CHAPTER II: LITERATURE REVIEW

2.1 Preview

This literature review provides a comprehensive examination of the academic and clinical landscape surrounding adolescent traumatic stress and its treatment within systemic family therapy. As the mental health landscape in Malaysia, and specifically in the state of Selangor, continues to evolve, there is an urgent need to ground local practice in both global evidence and cultural specificity. This chapter begins by analysing the foundational theories, including Attachment Theory, Systemic Theory, and Cognitive-Trauma Models, that inform our understanding of how trauma affects adolescents' lives. It then establishes a Theoretical Framework that integrates the structured tasks of Attachment-Based Family Therapy (ABFT) with the philosophical nuances of the Dialogical Approach.

The final and most extensive section reviews related studies, categorised by evidence base, including systematic work, specialised trauma interventions, adolescents' experiences in therapy, and the unique cultural factors affecting Asian adolescents. By socialising these diverse perspectives, this review highlights the critical gap in qualitative, adolescent-centric research in the Malaysian context.

2.2 Theories and Models Related to the Study

The primary theoretical lens for this study is Attachment Theory, which posits that the quality of the bond between a child and their primary caregiver is the most significant predictor of emotional regulation and psychological resilience. In late childhood and adolescence, this bond shifts as adolescents seek a balance between autonomy and connection.

Liddle and Schwartz (2004) emphasise that attachment is not a static trait but a dynamic process that continues to shape developmental outcomes throughout the teenage years. When an adolescent is exposed to trauma, their internal working model of the world as a safe place is severely disrupted. If the caregiver is unable to provide a supportive environment or a secure attachment base following the trauma, the adolescent may develop insecure or disorganised attachment patterns. Scott, Diamond, and Levy (2016) argue that for suicidal or highly distressed adolescents, the core of the problem is often a relational attachment rupture, which is a specific moment or period where the parent failed to provide protection, leading the adolescent to believe they must face their trauma alone.

Complementing this is Systemic Family Theory, which views the adolescent not as an isolated individual but as a component of a larger, interconnected family system. Systemic theory suggests that psychological symptoms are interactional rather than purely intrapsychic. Carr (2016, 2018) notes that family therapy models are designed to identify and alter the cycles of communication that maintain distress. For instance, in a family dealing with trauma, a negative cycle might develop where the adolescent's irritability leads to parental withdrawal, which in turn increases the adolescent's sense of isolation and trauma-related hyperarousal. Systemic theory shifts the focus away from the index patient (the adolescent) and toward the family's systemic functioning. This is particularly relevant in the Malaysian context, where family interdependence is high, and adolescents' well-being is often seen as a reflection of the family's overall harmony and success (Hashimoto et al., 2011).

Furthermore, the study is informed by Cognitive and Developmental Psychopathology Models. These theories focus on how trauma affects the adolescent's cognitive processing and neurobiological development. Meiser-Stedman (2017) and

Perrin et al. (2003) describe how traumatic stress leads to maladaptive appraisals, such as the belief that the world is completely dangerous or that they are permanently broken. These appraisals are often accompanied by Functional Somatic Symptoms, where the trauma manifests as physical pain or illness. Cruz et al. (2014) emphasise that these somatic symptoms are signals of a dysregulated stress-regulation system. In many Malaysian families, these physical symptoms are the primary and sometimes only acceptable way for an adolescent to express psychological pain. Therefore, a theoretical model for this study must account for the somatic, cognitive, and systemic layers of the trauma experience.

2.2.1 Malaysian Cultural Resilience, Sabar, Redha, and the Family Spirit

In the multi-ethnic and rapidly urbanising context of Malaysia, the process of trauma recovery is inextricably linked to local elements of cultural resilience. Cultural values such as Sabar, representing steadfast patience, and Redha, representing contentment or acceptance of divine will, serve as powerful psychological buffers for both the adolescent and their family. However, these values have two distinct sides: while they foster internal strength and endurance, they can also suppress adolescents' voices if misapplied. For example, an adolescent may feel pressured to remain silent about their pain to maintain family harmony or to avoid the cultural influence of malu (shame).

Furthermore, the ‘semangat kekeluargaan’ (family spirit) inherent in Malaysia's collectivist culture implies that the trauma of one individual affects the entire system. Unlike Western models that prioritise individual autonomy and individuation (Liddle, 2004), resilience in Malaysia is often relational and interdependent. Healing occurs when the family unit achieves a state of mutual understanding (saling memahami)

without resorting to blame. Integrating these spiritual and cultural values with clinical frameworks such as Attachment-Based Family Therapy (ABFT) is essential to ensure the intervention is culturally adapted rather than systematically misaligned with local family values (Jo, Kim, & Yoon, 2021).

2.3 Theoretical Framework of the Study

The theoretical framework of this study is the Assimilative Integrative Model, which combines the clinical rigour of Attachment-Based Family Therapy (ABFT) with the relational ethics of the Dialogical Approach. ABFT provides the study's primary content, including the specific tasks and interventions used to address trauma. As a manualized, process-oriented model, ABFT is built around five distinct clinical tasks.

Task 1 involves the Relational Reformulation, where the therapist shifts the focus from resolving the adolescent's symptoms to repairing the family relationship.

Task 2 involves the Adolescent Alliance Building, which is a solo session where the therapist validates the adolescent's pain and prepares them to disclose attachment ruptures.

Task 3 involves the Parent Alliance Building, where parents are supported in their own grief or trauma, enabling them to become a supportive base for their child.

Task 4 involves the Attachment Task, the core enactment in which the adolescent discloses their trauma or grievances, and the parent responds with empathy and accountability (Stern, King, & Diamond, 2022).

Task 5 involves Competency Promotion, in which the family applies their new relational security to external challenges such as school or social life.

Table 1. ABFT process and outcome goals for each task (Ewing et al., 2015)

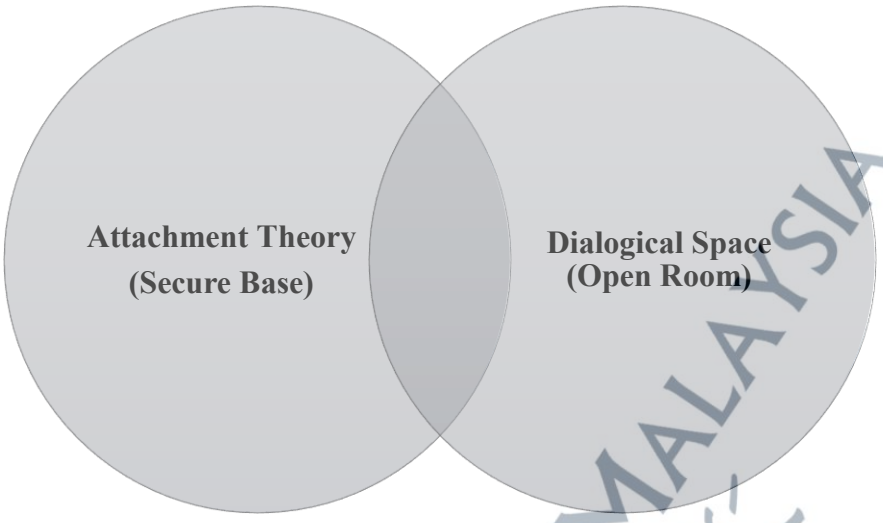
Task	Typical Duration	Process Goal	Outcome Goal
Relational Reframe	One session	Attributional shift in how family members view the problem and solution	Agreement to participate in relational-focused therapy
Adolescent Alliance	Two to four sessions	Better understanding of attachment narrative (i.e. thoughts, feelings, memories)	Revived valuing of attachment and willingness to renegotiate it
Parent Alliance	Two to four sessions	Shift in the parent's working model of the adolescent and their parenting role.	Revived caregiving motivation and acquisition of emotion coaching parenting skills
Repairing Attachment	One to three sessions	Engagement in conversations that work through attachment ruptures	Revised view of self and other and renewed interpersonal trust
Promoting Autonomy	Four to eight sessions	Parents effectively help adolescents resolve non-family-based problems (i.e. school, job, depression)	Resumed negotiation of more normative issues related to adolescent development

While ABFT provides the structure, the Dialogical Approach provides the operational process. This approach, popularised by Seikkula (2008) and applied to adolescents by Errington (2015), emphasises the creation of a dialogical space. This space is characterised by polyphony, meaning the presence of multiple, unmerged voices and perspectives. In this framework, the therapist is not an expert who provides a rigid plan but a participant-observer who facilitates a conversation in which the adolescent's voice is as powerful as the adult's. Errington (2015) argues that for adolescents, authenticity is the most important therapeutic condition. If the therapy feels like a performance or a technical exercise, the adolescent will disengage. By integrating ABFT's focus on attachment repair with the Dialogical Approach's emphasis on authentic presence, this study creates a framework that sensitively explores the experiences of 10 adolescents as they navigate the often intimidating environment of a family therapy room.

2.3.1 The Intersection of Attachment and Dialogical Space

The conceptual framework of this study is built upon the intersection of the structural dimensions of Attachment Theory and the process-oriented dimensions of Dialogical Space. Attachment Theory provides a secure base, in which the goal of therapy is to repair trust and security between the adolescent and the parent (Stern, King, & Diamond, 2022). Conversely, the Dialogical Space (Errington, 2015) provides an open space where authenticity and a polyphony of voices can exist without the threat of judgment or diagnostic labelling.

Figure 3. The Intersection of Attachment and Dialogical Space



This framework illustrates that attachment repair can occur only when there is a safe space for dialogue. By combining the Clinical Tasks of ABFT with the Philosophical Stance of a dialogical therapist, the study explores how the ten participants move from relational rupture to collaborative healing.

2.4 Review of the Related Study

2.4.1 The Global Evidence Base for Systemic Interventions

To understand adolescents' experiences in therapy, we must first examine the robust evidence base for the interventions they receive. Alan Carr's (2016, 2018) reviews provide a comprehensive synthesis of over two decades of research, showing that systemic interventions are either as effective as, or superior to, individual treatments for a wide range of adolescent problems. For example, Carr (2016) highlights that models such as Functional Family Therapy (FFT) and Multisystemic Therapy (MST) have a strong evidence base for reducing conduct problems and substance abuse by focusing on the environmental context of adolescents' lives.

Furthermore, for internalising problems like depression, which often co-occurs with traumatic stress, Aswegen et al. (2023) conducted a meta-analysis showing that family-based therapy significantly outperforms treatment as usual. The mechanism of change in these studies is often cited as reductions in parental criticism and increases in emotional attunement. For an adolescent in Malaysia, where academic and social pressures are high, the family's ability to shift from a critical stance to a supportive one is a key determinant of recovery. These studies provide the clinical justification for why the ten participants in this research were referred to family therapy in the first place.

2.4.2 Specialised Interventions for Trauma and PTSD

The literature on trauma has moved toward trauma-informed systemic care. Meiser-Stedman's (2017, 2025) recent trials on Cognitive Therapy for PTSD emphasise the need for early intervention. However, his work also suggests that for adolescents exposed to multiple traumatic stressors, a pragmatic and flexible approach is required. This is where the integration of EMDR (Eye Movement Desensitisation and Reprocessing) into family therapy becomes significant. Field and Cottrell (2011) and Dellorco et al. (2024) explore how EMDR can be integrated into family-based models such as ABFT.

In these integrative models, the adolescent processes the neurological aspects of the trauma, which include the intrusive images and body sensations, using EMDR, while the family therapy sessions address the relational impact of that trauma. This is a critical development for the Malaysian context, where trauma is often a shared family event such as a car accident, domestic violence, a house fire, or a family loss. If only the adolescent is treated, the family system may continue to trigger the trauma through avoidance or lack of understanding. The work of Rowe and Liddle (2008) following

Hurricane Katrina demonstrated that multi-dimensional family therapy is essential for adolescents who are dealing with both trauma and the family disorganisation that follows a crisis.

2.4.3 The Adolescent Voice, Challenges of Engagement and Participation

Despite the highly regarded status of many family therapies, a significant portion of the literature reveals a difference between clinical success and adolescent satisfaction. Vossler (2006) conducted a landmark study on the experiences of 17 young people in family counselling in Germany. His findings were clear: many adolescents felt like passive participants in therapy rather than active members. They reported feeling excluded from the decision-making process and felt that the therapist and parents often spoke about them rather than with them.

This sense of being treated as the problem individual is also explored by Conti et al. (2017) in their study regarding external roadmaps. They found that while parents often felt relieved by the structure of family-based therapy for anorexia, the adolescents felt invaded and pathologised. This highlights a major theme in the literature: the power dynamics within the therapy room. If the adolescent perceives the therapist as a parental ally who is there to enforce rules, the dialogical space (Errington, 2015) fails.

Collyer, Eisler, and Woolgar (2020) further analysed why families drop out of therapy, finding that adolescent engagement is the single most important factor for retention. For the ten adolescents in this research, their willingness to stay in therapy depends on whether they feel their perspective has a place in the conversation.

2.4.4 Cultural Nuances, Parenting, Self-Image, and the Asian Context

The final cluster of research addresses the study's cultural landscape. Hashimoto et al. (2011) provide a vital bridge to the Malaysian experience through their study of 731 Japanese adolescents. They found that an adolescent's image of their parents, specifically whether they perceive their parents as caring or controlling, directly predicts their level of anxiety and depression. In many Asian cultures, including Malaysia, control is often equated with care. However, for a traumatised adolescent, high levels of parental control without high levels of attunement can be perceived as invalidating.

The work of Jo, Kim, and Yoon (2021) on Korean counselling systems and Chan (2011) on Hong Kong adolescents highlights that Asian adolescents often use metaphors to describe family pain because direct verbal expression of anger toward parents is culturally discouraged. Chan (2011) found that adolescents viewed their families as highly unstable or conflict-prone, representing suppressed emotional heat. Similarly, Kalibatseva et al. (2024) in their longitudinal study of Asian American adolescents found that while parental closeness is a protector against depression, parental control can sometimes act as a barrier to seeking counselling. These studies suggest that for the adolescents in Malaysia, the experience of family therapy is not just about resolving trauma, but about navigating the delicate balance of Filial Piety, which involves respecting their parents while also finding a way to voice the pain that those same parents may have inadvertently caused.

2.4.5 Attachment Ruptures and the Mechanism of Change

A significant portion of the literature focuses on the specific mechanism of repair within the family system. Stern, King, and Diamond (2022) utilised a detailed task analysis to deconstruct the attachment task within Attachment-Based Family Therapy

(ABFT). Their research identified three distinct phases in the successful repair of a relational rupture: the adolescent's disclosure of the rupture, the parent's empathetic response, and a subsequent mutual conversation that stabilises the new connection. For the ten adolescents, this research is crucial because it suggests that healing is not found in a single session, but in the successful navigation of these specific emotional stages. If a therapist fails to facilitate the parent's disclosure or empathy, the adolescent may leave the session feeling more isolated than before.

Tsvieli et al. (2019) further explored this by examining productive emotional processing. Their study of 30 depressed and suicidal adolescents found that when therapists focused on primary adaptive emotions, such as the underlying sadness or fear beneath an adolescent's anger, the therapy was more likely to succeed. Conversely, focusing solely on rejecting anger, which is the outward behaviour often seen in traumatised adolescents, led to the discontinuation of emotional processing. This is a vital insight for the current study in Malaysia because it suggests that the adolescents' experience of being understood depends on the therapist's ability to look past their defensive behaviours and reach the primary source of their traumatic stress.

The Tension Between Manualization and Authenticity

A primary critique in the literature concerns the conflict between highly structured, manualized treatments and adolescents' need for an authentic therapeutic relationship. Evidence-based models such as Functional Family Therapy (FFT) and Attachment-Based Family Therapy (ABFT) are praised for their clinical rigour and reproducible outcomes (Carr, 2018, 2019). However, qualitative data from adolescents suggest that the very structure that provides safety for the therapist can feel like a rigid plan belonging to someone else (Conti et al., 2017). For this research, this critique is

vital. In a culture where rigid protocols and hierarchical deference often govern social interactions, a therapy that feels like another set of instructions from an adult may fail to foster a genuine connection. If the therapist follows the manual at the expense of the dialogical space, the adolescent may perform the required tasks without undergoing a genuine emotional shift (Errington, 2015).

2.4.6 Specialised Techniques, EMDR, Art Therapy, and Therapeutic Tools

The literature also highlights a shift toward multimodal, systemic work, in which other therapeutic tools supplement verbal dialogue. Field and Cottrell (2011) and Dellorco et al. (2024) discuss the assimilation of Eye Movement Desensitisation and Reprocessing (EMDR) into family therapy. This integration allows the adolescent to process unresolved traumatic memories neurobiologically while the family session provides the relational safety to discuss those memories. For adolescents in Malaysia who may find it culturally difficult to voice their trauma, EMDR offers a way to reduce the somatic distress described by Cruz et al. (2014) without requiring immediate, high-level verbal disclosure.

In addition to EMDR, Family Art Therapy is effective in revealing hidden dysfunctions that adolescents cannot put into words. Nielsen et al. (2021) demonstrate that through non-verbal visual communication, adolescents can express their sense of isolation or their perception of a parent's illness. This is particularly relevant for the current study's age group (13-16), as adolescents often feel unable to progress past their trauma. By creating art together, the family can achieve a level of attunement that verbal therapy sometimes misses. Similarly, Lo and Ma (2022) explore the use of nature and photo-elicitation in Hong Kong, finding that open, quiet outdoor settings can help Asian

adolescents feel more comfortable sharing their inner worlds. In the Malaysian context, these innovative therapy spaces represent a new way to engage adolescents.

The use of Therapeutic Tools, as detailed by Cruz et al. (2014), provides another layer of support. These sheets help externalise the trauma, framing the adolescent's symptoms like headaches or anxiety as a natural activation of the body's stress system rather than a personal failing. This reduction in parental reactivity is essential in families, where parents may initially feel blamed for their child's trauma. By providing a stress-system framework, the therapist reduces the shame associated with traumatic stress, allowing the adolescent to experience therapy as a collaborative investigation rather than a disciplinary process.

The Neglect of Somatic and Non-Verbal Narratives

A significant gap identified in the literature is the heavy reliance on verbal disclosure as the primary marker of healing. Many models, such as ABFT Task 4, require the adolescent to verbally express their grievances to their parents (Scott, Diamond, & Levy, 2016). However, the work of Cruz et al. (2014) on functional somatic symptoms reminds us that trauma often resides in the body, manifesting as headaches, stomach pains, or fatigue. For many Malaysian adolescents, these physical symptoms are the primary expression of trauma. The critical analysis of current literature suggests that purely talk-based systemic models may be inadequate for adolescents who manifest stress physically. This justifies the inclusion of more innovative, non-verbal interventions such as Family Art Therapy (Nielsen et al., 2021) or nature-based photo-elicitation (Lo & Ma, 2022), which allow the adolescent to bypass the pressure of verbal confession and communicate their experience through alternative mediums.

2.4.7 Global vs Local, The Cultural Context of Southeast Asian Adolescents

The review must account for the unique socio-cultural environment of Malaysia. Jo, Kim, and Yoon (2021) provide a detailed look at Asian counselling systems, noting that unique stressors such as extreme academic competition and the pressure to maintain public respect define the adolescent experience. In Malaysia, the value of Filial Piety creates a specific loyalty conflict for a traumatised adolescent. If a family member caused the trauma or if the parents are perceived as controlling rather than caring (Hashimoto et al., 2011), the adolescent may feel that speaking up in therapy is an act of betrayal.

Kalibatseva et al. (2024) found that for Asian American adolescents, who share many cultural roots with Malaysian adolescents, parental closeness is a protective factor against depression, but high control often prevents them from using counselling services effectively. This suggests that the ten participants in this research may enter the therapy room with a significant amount of anxiety related to cultural expectations before therapy begins. Chan (2011) used metaphors to show that Hong Kong adolescents often view their families as financial burdens or highly unstable environments, reflecting a sense of debt or emotional suppression. The current study will investigate whether Malaysian adolescents use similar symbolic language to describe their family therapy experience, providing a culturally grounded understanding of trauma recovery.

Cultural Applicability of Attachment and Autonomy

A critical review of the literature reveals a Western bias in the conceptualisation of healthy adolescent development. In the Western models of Liddle (2004) and Diamond (2016), there is a strong emphasis on individuation and autonomy. However, in the Malaysian context, the adolescent's development is deeply intertwined with the

family's collective identity. Hashimoto et al. (2011) and Jo, Kim, and Yoon (2021) point out that Asian adolescents may value harmony and interdependence more than individualistic autonomy. Therefore, when a Western-derived therapy encourages an adolescent to confront their parent about a trauma, it may trigger a sense of cultural shame or a violation of filial piety. The critique here is that attachment repair in an Asian context may look very different, perhaps manifesting as a quiet return to togetherness rather than a dramatic verbal enactment. This study's qualitative exploration is essential to determine how these ten adolescents balance their need for trauma resolution with their cultural identity.

2.4.8 Barriers to Retention and the Index Patient Trap

Finally, the literature review examines why therapy fails. Collyer, Eisler, and Woolgar (2020) conducted qualitative interviews with families who dropped out of Functional Family Therapy (FFT). They found that adolescent engagement was the primary predictor of retention. Adolescents dropped out when they felt the therapist was not on their side or when the parents entirely dictated the problem definition in the room. This is what Vossler (2006) describes as the marginalised index patient position, a situation where the adolescent is the reason for the therapy but has the least power in the room.

Conti et al. (2017) describe this experience as being given an imposed plan. For the ten adolescents in this research, the risk is that therapy becomes another chore or requirement imposed by the adult world. Sheridan, Peterson, and Rosen (2010) found that parents often feel confused and angry when they first enter therapy. If the therapist focuses too much on calming the parents, the adolescent's trauma narrative can be lost. This study seeks to understand whether adolescents felt they were owners of their

therapeutic process or merely passive participants in a process directed by their parents and the clinician.

The Index Patient Trap in Systemic Models

Despite the systemic label, much of the research still implicitly treats the adolescent as the problem to be fixed. Vossler (2006) identifies this as the therapeutic marginalisation position. In his analysis of German adolescents, he found that even when families were present, the conversation often centred on the adolescent's symptoms, such as their school refusal or conduct issues, rather than the systemic failures that contributed to those symptoms. For an adolescent with traumatic stress, this focus can be re-traumatising. If the therapy room becomes a place where the adolescent's failures are discussed in front of their parents, the relational reformulation promised by models like ABFT (Stern, King, & Diamond, 2022) cannot occur. The literature suggests that for a systemic model to be truly effective, it must move beyond viewing the adolescent as the carrier of symptoms and instead address the unmet attachment needs of the entire system (Tsvieli et al., 2019).

2.5 Chapter Conclusion

The synthesis of the previous research presented in this chapter reveals a complex and often contradictory landscape for the traumatised adolescent. On one hand, there is overwhelming quantitative evidence that systemic family therapies like ABFT, FFT, and MDFT are effective in reducing symptoms of PTSD, depression, and suicidality (Carr, 2018; Aswegen et al., 2023; Scott et al., 2016). These models provide a robust clinical framework for repairing attachment and improving attunement. On the other hand, the qualitative literature (Vossler, 2006; Conti et al., 2017; Collyer et al.,

2020) highlights a persistent gap where adolescents feel silenced, misunderstood, or excluded from their own healing process.

Specifically, in the Malaysian context, this review has identified a critical lack of research. We understand attachment theories and systemic intervention models, but we lack direct perspectives from Malaysian adolescents. We do not yet know how the cultural pressures of the Klang Valley, the values of filial piety, and the specific nature of local traumas influence the experience of the therapy room. The literature suggests that for therapy to be successful, it must create a safe dialogical space (Errington, 2015) that respects the adolescent's authenticity. This study is designed to bridge this gap by exploring the experiences of ten adolescents in Selangor, ensuring that their narratives move from a marginalised position to the centre of clinical knowledge. The following chapter will detail the qualitative methodology used to capture these voices and honour their journeys.

The critical analysis reveals three distinct gaps that this study aims to fill. First, there is a Geographic Gap: most systemic trauma research is situated in North America, Europe, or East Asia (Japan, Korea, Hong Kong), with almost no qualitative data representing the multi-ethnic, rapidly urbanising context of Malaysia. Second, there is a Methodological Gap, which means that while we have meta-analyses proving that family therapy works (Carr, 2018; Aswegen et al., 2023), we lack phenomenological studies that explain how it feels for the adolescents, especially when their experience contradicts the clinical plan (Conti et al., 2017). Third, there is a Process Gap, meaning we need to understand the role of authenticity and dialogical space (Errington, 2015) as mediators of change in a culture where direct communication about trauma is often suppressed.

Ultimately, this literature review confirms that we cannot fully understand the effectiveness of therapy without listening to the experience of those it serves. For the ten adolescents in this research, the therapy room is not just a place for symptom reduction; it is a site where they must navigate their trauma, their family loyalties, and their cultural identity. This study is now positioned to provide that missing narrative.