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THERAPEUTIC ENGAGEMENT WITH ADOLESCENTS IN PSYCHOTHERAPY

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Therapeutic engagement of adolescents is critical to maximizing the success of any psychotherapy intervention. Therapists have found that engaging adolescents is especially challenging and that there are several reasons for this. Most psychotherapy models are based on treatments that work for adults. These methods are frequently not conducive to engaging adolescents because of their developmental immaturity, the stigma many adolescents associate with psychotherapy, and adolescents feeling forced into psychotherapy. Existing empirical and clinical knowledge about therapy process, adolescent development, and adolescent interactions with their social ecology can be used to guide psychotherapists working with this population. Engaging adolescents in psychotherapy and establishing a strong therapeutic alliance with adolescents require that therapists express empathy and genuineness, utilize developmentally appropriate interventions, address the stigma, and increase choice in therapy.

The prevalence and impact of mental health issues among adolescents are astonishing. Recent reports indicate that 1 in 10 children and adolescents suffer from impairing mental illness (Kessler, McGonagle, & Shayang, 1994; U.S. Public Health Service, 2000). Depression and depressive syndromes are common among adolescents, with more than 25% of high school students reporting persistent dysphoria and hopelessness severe enough to affect social and academic functioning, and 8 to 9% of youths admitting to attempts at suicide (Centers for Disease Control and Prevention [CDC], 2002). Five percent of all high school youths report weight control strategies that indicate a potential eating disorder (CDC, 2002). Nearly 27% of eighth graders, increasing to nearly 54% of high school seniors, report illicit substance use (National Institute on Drug Abuse, 2001), with 11% of high school students having a substance abuse problem.

These mental health problems lead to serious consequences that include impaired social, academic, and occupational functioning; increased risk for behavioral problems; and accidental injury and death. Yet, fewer than one in five youths in need of mental health services receive the needed treatment (National Institute of Mental Health [NIMH], 1999). So, while adolescent mental health problems are pervasive and increasing, access to treatment is decreasing (NIMH, 1999). Consequently, maximizing adolescent use of psychotherapy and providing effective mental health services to adolescents are significant concerns for therapists (Dakof, Tejeda, & Liddle, 2001). However, therapy with adolescents is thought to be difficult (Church, 1994; Hanna & Hunt, 1999; Liddle, 1995; Mar-

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golis, 1995; Sommers-Flanagan & Sommers-Flanagan, 1995, 1997). In contrast to the adult, child, and family therapy literature, in which a variety of therapeutic process variables that enhance psychotherapy have been identified, little empirical work has been done to identify specific process or relationship variables that enhance therapy with adolescents (Diamond, Liddle, Hogue, & Dakof, 1999; Shirk & Saiz, 1992).

In the absence of specific empirical knowledge about engagement of adolescents (Morris & Nicholson, 1993; Norcross, 2001), researchers and therapists need to rely on information gleaned from the therapy process literature, the literature on adolescent development, and socioecological studies to better understand how to engage adolescents in therapy. Our intent in this article is to review the most recent clinical and empirical literature and then indicate how this information can contribute to adolescent therapy practice. First we review what is known about therapy process research with adults, children, and families and extract from this suggestions for effective engagement of adolescents. Second, we evaluate salient aspects of adolescent development and deduce from these additional means for effective engagement. Last, we consider the social ecology of the therapy context and how adolescents regard the therapy environment, how this interaction can lead to barriers to effective engagement, and how these barriers can be overcome. We believe that integrating this theory, research, and therapy practice is vital to therapists and researchers who work with and study adolescents.

The Therapy Process Literature

Contributions From Therapy Process Research to Engagement of Adolescents

Arguably, the most important component of psychotherapy is therapeutic engagement and the therapeutic relationship factors that engagement entails (Liddle, 1995; Norcross, 2001; Shirk & Saiz, 1992; Weinberger, 1995). However, therapeutic techniques and procedures designed for engaging adult and child clients often do not work as effectively for adolescents because adolescents bring unique attributes to the therapy process that distinguish them from other therapy populations (Rubenstein, 1996, 1998; Shirk & Saiz, 1992). Nonetheless, the therapy process literature can inform psychotherapists on effective means of treating adolescents.

In general, therapeutic engagement is a reciprocal interaction in which both therapist and client(s) have a responsibility for establishing an effective rapport. Psychotherapists initiate therapy sessions and join with clients by expressing concern about the well-being of the client and other family members and by inquiring about personal problems (Liddle & Dakof, 1995). Clients, in turn, are expected to be attentive and actively involved and not merely compliant (Shirk & Saiz, 1992). As engagement matures into an emotional involvement between therapist and client(s), a therapeutic alliance is created (Friedlander, Heatherington, Johnson, & Skowron, 1994; Horvath, 2001; Ogrodniczuk, Piper, Joyce, & McCallum, 2000). This degree of mutual relationship and collaborative working involvement between therapist and client(s) generates an optimum therapeutic outcome.

A variety of attitudinal, interpersonal, and socioecological factors seem to affect therapeutic engagement (Robin & Foster, 1989). For example, for adult clients, therapist and client "first impressions" are important factors in therapeutic engagement. Strupp (1993) found that therapists' attitudes toward clients (positive or negative) tended to take shape within the first few minutes, did not change later on in therapy, and often created a self-fulfilling prophecy. Therapists who expressed a positive attitude toward their clients tended to give more benign diagnoses, more favorable prognoses, and communicated more empathically with their clients. Research findings have also indicated that clients' perceptions of therapists predict therapeutic outcome (Blatt, Zuroff, Quinlan, & Pilkonis, 1996; Garcia & Weisz, 2002; Strupp, 1993). When clients, as early as the second session, perceived their therapist as empathic, caring, open, and sincere, more favorable therapy outcomes occurred.

Child and family therapy process research has found that therapist flexibility and the capacity to meet the needs and goals of multiple family members, particularly parents, are necessary features of effective therapeutic engagement (Diamond, Diamond, & Liddle, 2000; Garcia & Weisz, 2002; Kazdin, Holland, & Crowley, 1997; Kazdin & Weisz, 1998; Kuehl, 1993; Liddle, 1995; Patterson & Forgatch, 1995; Weiss & Weisz, 1995). Failure to form a therapeutic alliance can occur as a result of family member re-

sistance or because the therapist provided insufficient support for the family (Celano, 2000). For example, because family therapists understand behavior in a systemic context, family members sometimes feel blamed just by association and participation in treatment. Family members frequently do not understand the nature and impact of family therapy and may resist participating, especially when treatment is due to an adolescent's delinquent or substance use behavior (Barbera & Waldron, 1994).[1] Moreover, family distress has been associated with higher rates of negative family communication (Barton, Alexander, & Turner, 1988). Consequently, absent constructive input from the therapist (and even sometimes when it is present), family members sometimes experience family therapy as a noxious encounter. Finally, there are simply more participants in family therapy than in individual therapy, thus increasing the opportunity for resistance (Barbera & Waldron, 1994).

Enhancing Therapeutic Engagement With Adolescents on the Basis of Therapy Process Research

These general themes from adult, child, and family therapy process research may have some utility in developing strategies for, or at least understanding hazards to be avoided when, engaging adolescents in psychotherapy. For example, therapists sometimes have negative preconceptions of adolescents because teenagers can intimidate adults (Sasson Edgette, 2001). Working with adolescents who are offensive or resentful can affect a therapist's initial response, ultimately creating a self-fulfilling prophecy that results in a failed therapy.

Empathy and genuineness. Most adolescents begin therapy in the precontemplative stage of therapeutic change. Consequently, to avoid early termination, it is important to engage proactively and to match therapist interventions with the client's precontemplative reluctance to change (Prochaska & Norcross, 2001). To this end, psychotherapists attempting to engage adolescents in therapy may need to use *judicious advocacy,* which can be expressed in a variety of ways. Empathy, an empirically supported therapeutic relationship factor (Norcross, 2001), is necessary for developing a therapeutic alliance (Greenberg, Elliott, Watson, & Bohart, 2001; Morris & Nicholson, 1993) with adolescent clients, but is not sufficient. Many adolescent clients need to feel that their therapist will understand them and that he or she will be a source of support (Diamond et al., 1999; Hanna & Hunt, 1999). Extending nonjudgmental acceptance to adolescents and respecting their perspectives are more engaging than the more traditional neutral stance often assumed by psychotherapists (Rubenstein, 1996, 1998; Sommers-Flanagan & Sommers-Flanagan, 1995; Young, Anderson, & Steinbrecher, 1995). Moreover, validating adolescent clients by appreciating their rationale and justifications of their behavior, however faulty or maladaptive, offers adolescents a way of saving face and building rapport with the therapist. Ultimately, adolescents will recognize and respond to therapists who convey that they are committed to them and their well-being (Sommers-Flanagan & Sommers-Flanagan, 1995). Of course there are limits to the effectiveness of empathy (Greenberg et al., 2001) and occasions when empathizing with an adolescent may be inappropriate. For example, therapists need to use caution and avoid having adolescents perceive therapist empathy as condoning antisocial or maladaptive behavior.

Being genuine in therapy with adolescents is a critical aspect to engaging adolescents in the therapeutic process. Adolescents, particularly those in therapy, detest insincerity and pretense (Rubenstein, 1996). They respond poorly to therapists and other adults who attempt to be "cool" by adopting youthful mannerisms and language (Hanna & Hunt, 1999). Adolescents respond more favorably to candor or "being real" (Sasson Edgette, 2001; Young et al., 1995). Therapist candor is intriguing to adolescents because of the personal and nondefensive stance assumed by the therapist. Candor is most effective if the therapist truly cares for the adolescent and when it is "disciplined, benevolent frankness that is squarely in the service of young people's

[1]Adolescents who enter therapy for substance use problems present unique challenges for the process of therapeutic engagement and can be among the most difficult of populations to engage (Margolis, 1995). Occasionally we use examples of substance abuse treatment in this article to illustrate how some of our ideas are manifested with these more difficult clients. In many situations, the engagement strategies that are effective with this particular group of adolescents may be even more potent with adolescents who have relatively less severe problems.

needs and invites them to look at themselves differently" (Sasson Edgette, 1999, p. 40).

Candor implies telling adolescent clients the truth. The social nuances and euphemisms of adult therapy are lost on adolescents, although it is important to seek a palatable way for adolescent clients to face reality. Because adolescents may not have sophisticated social perspective-taking abilities and typically do not share a similar social ecology with adults, truth telling must be metered to correspond with the adolescents' developmental capacities and context. For example, in the treatment of adolescent substance abusers, candor entails advocating for sobriety. The therapist must navigate between confronting an adolescent with his or her substance abuse, thereby risking the adolescent feeling rejected, and not saying enough, leaving the adolescent believing that the therapist tacitly accepts or condones his or her substance use. In this case and cases like it (e.g., suicidality, disruptive behavior, eating disorders), assertion is the most appropriate tactic so that adolescents know that their therapist is committed to treating the problem. Challenge and confrontation are useful tools in treating adolescents, but typically not during the engagement phase (Liddle, 1995).

Involving parents. Having the cooperation of parents, either as active participants or in supporting roles, may be a key feature to engaging adolescents in psychotherapy (Liddle, 1995; Rubenstein, 1998; Weisz & Hawley, 2002). However, aligning with both parents and their adolescent offspring can be difficult given their conflicting opinions and values, the sometimes obnoxious nature and potential dangerousness of adolescent behavior, and the need to maintain confidential relationships. Psychotherapists attempting to engage adolescents in psychotherapy may also find it useful to avoid ascribing blame to adolescents, parents, or families, working instead with them to take responsibility for change. Last, it may be useful in working with adolescents and their families to begin by muting intense emotional issues, thereby attenuating the potential unpleasantness of therapy sessions.

Confidentiality. Involving parents while developing a trusting relationship with adolescents can raise complicated issues related to confidentiality (Morris & Nicholson, 1993). To begin, it is necessary to identify clearly who is the client. In some cases, the adolescent meets individually with the therapist and is accorded the same rights to confidentiality as adults. However, family therapy, in which the family is construed as the client, and multisystemic therapies afford a lesser degree of confidentiality simply by the nature of the therapy. Even when adolescents are accorded confidentiality in therapy, circumstances arise in which they report activity or plans that involve danger to self or others or illegal activity that presents statutory and ethical obligations for the therapist to breach confidentiality (Morris & Nicholson, 1993; Rubenstein, 1998). In these circumstances, therapists must be knowledgeable about the law and professional regulations regarding confidentiality for their jurisdiction and setting, and how confidentiality rights vary depending on the type of therapy being conducted (e.g., substance abuse treatment; Brody & Waldron, 2000; Morris & Nicholson, 1993). In any case, it is important that the therapist explicitly informs his or her clients about the limitations of confidentiality as well as his or her practices regarding privacy and confidentiality and maintains an ongoing discussion of this issue with adolescent clients.

The Developmental Literature

Contributions From Developmental Research to Engagement of Adolescents

Although developmental themes have traditionally been a central part of child therapy, only recently have researchers and therapists begun to consider adolescent development as an important aspect of psychotherapy with adolescents (Holmbeck & Updegrove, 1995; Liddle, 1995; Rubenstein, 1998; Weisz & Hawley, 2002). Second only to infancy, adolescence entails the most rapid and pervasive developmental changes involving physiological, cognitive, emotional, and social transformations (Holmbeck & Updegrove, 1995; Weisz & Hawley, 2002). Moreover, there are considerable individual differences in rates of developmental maturation among adolescents. Adolescents tend to follow one of several developmental pathways (Compas, Hinden, & Gerhardt, 1995). Some adolescents proceed along stable, adaptive trajectories or along maladaptive ones, whereas others vacillate between healthy and problematic conditions. There are a wide variety of precursors that precipitate maladaptive trends. One that has received particular note is the

pronounced physical changes occurring in adolescence that can affect an adolescent's psychological adjustment and self-concept.

The public perception of adolescents is that they are "fueled by raging hormones" that create considerable emotional lability. Although endocrine changes play an important role in physiological and neurological development (Susman, 1997; Walker, 2002), these changes are most pronounced in early adolescence, and the overall effect of hormones on the psychological adjustment of teenagers' behavior is overshadowed by socioecological factors (Buchanan, Eccles, & Becker, 1992; Weisz & Hawley, 2002). However, the timing of pubertal changes is important to understanding an adolescent's psychological adjustment. Early maturation can expose both boys and girls to greater psychological risk. Although early maturation is often a self-esteem boost for boys, it tends to challenge the self-concept of girls. Moreover, early maturation often results in greater disruptive behavior for both boys and girls because, in part, of exposure to older and antisocial peers (Weisz & Hawley, 2002). In addition, neurological transformations almost certainly have a hitherto unrecognized effect on adolescents and their psychological maturity. Recent studies (Giedd et al., 1999; Sowell, Trauner, Gamst, & Jernigan, 2002) have found significant central nervous system development and neuroplasticity throughout adolescence. This neurological growth may influence executive functioning that includes behavioral inhibition, impulse control, and emotional regulation (Spear, 2000; Walker, 2002).

In concert with the neurological changes occurring in the adolescent brain, there are a wide variety of cognitive changes that transpire throughout adolescence. Ordinarily, adolescents have acquired a substantial fund of knowledge, have increased capacities for storing and retrieving memory, and, perhaps more important for the therapy enterprise, they begin to demonstrate improvements in their capacity to process information and reason abstractly (Holmbeck et al., 2000; Holmbeck & Updegrove, 1995; Weisz & Hawley, 2002). These cognitive changes may enhance an adolescent's receptivity to psychotherapy and help create the potential for him or her to take advantage of therapies that emphasize cognition and insight (Cicchetti & Toth, 1996; Holmbeck et al., 2000). However, cognitive competencies are highly contextual and situation dependent (Gardner, Scherer, & Tester, 1989; Steinberg & Cauffman, 1996), and adolescents may manifest very different cognitive capacities in different social settings. In addition, many adolescents from the clinical population (particularly delinquent teens and substance-abusing youths; see Margolis, 1995) demonstrate indications of cognitive developmental delays that often frustrate therapists attempting to engage adolescents in therapy.

Socioemotional changes occur in unison with physiological and intrapsychic developments during adolescence. Adolescents seek more independence and autonomy than young children, and over time they negotiate a shift from dependency on parents and family to a greater emphasis on attempting to "fit-in" with peer groups (Hops, Davis, & Lewin, 1999). Adolescents' fledgling attempts at autonomy can be awkward and are often perceived as rejecting and defiant by parents and other important adults in an adolescent's life. Consequently, parents and other adults frequently feel inadequate in their communications with adolescents and are unable to manage their behavior (Holmbeck & Updegrove, 1995). At the same time, adolescents can have great difficulty in integrating needs for help and needs for autonomy (Sasson Edgette, 2001). To some extent, adolescents' internal working model of attachment may inform the manner in which adolescents pursue autonomy. Adolescents with secure attachment models may have more success in validating relationships with adults while meeting their own needs for independence. However, the population of adolescents referred for psychotherapy is more likely to have insecure attachment paradigms (Liddle & Schwartz, 2002), which can complicate efforts to engage them in psychotherapy.

Enhancing Therapeutic Engagement With Adolescents on the Basis of Developmental Knowledge

Psychotherapy interventions for adolescents are frequently patterned after adult intervention strategies (Diamond et al., 1999; Shirk & Saiz, 1992; Waldron, Brody, & Bolton Oetzel, 2001). However, the techniques and strategies in adult interventions do not necessarily translate to adolescents because of differences in manifestations of psychopathology and problem behavior, cognitive ability, awareness and value placed on con-

sequences, as well as coping strategies and abilities (Brown, Creamer, Aboitz, & Taylor, 1987; Rubenstein, 1996). Consequently, therapists treating adolescents need to begin their work by assessing a variety of developmental considerations and determining how these developmental factors may help or hinder therapeutic engagement.

Physical maturation considerations. It is often useful to understand how and when an adolescent entered puberty. Girls who acquire physical sexual characteristics early are vulnerable to developing psychological adjustment problems that sometimes fester into internalizing psychopathology, and both girls and boys with early sexual development have more contact with older and often delinquent peers. This creates more opportunity and exposure to premature sexual encounters, delinquency, and substance use, resulting in more advanced psychological problems. A longer history of problems may result in adolescents being more casual about problem behavior and less amenable to therapeutic interventions. Early substance use may also affect the adolescent's neurological maturation during a critical period of development. Knowing about an adolescent's experience of puberty may help a psychotherapist anticipate issues related to peer encouragement of problem behavior and resistance that is due to substance addiction.

Cognitive considerations. Troubled adolescents may be less cognitively and socially mature and less able to understand the rationale behind treatment and the need for it. As a consequence, they rarely refer themselves to treatment and often show much less concern about their problems than do others (Kazdin, 1996; Shirk & Saiz, 1992). Lacking motivation and understanding of treatment, adolescents frequently fail to see the purpose in psychotherapy and doubt that it will have any meaningful impact on them. These thought processes make engagement more difficult and have a negative influence on the therapeutic process (e.g., resistance) and therapeutic outcome (e.g., dropout).

Adolescents express different degrees of cognitive competence across domains and may use abstract logic and reasoning in response to academic issues, yet rely on less sophisticated cognitive processes in response to emotionally charged personal and social situations. Consequently, adolescents often lack the cognitive abilities and experience to fully appreciate the therapeutic process. Many psychotherapies require that clients have the ability to self-reflect, manipulate complex concepts mentally, bear in mind the future consequences of behavior, and consider the perspective of others, while experiencing intense emotions. This degree of abstract and causal reasoning exceeds the capacities of many adolescents and contributes to adolescents' reluctance to participate in therapy because they feel at a disadvantage in the psychotherapy setting (Margolis, 1995; Shirk & Saiz, 1992).

As a consequence, a psychotherapist attempting to engage an adolescent must be prepared to vary the levels of abstraction and cognitive sophistication with which he or she presents ideas (Weisz & Hawley, 2002). Talking too abstractly to a cognitively delayed adolescent risks having the adolescent not appreciate or understand the relevance of the therapist's perspective. Cognitively immature adolescents require the therapist to use simple inquiries devoid of abstract terms, concrete examples, and guidance in how to establish therapeutic rapport. On the other hand, talking too concretely to an adolescent who prefers higher order reasoning may result in the adolescent's feeling infantilized. Adolescents with sophisticated cognitive abilities have a greater capacity for dealing with the ambiguities of the therapy setting and are more likely to respond positively to conjecture and repartee.

There are forms of cognition that when present in adolescent clients can either deter or augment the therapy engagement process. Delinquent rationalizations are cognitions used frequently by antisocial adolescents to justify maladaptive behaviors (Samenow, 1984). These types of cognition contain irrationality or illogic that, when used by troubled adolescents, facilitates continued maladaptive behavior. These errors in thinking are an impediment to therapeutic engagement. They frustrate efforts to build and sustain an adolescent client's motivation for therapy and need to be addressed as part of the engagement process and prior to initiating attempts at behavior change. On the other hand, adolescents who evince skills at social perspective taking and future time perspective are more amenable to engagement tactics that involve self-monitoring, establishing therapeutic goals, and directly addressing the relationship between therapist and client. Adolescents who use these cognitive skills have

the potential for responding positively to inducing cognitive dissonance by challenging the inconsistencies between their goals and their thoughts and behaviors.

Attachment and social maturity considerations. Seeking help, admitting to psychological problems or discomfort, and engaging constructively in psychotherapy may conflict with an adolescent's striving for autonomy. This may be particularly difficult for adolescents who have attachment difficulties and little experience engaging constructively with adults. Developing an impression of an adolescent client's attachment style can be very useful in planning therapeutic engagement strategies. Adolescents' experience with other adults will establish a template of their expectations for how to relate to a therapist. Most adolescents in treatment will manifest some form of anxious internal working model of attachment. Some will be seeking connection and relationship as a way of coping with their apprehension. As a consequence, they will be relatively amenable to the establishment of a therapeutic rapport and pursuit by the therapist. Others cope with attachment anxiety through manipulation and "sneakiness." In these cases, pursuit by a psychotherapist will engender more manipulation that can hinder the establishment of a therapeutic rapport. A third way that adolescent clients express anxiety regarding attachment and relationships with adults is by being downright dismissive and distancing. Pursuing a more intense therapeutic engagement in these cases is likely to engender more distancing in the form of anger, scorn, and missed appointments. In these latter cases, to establish engagement, the psychotherapist will need to be present, available, and self-assertive but eschew more directive techniques (e.g., prompting, personal inquiries, confronting) that can be perceived as intrusive and domineering. Last, adolescent clients often find emotionally intense circumstances overstimulating, and they may lack effective skills at emotion regulation. Indeed, these skill deficits are often implicated in the development of conduct and substance abuse problems and precipitate the need for therapy. Consequently, to engage these adolescents effectively, it is often necessary to react to the intense emotional circumstance surrounding their entrée into therapy with a more muted and restrained response.

Socioecological Considerations

Understanding the Adolescent-Context Mismatch

Adolescent development and adjustment can also be conceptualized as a function of the match between the social environment (Eccles & Midgley, 1989) and the characteristics of the individual. Adolescents react physically and behaviorally to their environment, and their social ecology can either augment or deter their development. Social environments convey expectations, values, and preferences (Compas et al., 1995) with which adolescents may or may not feel compatible. The psychotherapy setting is a social environment that adolescents are typically unfamiliar with and one in which they often do not feel competent. For many adolescents, a mismatch occurs between their developmental capabilities and the demand characteristics of the psychotherapy setting. This mismatch offers an opportunity for the adolescent to develop new capacities, particularly if it results in a positive outcome. However, this mismatch may also overwhelm the capabilities of the adolescent and result in therapy engagement difficulties (Compas et al., 1995; Liddle, 1995; Rubenstein, 1996). Two issues, in particular, enhance the opportunity for an adolescent–therapy environment mismatch: the stigma associated with psychotherapy and the lack of choice adolescents face when entering psychotherapy.

Many adolescents are very suspicious about the psychotherapeutic enterprise, in part, because they are in a time of transition and identity consolidation that leaves them feeling vulnerable and unsure of themselves, particularly in a novel psychotherapy setting. At times they perceive psychotherapy as an effort to control them and diminish their autonomy (Hanna & Hunt, 1999). Being subject to a therapist's probes about personal thoughts and emotions can be experienced by adolescents as intrusive and threatening rather than as an effort to be supportive and caring. Often, adolescents perceive therapy as being for "crazy" or "mental" people, those who "belong in a mental hospital" or who are "living on the streets." The stigma attached to receiving therapy can be quite negative among peer groups and result in adolescents feeling scorned and ridiculed by their cohorts. As a consequence, troubled adolescents beginning psychotherapy

can be quite resistant to the efforts of the therapist, in an attempt to defend themselves and compensate for their perceived vulnerability.

Adolescents are frequently compelled or mandated to enter treatment by authority figures such as a parent, school official, probation officer, or judge (Rubenstein, 1998). This condition is especially common in delinquency and substance abuse treatment when adolescents are required to seek psychotherapy as an alternative to more restrictive forms of treatment (e.g., group homes, residential treatment centers) or detention (Margolis, 1995). In most, if not all, of these instances parents, school personnel, probation officers, and judges frequently have a greater investment in treatment and awareness of its possible positive outcomes than do adolescents (Dakof et al., 2001). Adolescents mandated to treatment are less likely to participate fully, collaborate, or engage in positive interactions, all of which have been demonstrated to be hallmarks of successful therapy (Alexander & Luborsky, 1986; Marzialli, 1984; O'Malley, Suh, & Strupp, 1983).

Enhancing Therapeutic Engagement With Adolescents by Dealing With Stigma and Choice

Coping with the stigma of psychotherapy. Directly addressing the stigma associated with psychotherapy early in treatment is often necessary to engage adolescents. Adolescent clients have a unique relationship to psychological symptoms. Frequently, adolescents fail to perceive maladaptive symptoms as problematic, yet at other times they overestimate the significance of psychological symptoms and may be ashamed of reporting them. Consequently, it is frequently useful to educate adolescent clients and their families about the wide range of normative psychological experience and experimenting behavior that adolescents engage in and, when possible, to assure adolescents that their experience is within normal limits. Adolescents, and sometimes their families, often have inaccurate impressions of psychotherapy and the therapy process, which are generally made by media and stereotype. Hence, it is often necessary, especially with substance-abusing adolescent clients in which case stereotypes are insidious, to provide them with an in-depth explanation of what occurs in therapy, how it works, and what is expected of each participant.

Providing choice. It is commonplace for adolescents in therapy not to see themselves as needing treatment (Dakof et al., 2001). They participate in therapy, at least at its onset, because others—such as the juvenile justice system, school personnel, and parents—want them to be in treatment (Melnick, DeLeon, Hawke, Jainchill, & Kressel, 1997; Sasson Edgette, 2001). This condition establishes at least two challenges to the development of an effective therapeutic rapport. When adolescents are faced with a lack of choice or perceive limits to their freedom to choose, they react, often in opposition to the therapist and his or her efforts to engage the adolescent (Hanna & Hunt, 1999; Sommers-Flanagan & Sommers-Flanagan, 1995). Second, when adolescents attend therapy because they are compelled to by external entities, intrinsic motivations are undermined. When this happens, adolescents fail to perceive the relevance of treatment and are more likely to drop out when treatment does not meet their expectations (Kazdin & Wassell, 1999). Although it is not always feasible, providing adolescents with some degree of choice about their participation in psychotherapy may optimize the potential for therapeutic engagement. Allowing adolescents to choose their therapist, or giving them treatment intervention options from which to choose, or offering them the choice of what to discuss in therapy may enhance the relevance of and motivation for psychotherapy for the adolescent client, leading to a higher level of engagement (Church, 1994; Hanna & Hunt, 1999; Liddle, 1995; Loar, 2001; Rubenstein, 1996).

A Summary of How to Better Engage Adolescents in Psychotherapy

The need for effective interventions with adolescents is critical, yet succeeding as a psychotherapist with adolescents can be challenging. However, there is a growing body of empirical and clinical knowledge about therapy and engagement strategies with adolescents that can maximize success. However, it is important to note that there are limits to what a psychotherapist can accomplish when adolescents are belligerent, threatening, defensive, and ready for a battle (Jurich, 1990; Sasson Edgette, 2001). In treating delinquent and substance-abusing teens, in particular, humility and recognition of how little control the psychotherapist has may be most

appropriate (Margolis, 1995). Moreover, it is important for psychotherapists to recognize that engagement is a process, not a one-time event, and that effective engagement continues throughout therapy and determines the intensity of the intervention (Liddle, 1995; Young et al., 1995). Still, engagement themes are concentrated in the initial sessions, and there are a variety of methods that psychotherapists can use to minimize barriers and engage with adolescents.

Although effective engagement is typically a reciprocal process between therapist and client, working with adolescents may require that the psychotherapist assume more responsibility and initiative for developing therapeutic rapport. Adopting a more traditional neutral style and waiting for adolescents to seek out rapport with the therapist generally fail because adolescents frequently do not perceive the need for therapy and do not initiate therapy contact. Engaging adolescents in psychotherapy typically requires a more proactive and directive approach. Making a good first impression by presenting a positive and hopeful attitude, emphasizing the adolescent's competence, and expressing confidence in the therapy process is vital (Rubenstein, 1996). Adolescent clients respond best to therapists who are empathetic yet forthright and assertive, who do not flaunt expertise, and who are not abrasive or confrontational. Parents and families are an invaluable resource for supporting therapeutic goals; consequently, finding a means of including and supporting parents and families can facilitate the engagement process.

Last, it is especially important to design therapeutic interventions that are developmentally appropriate and that take into account socioecological factors. An assessment of an adolescent's physical and cognitive maturation and his or her attachment style will yield information that can inform a psychotherapist on how to adjust his or her therapy tactics. Moreover, addressing the stigma many adolescents associate with psychotherapy and offering choices whenever possible may facilitate an adolescent's entrée into psychotherapy.

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