A Multidimensional Model for Treating the Adolescent Who Is Abusing Alcohol and Other Drugs

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Introduction and Overview

In the early eighties, the empirical establishment of a successful family therapy approach to the treatment of heroin abuse by young adults (Stanton and Todd, 1982) heightened interest in family-centered approaches to treatment of adolescents. In 1983, the National Institute on Drug Abuse (NIDA) initiated research to explore construction of relatively short-term, outpatient family therapy models to treat this population. This paper presents aspects of a model developed within the Adolescents and Families Project, a part of that NIDA research initiative (Liddle, et al., 1991).

The model, Multidimensional Family Therapy (MDFT), was developed within a research project and was built on a tradition of valuing research-based knowledge and applying it to clinical work. The model is informed by research findings about adolescent development and the course of adolescent drug use. MDFT also reflects an underlying belief in the complexity of human problems and emphasizes the importance of the multiple systems and subsystems in the adolescent's life. The conceptual background of MDFT, including key assumptions and research findings that underpin the model, are presented, and the Adolescents and Families Project is briefly described here. The MDFT model is explained and is distinguished from other approaches to treatment of this population.

Conceptual Framework: Key Assumptions and Relevant Research Findings

The Multidimensional Family Therapy model rests on several key assumptions about human existence and functioning:

1. There are numerous domains of human existence, which include the affective, behavioral, temporal, moral/ethical, spiritual, and interpersonal.

2. These domains of human existence are interconnected and overlapping.

3. Human problems are accessed through these interconnected and overlapping domains of functioning, and solutions can be generated by work in any one or all of them.

4. Therapists are handicapped if they conceive of the primacy of one domain over another, or intervene into only one domain.

In addition to these assumptions, the MDFT model is informed by major research findings on adolescence as a developmental stage and on the problem of drug abuse in this age group. Several specific findings have been particularly useful in building the model and will be presented briefly here.

The first set of relevant findings concern adolescence as a developmental stage. While traditional research contends that the central

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task of adolescence is separation from the family (Blos, 1979), contemporary adolescent and family research challenges this view. Also, the literature has increasingly suggested that positive family relations play a central role in the adolescent's ability to negotiate this important, sometimes difficult, developmental phase (Bell & Bell, 1982; Jurkovic & Ulric, 1985; Cooper & Grotevant, 1986; Hauser, et al., 1984; Hauser, et al., 1985). Cooper, Grotevant, and Condon (1983) have suggested that the major developmental tasks of adolescence are struggled with in the family context. And Steinberg & Silverberg (1986) report that emotional distance from parents results in heightened vulnerability to antisocial peer influences. Additionally, recent work has highlighted the importance of parenting style (Coombs & Landsverk, 1988) and parents' influence on adolescent behavior (Baumrind, 1987; Maccoby & Martin, 1983). In sum, it seems clear that adolescent development and problems are very much a family affair, a finding that guides the targeting and nature of the interventions in the MDFT model.

The development of MDFT has also been guided by the findings of researchers in the field of adolescent drug abuse. While many treatment professionals hold that drug abuse is necessarily *primary* and accounts for the other difficulties these young people experience, Kandel (1978) has warned about the major difficulties in identifying and differentiating between antecedents, concomitants, and consequences of adolescent drug abuse. Others have identified a "network of influences on adolescent drug involvement" (Brook, Nomura, & Cohen, in press) and a network of correlated deviant behaviors (Jessor & Jessor, 1977; Dishion & Loeber, 1985; Elliot, Huizinga, & Ageton, 1985; Newcomb & Bentler, 1988a, 1988b, 1988c). Still others have found multiple causal factors related to initiation and maintenance of drug use (Newcomb, Maddahian, & Bentler, 1986; Pandina & Scheule, 1983).

These and other related findings underpin the MDFT conceptualization of adolescent alcohol and other drug abuse (AODA) as one problem within a complex of many problems that are interrelated in ways that are not yet well understood. This conceptualization differs from the addiction or disease model of adolescent AODA and leads to different emphases in the therapy. This will be discussed further later.

Thus, poor relationship skills, learning and behavior difficulties in school, poor self-esteem, family disorganization or dysfunction, and movement in a trajectory of failure that places them outside the mainstream of their peer culture are typical patterns in these youngsters. The MDFT model addresses this myriad of issues through interventions in each of the multiple dimensions of the adolescent's existence. Within this conceptual framework, the MDFT model was designed and implemented in the Adolescents and Families Project.

The Adolescents and Families Project

Started in 1985 at the University of California in San Francisco and moved to Temple University in April of 1990, the six-year Adolescents and Families Project is nearly complete, with all treatments and most 6-month and 1-year followups done. Adolescents in the study were assigned to three treatment groups consisting of 40-42 randomly assigned cases each — the Multidimensional Family Therapy model, a group therapy (for the adolescent alone) model, and a multifamily treatment model. A nonclinical sample from the normal population served as a comparison group.

A presenting problem of drug abuse was a requirement for admission to the study, but these adolescents, ranging in age from 13 to 18, invariably had multiple problems. They evidenced deficits in school performance and behavior, interpersonal relationships, job skills, etc. More than 50 percent were probation-

referred and were not in mainstream schools or had dropped out entirely. Their families were involved with multiple social systems.

The family therapists in the project were trained in MDFT and were live-supervised throughout the research project. All treatments were 16 sessions and took place over 5 or 6 months. None of the adolescents were involved in 12-step or other self-help programs, so that outcomes would not be effected by interventions other than those in the treatment under study.

Several individual and family subsystems believed to be of importance were assessed pretreatment, posttreatment, at 6 months, and at 1 year. These included each individual in the family, the parental unit, the sibling subsystem, and the marital relationship. The assessments consisted of standardized instruments that measured change in individuals, dyads, and the whole family. Self-report, biochemical (urinalysis), and observer ratings (videotaped family interaction) were all used, reflecting the multimodal assessment philosophy.

Treatment outcome data are still being collected and analyzed as a few families have yet to complete the 1-year period following treatment. In developing outcome measures, simply looking at the level of adolescent drug use at specified intervals was considered inadequate. Just as MDFT conceives problems as being complex and multidimensional, it also conceives outcomes in this way as well. As the remaining families complete the 1-year posttreatment period and more data are analyzed, the findings will be incorporated, and the model will continue to evolve.

Distinguishing Characteristics of Multidimensional Family Therapy

The Multidimensional Family Therapy model exists in the structural-strategic family therapy tradition but incorporates additional notions about the targets, mechanisms, and methods of change. While the traditional structural-strategic approach stresses a continued focus on the presenting problem of alcohol and other drug abuse, MDFT by design addresses a wider array of behaviors. This development was driven by the perceived need to build a specialized, clearly defined treatment model to address the particular complex of problems presented by drug-abusing adolescents as demonstrated in the research in this area.

MDFT emphasizes individuals and subsystems as opposed to focusing on the family as a whole more than many other contemporary family therapy approaches. The model rejects family reductionism whereby the family is credited or blamed for the health or pathology of its members. The family is important, but individualistic developmental aspects of the adolescent's existence are also considered important (Liddle, Schmidt, & Ettinger, in press).

In this model, the therapist views the adolescent's involvement as important to the therapy and advocates active engagement of the youth in the treatment. While some family therapy models presume that work with the parents is the route to change in the adolescent, and the youngster's personal involvement is less important, the MDFT model advocates helping the teenager to see the therapy as a place in which his or her own needs can be met. Indeed, MDFT recognizes, values, and cultivates distinct therapeutic alliances between the therapist and the adolescent, and between the therapist and the parents. Using developmental norms, another distinct and essential alliance is cultivated between the adolescent and the parents.

Multidimensional Family Therapy: The Work

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problems and conceives all problems as being multidimensional, many avenues for intervention are presented. As in any therapeutic approach, the first task is to frame the problem as solvable and enlist the participation of key actors in the solution efforts.

As stated above, MDFT does not subcribe to the conceptualization of adolescent drug abuse as a disease or an addiction. The research evidence to date simply does not support this notion, and the notion is fraught with problematic implications of a lifelong battle. The disease model has been applied to adolescents because alternatives that fit the developmental stage of adolescence have heretofore been absent. This observation does not imply that there is no such entity as "addiction" or a "disease process"; it simply says that the traditional addiction model does not fit adolescents very well and is not clinically useful.

While we do not frame adolescent abuse of alcohol and other drugs as a disease, neither do we advocate telling an adolescent that he or she does *not* have such a problem. By all means, if the family has been exposed to the disease notion and accepts it, we suggest the therapist take a pragmatic, solution-oriented approach. He or she can support the observation that many problems have been associated with the youngster's abuse and that continued abuse and further problems are likely without major change. The therapist should never be argumentative or negative about the family's disease conception of the problem as it is consistent with the goals of the therapy. We simply do not see it as a generally useful conceptualization of the problem and do not introduce the idea into the therapy.

The Early Work

The early work of the therapy is to establish an alliance with both the youngster and the parents. These are distinct relationships, with their own courses, expectations, and contracts for what therapy can and will be. Success with one in no way guarantees success with the other. The alliance between therapist and parent, for instance, does not necessarily predict an equal working relationship between therapist and teenager. An effective therapist-parent relationship may, in fact, lead to difficulties in the therapist-teenager alliance. (We are currently exploring the relationship of various alliances in family therapy to outcome and attempting to define in more detail what we mean by multiple therapeutic alliances.)

At the outset, the teenager is helped to feel that therapy can address his or her own concerns. The adolescent is helped to formulate personal thoughts and feelings about his or her life and family, and over time is helped to express some of this to the parents. In the beginning phase of MDFT, the therapist assists the teenager to articulate an agenda different from that of his parents (Liddle, 1991).

At the same time, he or she sees the parents alone and helps them to define their parental belief system and preferred parental style(s), paying close attention to the developmental aspects of their ideas. We look for opportunities to insert developmental content into these discussions. Findings that indicate how adolescent identity development is fostered through a continued familial interdependence rather than emotional separation (Grotevant & Cooper, 1983) and the influence of different parenting styles on adolescent personality are interwoven in our clinical work. For example, a parent might be told, "Your son *does* need you to talk to him about his concerns and worries. You can be the best medicine in the world for him." Interdependence and the necessity of both parents and adolescents negotiating the youngster's transition to adulthood (Steinberg, 1991) become content themes and goals of the therapy.

Parental belief systems (Goodnow, 1987, 1988; Sigel, 1985) and parenting styles (Baumrind & Moselle, 1985; Steinberg, 1990) become important topics of discussion with parents as we help them articulate and reassess their own parenting philosophies and styles. These themes are useful in helping parents cooperate with one another and build the parental coalition long considered by family therapists to be important (Minuchin, 1974).

Parents and teenagers are seen both together and alone at all stages of this therapy. We assume change can occur at individual, dyadic, multiperson, or familial levels, and can be promoted in myriad ways. Care must be taken not to expect too much of the parent or teenager at the early stages of relationship repair. Change is thought of as being phased in a bit at a time. Seeing the teenager and the parents individually and working in a number of domains of functioning (i.e., working in the behavioral and cognitive domains as well as in the affective and interpersonal) assist the therapist to manage the pace of change in the proximity of the parent(s)-child relationship.

In a sequence in which a parent is helped to respond more adequately to his or her teenager, after being hurt and angered by the adolescent's behavior, several methods are likely to be used. Reformulating cognitive attributions, behavioral rehearsals, and working for increased acceptance of each other through emotional expression and clarification, for example, are seen as complementary techniques.

The Ongoing Work

The MDFT therapist intervenes not just in the family but in the multiple systems and subsystems in the adolescent's life. Some of these systems overlap and affect each other. The school, the juvenile justice system, and the teenager's peer group are primary foci of assessment and intervention. The therapist assists the family to contact school officials, including teachers, school counselors, and administrators. They should be cultivated as friends of the family, all of whom care about and are working in the best interest of the adolescent. Probation officers are called in regularly to bolster treatment by providing information and input into the teenager's formulations about his or her life. Peers are included in sessions as potential sources of strength, identity formation, and support.

To accomplish intervention in these various systems, the therapist must be active, persistent, and upbeat about the possibilities for change. The therapist may assume a convening or networking stance, a position with a long history in family therapy. In some cases, the therapist can work preventatively, being sure that all concerned extra-familial agents are working in a manner consistent with the therapeutic goals.

Another aspect of the work is the exploration of many and varied themes during the course of treatment. The multiple content realms in which personal and relationship problems reside are vitally important to understand and use. Clinicians can, in their quest for certainty and self-efficacy, delude themselves into believing they know the precise locale of a problem. Alcohol and other drug abuse, conduct disorders, and developmental problems all point the way toward precise definitions, but also potentially limit the therapist's conceptualization.

There are occasions when the therapist must focus more specifically and almost exclusively on the drug abuse, however. When the drug use is very advanced, the youngster may need much direction and support especially around this issue. Still, emphasis is given to the intrapersonal and interpersonal contexts of the teenager's drug use. We tell adolescents that their use of drugs makes them ineffective at expressing their legitimate concerns and complaints. Our stance is that teenagers do

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have some valid reasons for their behavior and unhappiness, and that these problem behaviors are related to their inability to explain competently their thoughts and feelings (that is, identity struggles, past hurts) to the adult world (parents, teachers, etc.). The therapist works with the adolescent to convince him or her that therapy can be a forum in which such communication ability improves.

Core themes might remain constant (e.g., parental competence and developing a new relationship with their teenager), but the content that comprises these themes changes over time in treatment. The content is frequently related to generic issues of family life that are manifested in the family's idiosyncratic "big questions" (Liddle, 1985). These are core issues for each family presented by the family members' beliefs about what families are and what each member expects from his or her intimates. Family members are helped, for instance, to clarify for themselves *their* definition of "family." What does it mean to be a parent, a father or a mother, in this family? What does the adolescent think about his or her role in the family?

Additionally, the MDFT model incorporates the temporal realm by dealing with past hurts and trauma in the lives of teenagers and families. Sometimes ignoring this content keeps the therapist stuck in an ineffective, present-centered problem-solving quest.

Finally, the question arises as to whether there are instances in which the teenager must be hospitalized for the treatment of alcohol or other drug abuse. MDFT is an outpatient approach, and we have the same reservations about hospitalization that are standard concerns of family therapists. Families are separated; the inpatient and outpatient care are often inconsistent with one another; and parents are not adequately involved and are not treated with respect. Still, there are times when an adolescent is in danger of overdose or refuses or fails to abstain or cut down enough to comprehend and participate in the therapy. In these cases, a short hospitalization may help to establish a drug-free state. The nonphysician therapist can be limited in his or her impact on the inpatient treatment and the way the family is included (or not), but he or she works to support the family and pave the way for the outpatient work to be done after discharge.

Termination in Multidimensional Family Therapy

In the Adolescents and Families Project, the number of sessions (16) was controlled for research purposes. Thus, the preparation for the termination had to take place at a specified time. In nonresearch settings, however, the duration of the therapy, while intended to be relatively short, would vary somewhat depending on several factors. The most important factor would be problem severity, which is often related to the duration and frequency of drug use and the nature of the drugs used.

In any case, change is expected on many fronts. Just as problems are conceived as arising within multiple, interrelated domains, so is change seen as being reflected in multiple domains. Does the adolescent demonstrate improved judgment? Improved relationships? Has his drug use stopped or been greatly diminished? Is he or she able to problem-solve and avoid escalation of troublesome encounters with others? Has the family process of handling difficult situations changed in a way that increases the likelihood of problem resolution? The therapist looks for multiple confirmations that there has been significant change in fundamental aspects of functioning. At termination, the therapist helps the family assess and summarize its progress and change. The applicability of its new attitudes and skills to a variety of situations is emphasized.

This work, like the interventions of therapy, is accomplished in multiple domains. Working in the cognitive realm, the therapist may help

the family members to articulate the ways in which their beliefs about each other have changed (as well as some that have stayed the same). The parents typically alter their negative stereotype of the teenager's behavior and attribute his or her actions to more normal processes, rather than to "teenager acting-out" or "psychopathology." In the affective realm, the therapist might have the family members reminisce about a particularly difficult crisis point in the therapy, one in which they persevered and negotiated through to a solution together. In the behavioral domain, the therapist might review the problem-solving strategies that have been learned during therapy, as well as discuss some of the key events on which they were used. The focus at termination is on sealing the changes that have occurred in these various domains and helping all of the family members to see that each has contributed significantly to the treatment's outcome. Just as the outset of therapy emphasizes both individual and collective (that is, subsystem: marital/parental, adolescent) responsibility, termination also stresses responsibility and credit-taking in these same ways.

Sometimes, the adolescent and family present the therapist with dramatic evidence of change that can serve as an appropriate focus for the summary and termination. This was the case with Linda, a 16-year-old girl in the study, who originally presented with multiple behavioral problems, including heavy drug use and two suicide attempts. Linda's mother wanted her to terminate her relationship with a boyfriend who was using and dealing drugs. Linda eventually decided to terminate the relationship, stressing that she would do so "in my own time and my own way." She described to the therapist how she had explained this to her mother. Linda said her mother had supported her, even as she had admitted her own fears and discomfort with the situation. Her mother had shared a story of her own teenage experience in breaking off with a boyfriend and they had talked long into the night. The girl was touched and pleased with this kind of interaction, which was dramatically different from their pattern on entry into treatment. The mother independently reported the same episode and expressed her own pleasure and satisfaction. Thus, this family presented the therapist with a powerful focal point for summary and termination.

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Summary

Multidimensional Family Therapy is a specialized approach to treating adolescent drug abusers that focuses on the many interrelated domains of human functioning, including cognitive, affective, behavioral, temporal, moral/ethical, spiritual, and interpersonal. The model was developed within a research project and was shaped by research findings regarding adolescent development and adolescent drug abuse. It addresses the many systems and subsystems that are important in the life of the adolescent and values the full engagement and participation of the adolescent himself or herself in the therapy.

MDFT is a model that accepts and uses the complexity of human existence and experience. It aspires to make multidimensional change possible, and helps teenagers and their families to work together in the various realms to achieve these changes. Because families of teenagers in trouble have often been having problems for some time, powerful comprehensive models are needed to address their problems. The systems models of tomorrow will need to be empirically based and sufficiently broad in conception and scope. The families who come for help need and deserve no less than this.

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