to 16 years. All families included in the follow-up interviews completed all twelve sessions of the family therapy intervention.

In describing components of therapy sessions, parents and youths noted the importance of engagement in the therapeutic process. In doing so, they identified specific tasks and relationship issues that built alliances with their therapists. These comments fell into one of two categories of therapist-oriented engagement: relationship building and task-centered alliance. In addition, parent and youth participants also reported that the bond with their therapists facilitated stronger relationships among family members, resulting in a shared family alliance (family oriented engagement).

Therapist-Oriented Engagement

Relationship Building—Parents and youths described their family therapist as someone with whom they felt a positive connection and in whom they had developed a collaborative relationship. Various therapist traits were credited for creating change in the family and within sessions.

Parent Perspective: Therapist traits were mentioned by parents in 68% (n = 13) of the interviews. In general, parents described the therapist as helping them and their children feel comfortable and accepted. For example, "he's just wonderful, very effective, makes you feel comfortable… You can tell he cares."

More specifically, parents frequently mentioned that their therapists had a calming presence on the family that served to de-escalate conflicts and refocus discussions into more productive interactions. They valued the neutral and composed demeanor of the therapist during tense moments. They also recognized that the therapist was in a position to elicit responses from their children concerning topics parents often were unable to introduce. Therapists who remained neutral and were nonjudgmental were especially appreciated. These traits appeared particularly important to parents as they sought their therapist's advice when family members' views differed. Their calmness and neutrality was related to a nonjudgmental attitude. For example, one parent expressed appreciation that the therapist "didn't argue; she didn't say you're wrong."

Parents mentioned their comfort level with the informality and relaxed nature of the therapist. Therapists who appeared calm, friendly, and did not rush through the process were accepted readily by parent respondents. Whether being dressed casually or being willing to sit on the floor to join the family in an activity, informality appeared to break down barriers between the therapists and their clients. Therapists actively joined with their clients as "part of the family" or "like somebody you'd known for a while. He would come in and say 'hi' and laugh and then we would start."

Youth Perspective: In 32% of the interviews (n = 6), youth described qualities of the therapist that were especially helpful in creating a connection. Youth respondents commented on many of the same traits as mentioned by parents, including a calm presence and the importance of being impartial. One youth said she was comfortable with her therapist because of "her demeanor, just the way she was. She was very friendly, very open, very unbiased."

Therapists who were perceived as truly authentic and attentive also were considered an asset. Youth were appreciative of therapists for actively listening, not just "acting like they are listening the whole time." They valued therapists who participated actively in discussions, openly expressed themselves, and joined in session activities. These therapists were perceived as genuinely invested. One youth commented, "That made it seem like she was actually paying attention." Some youths also emphasized their appreciation for the therapist's humor, relating this to an increased level of comfort and connection.

Task-centered Alliance—Therapists who demonstrated skills related to problem solving or methods for dealing with the family's specific problems were viewed positively. Participants noted appreciation for the application of a specific skill through direct advice or directed tasks. However, participants also developed skills based on their own insights that emerged from interactions between family members and the therapist.

Parent Perspective: All of the parents interviewed (100%, n = 19) indicated they appreciated learning new skills and gaining insights during their sessions. Several shared the sentiment of a parent who remarked, "It may have been small, it may have been big, but every time she left

I had a new way of looking at something." More specifically, parents mentioned learning a variety of communication skills. Therapists suggested ways to relate to one another and often were credited with eliciting insights about communication patterns within the family. Parents valued the increased awareness of their own communication styles and how those patterns affected their interactions with other family members. One parent stated that her therapist "made me more aware of not talking so much; to try to listen more," by modeling this type of listening during sessions. Some parents also commented on the therapist's ability to draw out difficult-to-engage youth and set a precedent so that after sessions, "I find that she [daughter] comes to me more… [Therapist] opened that. I feel like he opened that for us because she is able to come to me about some things now."

Several parents commented on their therapist's ability to help them develop insight into typical teenage behaviors and better understand the origins of conflict with their children. One parent commented, "Things are a whole lot different than when I was growing up," and the insight helped her reconsider her teenager's reality and stressors.

Several parents noted that they used conflict resolution skills and anger management strategies the therapist had taught them during treatment sessions. In some cases, they described implementing techniques learned from their therapist when attempting to handle frustrating situations by asking themselves, "what would my therapist say?" For example,

> "She [therapist] didn't nag. She would just try to say, 'so maybe you do it this way and then when I come back next week, you can tell me how it went.' For instance, try to talk, try to solve your problems. If you can't solve your problems, go your separate ways and then come back and talk."

In building task-alliance, it was particularly important that tasks and goals accurately reflected the interests and abilities of the family. Therapists who were in tune with the needs and abilities of the families with whom they worked were especially effective in building an alliance with parents. One parent commented, "…she always set out goals and objectives weekly. And I think that she picked goals and objectives that we could address."

Youth Perspective: Many youth (68%, $n = 13$) commented not only on learning new skills and gaining insights throughout the sessions, but also recognized that these skills and insights improved the relationships in their families. Several youth stated that the sessions created an environment in which their usual patterns of fighting and arguing were addressed and altered. Their continued use of these new skills improved communication after sessions concluded. One youth emphasized, "It helped us learn to talk to each other instead of fight…"

Another youth pointed out that improved understanding among family members helped bridge tensions and reduce discord that had long been the norm:

> "Before…I wasn't talking….first me and mom, we would…talk about everything. And then my step dad passed away, and then we stopped talking and she got close with [my sister]. Since [our therapist] has been helping us, I've been talking to my mom more and she's been trying to understand where I'm coming from more."

Many youths commented that family therapy sessions taught them to improve their ability to listen to family members and to interact and share more about their daily lives. They reflected on how changing these two behaviors created a more peaceful atmosphere in their families. Although the youth realized they and their family members were the ones to continue these behaviors outside of sessions, most attributed the shift to guidance from+their therapist.

Youths mentioned learning some specific skills, especially those related to anger management. Several youth commented that learning the concepts of relaxation, such as deep breathing and

taking time out to calm down when angry, helped them change their tolerance and response to frustration and stress. One youth described it as learning "how to relax instead of acting out."

Intra-Family Engagement

Relationships within the family were also a primary source of engagement in the therapeutic process. Development of connections between the youth and his/her parent(s) improved relationships and the ability to solve problems.

Sharing Time Together

Parent Perspective: Several parents and youth described how they enjoyed treatment sessions, especially as they encouraged the family to share time together. In fact, 63% (n = 12) of parents mentioned spending time together as an important component of the change process. Parents referred to "bonding" as a family and "coming together" as valuable, enjoyable, and something that previously had been a rare occurrence. Coming together in therapy sessions created a new quality of interaction among family members. Parents described their families as "calmer," "more focused," "able to accomplish tasks as a group," and "able to enjoy time together." These interactions were in contrast to the families' normal functioning, which had included "arguing and bickering." Instead "they [family members] were actually able to participate in one thing together without arguing." Treatment sessions provided a reason to join as a family, creating a rare alliance between family members. One parent noted: "[the kids] are usually in their room and I'm here in my room. But, we learned to work together." Another mother expressed delight in, "actually communicating like a family should do—sit at the dinner table and talk about… problems that were happening…"

The improved relationships created opportunities for family members to grow closer, especially as they developed new ways to communicate with one another. Respect and patience increasingly became expected family norms. The opportunity to interact differently in the context of therapeutic processes involving the entire family appealed to family members. One parent stated: "it gets everyone involved…lightened things up and set the atmosphere for improved communication."

Youth Perspective: Some youths (32%, n = 6) also mentioned that during their participation in the family therapy sessions they learned an appreciation for spending time with the family, especially "because we're all so busy all the time…." Many youths indicated that their families rarely "hang out together," and the in-home sessions were an exception to their daily lives. Sessions provided an opportunity for the family members to come together, reconnect, and simply enjoy one another's company.

Gaining Understanding of Self and Others—

Parents and youth recognized that the therapeutic process encouraged them to interact more authentically with one another. Getting to know each other and themselves better was mentioned by 74% (n = 14) of parents and 58% (n = 11) of youth.

Parent Perspective: Parents valued becoming more familiar and aware of their sons' and daughters' ideas and perceptions. One mother put it simply, "I like to know…how he [son] thinks and what kind of person he is." Increased understanding often involved recognizing and accepting that their child was growing up and becoming more independent. One mother said she started to "realize that she's [daughter] growing up and that she has her own thoughts and her own way of doing things, which doesn't make mine wrong, it just makes mine different…"

Conversely, several parents commented on the fact that family members grew more "in tune" with each other and found they shared many commonalities. One parent described gaining a

deeper understanding of her children: “it was good getting in touch with what’s meaningful to them and what’s meaningful to me. It’s kind of like we haven’t really ever talked about those things, you know, with each other. So, it was informative.”

Some parents noted the greater insight they had gained concerning their child’s unique personality, preferences, and viewpoints. Beyond likes and dislikes, parents discovered how other family members processed information, solved problems, and communicated. Parents recognized that they often approached problems differently than their children, which led to improved understanding of ways to interact more effectively.

In increasing their desire and ability to understand their children, parents learned more about themselves in relation to the rest of the family. Gaining insight into how differently parents’ and children’s minds operate helped to improve interpretation of others’ actions and words. They spoke of realizing the diversity of each family member’s personality and temperament. Some actions previously viewed as annoying and particularly challenging were recognized as typical of others with similar temperaments and communication styles. This was especially helpful if the parent and youth were “completely different” in temperament. For example, one parent suggested she naturally “thinks of solutions and safe routes,” while her son is “free-spirited,” and less concerned with the future. Other parents noted how differently they approached problems compared to their child(ren), such as the children simply “jump-in” to try and solve a problem with limited information, whereas they tended to think through consequences before taking action. Recognizing these differences helped parents modify their expectations of their children’s responses to problems.

Youth Perspective: Youth also mentioned that throughout the family therapy sessions they were exposed to new information about other family members and gained insights concerning their own behaviors. They associated this new information with improvement in their interactions and feeling more connected, especially when discovering they had more in common with their parents than originally thought. One youth commented, “Yeah. It was just a learning experience. You know, once you know a little bit more about somebody, it’s easier to relate to them.” One youth noted, with surprise and relief:

> “You wouldn’t think your whole family would probably have the same emotions toward one thing. Like when my grandma passed away…it’s kind of like we’ve been hiding everything about our emotions towards that when we could have just talked about it.”

Similar to parent reports, youth described the value of increased understanding of other family members. This increased knowledge helped improve family interactions, specifically when family members learned more about each other’s “triggers” and “what we stress about.” One youth stated she and her mother gained perspective on what irritates each of them: “I guess my mom didn’t know what stuff I got mad about and I didn’t know some stuff she got mad about.” This new knowledge allowed each to respect the other’s point of view, leading to decreased conflict.

Just as parents commented on their improved ability to recognize strengths and positive attributes as they grew to understand their teen child, almost half of the youths mentioned feeling a closer connection to family members after focusing on their positive characteristics. In remembering an activity that encouraged giving compliments, several youths commented on how much they enjoyed receiving compliments from other family members, particularly because “we don’t say that (compliments) to each other most of the time.” In these situations, the act of giving positive feedback seemed to break down communication barriers and create a special bond between family members.

Unenthusiastic Reactions to the Intervention

It should be noted that a few families reported difficulty engaging in the treatment process and building strong relationships with their therapists. These families were not the norm, but three parents (16%) mentioned difficulty engaging in the sessions and feeling a connection with the therapist. They pointed out that the therapy was too intense or over-whelming for them, and their child. In particular, one mother described her husband's resistance to exploring difficult material and issues in the family,

> "Our therapist could see that my husband truly wanted it all to work out and that his family meant a whole lot to him, but it just seems like when we would tell him what problems there were, he thought we were dogging him."

With this kind of response, sessions sometimes became tense and the aftermath was stressful and emotional for clients. Two of the parents remarked that certain intimate topics were too difficult or uncomfortable to discuss and led to increased tension and anger that the therapist was unable to help them overcome. One parent reported volatile arguments occurred after the therapist left their home; another spoke of a general negative mood preventing one session from being effective.

Some youth (26%, $n = 5$) agreed with parents that at times the material discussed in the session was too emotionally intense and sensitive. Youth who felt overwhelmed by especially emotional topics responded by closing themselves off from their previously developed connection with the therapist, as the therapist was viewed as the one creating the discomfort. For example:

> "I just sure remember getting so upset because I didn't know where to go with it anymore because like new things would start popping up that were not part of the subject and it was just like 'ugh.*'"

One youth stated, "I don't think counseling helps you if you're forced to talk about things that you're not ready to talk about." Another noted, "the counseling brought his [father's] anger out and he would be so mad and he wouldn't talk to us for hours afterward." While most participants felt the therapists and the family therapy sessions drew the family together, exceptions to this bonding were experienced occasionally and at cost to the development of engagement in the therapeutic process.

Discussion

This study aimed to examine the process of engagement of youth and family members in a series of family therapy sessions delivered in the home environment. Considered together, our findings suggest complex relationships between family members' alliances with the therapist and among family members themselves. Even though qualitative interviews conducted for this study were not collected with an a priori focus on therapeutic alliance, participant interviews suggested the importance of building relationships during the treatment process. This finding supports previous research suggesting that a strong therapeutic alliance significantly predicts outcomes, over and above the type of therapy administered, the length of treatment, or any other single aspect of the therapeutic process (Shelef, Diamond, Diamond & Liddle, 2005).

Limited research has compared parents and youths concerning their experiences and perceptions of family based treatment. Thus, this study sought responses and perceptions of parents and youths engaged in family therapy. Findings demonstrated that they identified surprisingly similar categories of engagement. For both, task-centered engagement was vital for learning new methods of managing family life. Although parents were more verbal in their descriptions, youths commented primarily on "tasks" the therapist modeled and encouraged them to develop, such as new skills and insights related to family relationships and

communication. For parents, therapeutic tasks that focused more broadly on parenting skills, such as teaching effective listening, providing guidance, and developing insights related to adolescent behavior were viewed as particularly helpful.

Therapeutic alliance that focused on relationship-building was discussed by most parents, but fewer adolescents. Parents had an affinity for therapists who had a calm and casual presence because it increased their level of comfort in family therapy sessions. Youths also appreciated the calming influence of therapists that improved their level of comfort with them, and favored therapists who appeared authentic, caring, and impartial.

Intra-family engagement, reflected in the building of familial relationships, appeared to improve through involvement in the family based therapy. Parents enjoyed bonding, spending time together as a family, and communicating more respectfully and positively with their child (ren). They valued learning more about their child(ren) and understanding their unique strengths and perspectives. Youths also mentioned their enjoyment of the time spent together as a family during family therapy sessions, adding that feeling connected and learning about commonalities and mutual interests among family members was a new experience. Therapy sessions often elicited discussion of information the family members previously had not discussed with one another. Similar to other research (Azrin, Donohue, Besalel, Kogan & Acierno, 1994; Liddle et al., 2001), improvement in parent-adolescent relationships and positive family interactions was an encouraging outcome of the family therapy sessions.

A challenge in understanding engagement in family therapy is the complex multi-person, multi-generational systems involved in treatment; no single individual can be considered in isolation (Beck et al., 2006). Recent literature on therapeutic alliance in family therapy emphasizes the need to consider the multiple, dual, and sometimes competing alliances that develop between child and therapist and parent and therapist (Diamond et al., 1999). In this study it appeared that the family therapy sessions seemed not only to build trust and appreciation for the therapist but also encouraged the development of stronger connections among family members. Youth participants, often viewed as resistant to treatment, noted that having an “unbiased,” “respectful,” “supportive”therapist encouraged them to discuss sensitive information within family sessions. Parents also noted greater understanding and expressions of warmth for their adolescent child when the therapist helped modulate negative interactions. Thus, recognizing the important role that parents play in treatment engagement in relation to their child(ren) (Kazdin et al., 1990) and the role the youth plays in the therapeutic encounter is vital for therapy to be successful. Although this complexity creates a challenge for family therapists who must build alliances with the youth and the parent, relationship-building with family members is crucial.

Although most families were able to build a positive alliance with their therapist and with other family members, the difficulties a few families reported in engaging in the therapeutic process indicate the various challenges of building an alliance. For example, therapists must develop a relationship with a variety of family members when conducting family therapy; difficulties may arise due to varied levels of commitment among family members. Participants’ comments suggested that some families or family members were unable to cope with the intense emotions or sensitive subject matter often brought out during family therapy sessions and simply disengaged from the treatment process. These concepts appear to be reciprocal such that families initially resistant to therapy may avoid engaging in treatment, which makes future sessions overwhelming and creates more resistance. Studies suggest that confronting negative client responses to therapists can improve alliance development and engagement (Beck et al., 2006; Digiuseppe et al., 1996). Transforming resistance and reluctance into a collaborative relationship with the therapist is one of the first and most critical tasks in the therapeutic process (Diamond et al., 1999).

The interrelationship between therapist-oriented alliances and family oriented alliances is an area for further research. What remains unclear is whether alliances with the therapist create opportunities and models for family members to build alliances with one another or whether developing a bond among members is what makes families more invested in the change process and thus better able to bond with their therapist. While the direction of these relationships is unclear, the results of this study indicate that developing both therapist and family oriented alliances enhances client engagement in the therapeutic process.

Limitations and Conclusions

This study's qualitative methods represent an important step in providing information relevant to developing family therapy interventions for this population. A concern inherent in all qualitative research is the clear limitation in generalizing findings from a small convenience sample. This limitation does not allow the results to generalize to all family therapy interventions, but the findings do provide evidence of the importance of the therapists' connection with clients. This study is an exploratory first step in understanding the process of engagement in home-based family therapy. Although the categories developed are supported by previous treatment engagement research in a variety of settings, further development of these areas is needed to increase practitioners' and researchers' understanding and awareness of sources of engagement in the therapeutic process.

Given these limitations, a logical next step would be to query a larger and more representative sample and test the potential of engagement in family therapy as related to outcome achievement. The qualitative interviews addressed only the perceptions of the treatment process among youths and parents; future research requires evaluation of otherfactors associated with the engagement process in order to tie these processes to outcomes. Despite the limitations, however, findings suggest that family therapists can increase the engagement of families with whom they treat by building alliances with family members and encouraging positive relationship building within the family. Therapists who assist families to develop new ways of interacting may advance alliances and promote engagement in family therapy.

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Table 1

Example of engagement activities

Meaningful events	Recording and sharing memories of events that were meaningful to parent and youth
Downward spiral	Board game that alerts participants to the consequences of substance abuse across social, emotional, familial, educational, occupational, and financial contexts
Garbage bag	Family writes and then symbolically throws away hurtful personal qualities or feelings to release problematic emotions, experiences, behaviors
Rush hour traffic jam	Focuses on group problem solving while providing insight into individual approaches to problem solving and constructive family interactions
3-D Storytelling	Play-doh is used to create 3-D characters and develop a story that encourages families to communicate feelings, concerns, and patterns in their relationships
To You but from Who?	Creates an opportunity to share positive words and compliments and builds recognition of individual and family strengths aimed at overcoming negative communication and increasing positive interactions
Bubble breathing	Blowing bubbles provides an opportunity to teach deep breathing techniques that are useful in reducing anxiety, anger, stress, etc.
Worry stones	Stones are used to illustrate levels of worry that leads to discussion of anxiety, challenges, and related concerns

Table 2

Broad categories, subcategories, and definitions with frequency and percentage of parent(s) and youth reporting each category

Broad categories	Subcategories	Definition	Interrater (%)	Parent #	Parent (%)	Youth #	Youth (%)
Therapist-oriented engagement							
Relationship building	Collaborative relationship Casual presentation Calm, neutral, unbiased Nonjudgmental Authentic Attentive, active participant	Aspects of the counselor's personality, presentation, or involvement that family members found helpful in the therapeutic process	76	13/19	68	7/19	37
Task-centered alliance	Communication styles Anger management Parenting skills Developing empathy Insight into youths' behaviors Goals fit needs of family Effective listening skills Relaxation techniques	Teaching skills, such as teamwork, effective listening, anger management, parenting practices. Therapist tasks included providing advice, guidance, insights, and opportunities to assess progress	71	19/19	100	13/19	68
Intra-family engagement							
Sharing time together	Bonding New quality of interactions Less arguing Increased respect "Hanging out" more	Family coming together, staying involved in treatment, and developing more positive relationships	68	12/19	63	6/19	32
Gaining understanding of self and others	Recognize youth's need for independence Learned each other's triggers Understand each other's different problem solving techniques	Getting to know each other better, understanding unique traits, tendencies, and similarities	84	14/19	74	11/19	58
Unenthusiastic reactions to the intervention							
Negative responses to sessions	The intervention brought up too much material at once Provoked anger Caused family members to withdraw Family members avoided involvement	Comments that expressed dislike or discomfort during sessions or the treatment process in general	100	3/19	16	5/19	26