

Multidimensional Family Therapy

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A. Name: Multidimensional Family Therapy

B. Synonym: MDFT

C. Introduction

Multidimensional Family Therapy (MDFT) is an evidence-based treatment for a range of adolescent problems, including co-occurring substance abuse and delinquency (Liddle, 2015). A family-centered treatment, MDFT is integrative and comprehensive. It is offered in diverse settings (substance abuse, mental health, juvenile justice, child welfare), across racial and ethnic groups, and at different levels of care (e.g., once a week outpatient, intensive outpatient, residential treatment) in clinical settings in the United States, Canada, and Europe. Over thirty years of NIH-funded MDFT research, independent studies, and scientific evaluations offer strong evidence for the model's effectiveness and transportability.

D. Prominent Associated Figures: Howard Liddle is the developer of MDFT. Gayle Dakof has contributed to all aspects of MDFT since 1986, and currently heads the training institute MDFT International. Cindy Rowe has contributed to all aspects of MDFT since 1996, and along with Dr. Dakof, she trains MDFT clinical personnel worldwide. Henk Rigter heads MDFT-Europe operations.

E. Theoretical Framework:

Structure of MDFT

Guiding theory influences include ecological and contextual theory, dynamic systems theory, and the risk and protective factor/processes research base and theoretical framework.

Treatment approaches. The family therapy approaches of Minuchin, Haley, and Montalvo are early influences.

MDFT incorporates key elements of effective adolescent drug treatment, including comprehensive assessment; an integrated treatment approach; family involvement; and development-enhancing interventions. The model is individualized and flexible. It is informed by the assessed, ongoing needs of the youth and family. Different adaptations of MDFT offer one to three sessions a week over the course of 3-6 months, both in the home and clinic. MDFT adaptations also vary according to client problem severity, treatment length/dose, and clinical setting. MDFT is practiced by clinicians in substance abuse, juvenile justice, mental health, and child welfare settings.

MDFT therapists work simultaneously in four interdependent treatment domains--the adolescent, parent, family, and extra-familial—each of which are addressed in 3 stages: Stage 1: Alliance/motivation and Building a Foundation for and Beginning Change, Stage 2: Facilitating Individual and Family Change, and Stage 3: Solidify Changes and End Treatment. Throughout treatment, therapists meet alone with the adolescent, alone with the parent(s), or together with the adolescent and parent(s), depending on the treatment domain and specific problem being addressed.

Stage 1 overall therapeutic goals are similar for both the adolescent and parent. For example, in Stage 1, goals for both the adolescent and parent are to develop a therapeutic alliance and enhance motivation to participate in treatment and to change their behaviors. In this stage, the therapist creates an environment where both the youth and parents feel empowered, respected, understood, and esteemed. The first treatment stage develops a strong therapeutic relationship with youth and parents, and enhances each individual's motivation to use treatment to reduce suffering, address specific problems, and enhance the life quality of all

family members. Accomplishment of these goals set the foundation for Stage 2 where the emphasis is on behavioral and interactional change.

By Stage 2, the longest stage in MDFT, distinctive goals in each of the four domains have been developed collaboratively in all domains (adolescent, parent[s], family, and extrafamilial). In the *adolescent domain* the therapist works collaboratively with both the parent and youth to help the youth communicate effectively with parents and other adults; and with the youth alone, we develop coping, emotion regulation, and problem solving skills; improve social competence; and establish everyday alternatives to substance use and delinquency. Individual sessions with the adolescent create an environment where the young person's point of view and his or her honest evaluations about any life events or day to day concerns can be discussed. Clinicians accomplish these process aims by avoiding critical, punitive, or moralistic tones about drug use or other aspects of their circumstances. The adolescents comply with these therapy aspects since the therapist has successfully created a setting, a relationship, and an ongoing conversation that focuses on the youth's perspective, and using the therapy to practically and actively address how life for the young person can improve. Focused discussions on the youth's conceptions about themselves at present, as well as their *possible selves* exemplify the positive youth development values and methods of the MDFT approach. A clinician uses the sometimes implicit discrepancies between the youth's current life activities and hopes and dreams for a better life. Desires such as graduating from high school, attending college, having a good job, avoiding more detention or jail, graduating drug court, living on their own one day are targeted. Internal motivation through self-reflection, discussion, seeing the therapist as an ally are goals here rather than any insight about the discrepancies. Shifts in the youth's interpretations and reactions to day to day life relate to internal and external events. For

instance, as parents constructively discuss their anger and disappointment and include an empathic and problem solving stance, young people generally respond well, and youth and parents create more flexible, less negative and automatic, and deeper discussions. A young person's expression of remorse, self-criticism, or their imagination of a different future are typical individual session events. These are examples of how individual session discussions and advances construct bridges to parent and family sessions. MDFT distinguishes between its four domains of work, but also, critically, we capitalize on the natural, and in our view, needed connections across the four domains.

In the *parent domain* of stage 2, MDFT focuses on increasing the parents' behavioral competency and emotional involvement with their adolescent. A range of empirically-established parenting skills, especially monitoring and relationship, are probed and targeted, again, collaboratively. This work involves clarifying parent expectations and speaking with their young person about the rationale underlying rules and consequences, supporting open and consistent limit setting, and articulating both negative and positive consequences. Transparency is another key in MDFT, the therapist communicates clearly the goals for sessions and reasons behind them. Session goals always touch on client motivation to participate. The therapist and family collaborate to face current, and often long-standing issues. But transparency, clarity of goals and effective communication about them are insufficient without an effective and ongoing treatment focus on enhancing the emotional connection between the parent and the young person. While this particular work arena may or may not involve addressing past hurts and transgressions, it is always guided by the developmental needs of the youth and parent (individual and interpersonal aspects), and emotion, thinking, and day to day behaviors.

Enhancing the natural but perhaps currently diminished love in the youth-parent relationship is an indispensable, and fundamental change mechanism in MDFT.

Working directly with family transactions in sessions with the parent(s) and young person, a clinician's work in the *family domain* aims to decrease family conflict, deepens emotional attachments, and improves communication and problem solving skills. The working frame of problems is developmentally-based. Substance use and antisocial behaviors are understandable and adaptive responses to individual, family, and contextual circumstances. At the same time, these problem behaviors compromise health and well-being. Family sessions focus on the urgency of addressing these problems through discussions of recent or significant past events that have been intense, dangerous, deeply distressing, and are frequently associated with crime, arrests, violence, running away, and drug relapses. Treatment is presented as a practical means to address these circumstances. Drug tests are used in the treatment as a way to encourage open communication about substance use, and hence avoid the debate about whether or not the youth is using. We use drug test results to enhance communication, trust and overall relationships within the family. They are in no way used to punish the youth nor are these results shared with extrafamilial providers like Probation officers.

Stage 3- Solidifies Changes and Ends Treatment – focuses on strengthening the achieved accomplishments as a means to retain gains. Concrete plans formulate how family members can respond to future issues (relapse, family arguments, disappointments). Specific strengths and competencies are discussed and understood as instrumental to ending treatment.

Program Features

Multidimensional Assessment

Therapeutic assessments are one of the most basic and necessary tools clinicians use to guide treatment. Clinical assessment provides a therapeutic blueprint; this blueprint directs therapists where to intervene across multiple domains and settings of the teen's and family's life. A comprehensive, multidimensional assessment identifies risk and protective factors in relevant areas, it further prioritizes and points to specific areas for change. Then an MDFT informed treatment plan is created. Multidimensional assessment includes individual and family interviews, observations of family interaction/dynamics and observation of family member interactions with influential others outside of the family as well. The therapist gathers further assessment information about functioning in each target area by collaborative and collateral contacts (e.g., referring source, previous treatment providers).

Four interdependent domains are explored with every case and the assessment captures information in the: (1) adolescent, (2) parent(s), (3) family interaction, and (4) extrafamilial systems. The multidimensional assessment includes a multiple systems formulation of how the current situation and behaviors are adaptations given the family's history and current risk and protective factors. Strength based interventions aim to enhance protective factors and to decrease risk processes known to be related to dysfunction development or progression. These risk factors include parenting problems, affiliation with drug using peers, disengagement from and poor outcomes in school. An ongoing assessment rather than a single event assessment at intake continues throughout therapy as new information emerges. The case conceptualization changes throughout treatment, offering the clinician new modes for directing treatment. Therapeutic planning is modified according to ongoing events and feedback from each session and between session events.

A *family session* generally starts treatment. Family sessions create opportunities for constructive conversation, sharing, and addressing disagreements. We also meet alone with the adolescent and the parent(s) within the first session or two. Individual meetings reveal the unique perspective of each family member, how events have transpired (e.g., legal and drug problems, neighborhood and peer influences, school and family relationship difficulties), what they have done to address the problems, what they believe needs to change with the youth and family, as well as a parent's own concerns and problems.

Therapists elicit the adolescent's life story during early individual sessions. Sharing life experiences contributes to the teen's engagement and motivation for therapy. It also provides a detailed picture of the severity and nature of the youth's drug use and circumstances, individual beliefs and attitude about drugs, trajectory of drug use over time, family history, peer relationships, school and legal problems, any other social context factors and important life events. A therapist must get to know, in practical terms, what is important to the youth – what are the things that he or she values. Therapeutic conversations sketch out an eco-map – the adolescent's current life space. This includes the neighborhood, indicating where the teen hangs or buys or uses drugs, where friends live, school or work location, and, in general, where the action is in the youth's environment. Therapists inquire about health and lifestyle issues, including sexual behavior. Comorbid mental health problems are assessed through the review of previous records and reports, the clinical interview process, and psychiatric evaluations. Adolescent substance abuse screening devices, including urine drug screens which we use extensively in therapy, are invaluable in obtaining a full, dynamic picture of the teen's and family's circumstances.

Assessment with the parent(s) includes functioning as parents and as adults, apart from the parenting role; we see parents as individuals with unique history and concerns. We assess the parents' strengths and weaknesses in terms of individual functioning, parenting knowledge, skills and parenting style, parenting beliefs, and emotional connection to their child. We inquire in detail about parenting practices, house rules, curfew, and expectations about family issues in individual sessions with the parent(s) as well as with the youth. In family sessions, clinicians observe and take part in parent-youth discussions, listening for point of view, critical incidents, references to significant past events, problem solving, and relationship indicators such as supportive or critical expressions. In discussing parenting style and beliefs, therapists ask parents about their own experiences, including family life when they were growing up. A parent's mental health status and substance use are also evaluated as potential challenges to improved parenting. On occasion we make referrals for individual treatment of drug or alcohol abuse or serious mental health problems, but these are rare.

We assess school, work, and community influences thoroughly. Therapists build relationships and work closely and collaboratively with juvenile court and probation officers regarding the youth's legal charges and supervision requirements. Clinicians help parents understand the potential harm of continued negative or deepening legal outcomes. Using a non-punitive tone, we help teens face and deal with their legal predicaments. Friendship network assessment involves encouraging teens to talk about peers, school, and neighborhood contexts in a detailed and honest manner. The creation of concrete alternatives that provide prosocial, development-enhancing day to day activities using family, community or other resources is a driving force in MDFT.

The clinician links themes that are interrelated between and within domains. Again, it is that 'eco map' that helps the clinician target which linked themes between domains need to be enhanced and which need to be changed. For instance, for an adolescent poor parenting (no rules, absent parent) can influence school performance. Thus the clinician works on creating change in the parenting domain. It could be that through sessions with client's friends the therapist finds that one particular friend is instrumental in helping the adolescent remain abstinent from drugs. The therapist will then use this relational strength to see how it can be used to say enhance the relationship between the adolescent and parent.

Adolescent Focus

Developing and sustaining a therapeutic alliance with the adolescent can be difficult; it is certainly an ongoing process. To enhance adolescent motivation and alliance we present therapy as a collaborative process. In particular, we work with the adolescent to define therapeutic goals that are personally meaningful to them. We take a curious, non-punitive and non-judgmental stance and thoroughly explore the adolescents' world. Simply put, we show the adolescent that we are interested in getting to know them, that we are there for them and that there is something they can get out of therapy. Goals then become apparent and real as the teen expresses his or her experience and discusses his or her life so far. Treatment aims to attend to these *Big Picture* dimensions. Problem solving, creating practical and reachable alternatives to a drug using and delinquent lifestyle, all of these remediation efforts exist within work that connects to a teen's conception of his or her own life, values, life's direction and meaning.

Success in one's alliance with the teenager does not go unnoticed with parents. Although it can cut both ways, we find that parents both expect and appreciate a therapist's reaching out to form a distinct therapeutic relationship with their teen. Individual sessions with teen prepare

(motivate, rehearse, coach) them to come together with parent/guardian to discuss matters needing improvement.

Parent Focus

Parents often come to therapy feeling unmotivated, with a sense that there is nothing they can do to reach their child. Many parents say “here he is, fix him...I want nothing to do with therapy”. In cases like these we focus on reaching the parent(s) as an adult with individual issues and needs, and acknowledging and normalizing declining motivation in her or his ability to influence their child. Our interventions include enhancing feelings of parental love and emotional connection, underscoring parents' past efforts, acknowledging difficult past and present circumstances, and generating hope. Intervention focusing on the expansion of a parent’s commitment and investment to their child’s welfare, is basic to the MDFT change model. When parents talk about these processes their investment and commitment to their child grows.

Cooperation with the parent(s) is achieved and motivation is grown by underscoring the serious, often life-threatening circumstances of the youth's life. This focus and the parents imagining what might be establishes a discussable connection between that caregiver’s involvement and the creation of behavioral and relational alternatives in the family. Here we follow the general procedure used with the parents—the attempt to promote caring and connection through several means, first through an intense focusing and detailing of the youth’s difficult and sometimes dire circumstances and the need for his or her family to help. The basis of that help will be a renewed relationship between parent and their young person – a relationship that has expanded caring, nurturance, and love.

Achieving these therapeutic goals sets the stage for later changes. These interventions grow parents' motivation and, gradually, their willingness to participate in therapy to address

relationship concerns and improve parenting strategies. Increasing parental involvement with one's adolescent (e.g., showing an interest, initiating conversations, creating a new interpersonal environment in day-to-day transactions), provides a new foundation for attitudinal shifts and behavioral change in parenting. Parental competence is deepened by some degree of teaching and coaching. Normative characteristics of teenagers, parent-adolescent relationships, consistent and age-appropriate limit setting, monitoring, and emotional support are typical topics. They are research-established parental behaviors that associate with development-facilitating family relationships.

Parent-Adolescent Interaction Focus

MDFT interventions also change family interaction directly. Shaping changes in parent-adolescent interaction are made in sessions through the structural family therapy method of enactment. Enactments are focused discussions on relationship topics, events and themes that are important in the everyday life of the family. Relationship strengths and problems become apparent in discussions of current and past events. Therapists support family members to discuss and try to address differences and solve problems in new ways directly in sessions. The therapist actively guides, coaches, and shapes increasingly positive and constructive family interactions, and these conversations contribute to problem solving and relationship healing. Treatment helps teens and parents to pull back from extreme, inflexible stances as these actions create poor problem solving, hurt feelings, and erode motivation and hope for change. This work might be done in individual sessions that gently cover important issues and prepare family members for family sessions where the issues will be discussed forthrightly and better ways of relating are tried.

Focus on Interactions and Outcomes with Social Systems External to the Family

MDFT also creates change in how the family and adolescent interact with involved extrafamilial systems. The teen and their family may be involved in multiple social systems. Success or failure in incorporating this very important domain can have considerable impact on short term and in some cases longer term life course. Close collaboration with the school, legal, employment, mental health and health systems influencing the youth's life is critical for initial stabilization and durable change. For an overwhelmed parent, aid in dealing with complex bureaucracies or in obtaining needed adjunctive services not only increases engagement, but also improves his or her ability to parent effectively by reducing stress and burden. Therapists and case managers work as a team to help set up meetings at school or with juvenile probation officers, and these relationships play an integral role in creating positive youth change. Understanding that successful compliance with juvenile justice supervision requirements is a core therapeutic task, clinicians regularly prepare the family for and attend the youth's disposition hearings. School or job skills are also basic treatment aspects since they represent real world settings in which youth develop competence, succeed and build pathways away from deviant peers, drugs and antisocial behavior. In some cases, legal, medical, housing, social service agency, immigration issues, or financial problems may be urgent areas of need. Therapists think through the interconnection of these life circumstances in specifying a flexible and dynamic case conceptualization. Clinicians know that these arenas of everyday life are influential in improving family functioning, parenting, and a teen's reclaiming of his or her life from the perils of the streets. Not all multisystem problems can be solved. But in every case, our rule of thumb is to assess all areas, establish priorities collaboratively and overtly, and as much as possible, work actively to help the family achieve better day to day outcomes relative to the most malleable and consequential areas.

Decision Rules about Individual, Family or Extrafamilial Sessions. As a therapy of subsystems, MDFT consists of working with parts (subsystems) to larger wholes (systems) and then from wholes (family unit) back down to smaller units (individuals). Session composition and intensity may be dictated by therapeutic needs of case. Individual sessions uncover aspects of relationships or circumstances that may be impossible to learn about in family sessions.

MDFT works in the four interdependent and mutually influencing subsystems with each case. This rationale for this multi person focus is theory-based and practical. While other family based interventions might address parenting practices by working alone with the parent for much of the therapy, MDFT is unique in its way of not only working with the parents alone but also focusing significantly on the teen alone, apart from the parent sessions, and apart from the family sessions. These individual sessions have enormous strategic and relationship building value. They provide essential information and reveal feeling states and historical events that may not be forthcoming in family sessions.

H. Research about the model:

Clinical Outcomes (See Liddle, 2016). MDFT youth and families engage and complete the program between 80% and 97% of the time. *Substance use* is significantly reduced and more youths achieve abstinence from illicit drugs in MDFT to a greater extent than comparison treatments. After treatment and at 1 year follow-up, MDFT participants had higher drug abstinence rates than comparison youths and families who were involved in other models like CBT. Additionally, *substance-abuse-related problems*, including antisocial, delinquent, externalizing behaviors, are significantly reduced in MDFT to a greater extent than comparison interventions, including manual-guided treatments. *School functioning* improves more in MDFT than comparison treatments (MDFT clients return to school and receive passing grades at higher

rates). *Family functioning* improves -- family conflict reduces, and family cohesion increases -- to a greater extent in MDFT than family group therapy or peer group therapy, and these gains are maintained at one year follow-up. *Psychiatric symptoms* show greater reductions in MDFT than comparison treatments. *Delinquent behavior and association with delinquent peers* decrease with MDFT youth, whereas youth receiving peer group treatment reported increases in delinquent behavior and affiliation with delinquent peers. These changes maintain at multi-year follow-ups. Juvenile justice records indicate that MDFT participants are less likely to be *arrested or placed on probation*, and had fewer findings of wrongdoing during the study period. MDFT has demonstrated reductions in *youths' high risk sexual behavior*, HIV and STD risk reductions (laboratory-confirmed STDs). Economic analyses find the average weekly costs of treatment is significantly less for MDFT (\$164) than standard treatment (\$365).

Case Example - MDFT Case Vignette.

James, 17 was referred from juvenile court. Currently repeating ninth grade, James was missing about half of his school days, arguing aggressively and disrespectfully with his mom in the house, ignoring curfew, and smoking marijuana with a small but close knit group of friends several times a week. James' mother had a stroke two years previous to the referral and had been unemployed since then. Her stress level high, Mrs. Jackson said she wanted help for James, indicating that was extremely concerned about his everyday life, and where things were headed generally. Mrs. Jackson reports no other family in the area, but involvement in her church included volunteer activities, and these connections were helpful.

Treatment Focus:

- Help mom develop better parenting skills
- Minimize the risk of neighborhood and negative school influences on James

- Help James address school attendance and behavioral problems, establish day to day routines that are alternatives to a deepening drug using lifestyle
- Enhance the mother-son relationship

MDFT Stage 1: Build the Foundation and Begin Change.

Because work is conducted with parents and teenagers together as well as separately early in therapy, the therapist met alone with Mrs. Jackson to hear and validate her concerns and acknowledge her distress. The therapist helped Mrs. Jackson set her priorities and reconnect to her love for and belief in her son. Although at times Mrs. Jackson felt like giving up, the therapist helped her focus on her desire not to give up on her son as her family gave up on her when she was 16. Meeting with James alone was critical for the therapist to understand more about his perspective on himself and to develop some understanding about what was contributing to his truancy and drug use. Initially, it seemed that James, making little eye contact with the therapist, would be difficult to engage. When the therapist talked to James alone in the first session, she had trouble getting him to talk about typical themes the MDFT therapist might explore in establishing a foundation with the adolescent, such as his own perspective on the problem, how things were for him at school, or his relationships with family members. When he talked about how he went to his neighbor's house to watch television because his mother "hollered" at him, the therapist found an opening to explore how he perceived the relationship with his mother. The therapist opened the door for deeper engagement and further exploration by stating, "James, you seem like a thoughtful guy, and you're not in an easy situation. I think your mom would like to be a better mom, and maybe she needs some help with that, too." Over time, the therapist was able to help James talk to his mother about his hurts and disappointments, which helped both to understand his truancy, disrespect, and drug use in the context of the

significant tension and changes in their relationship. The ecologies of school and neighborhood posed many risks for James, and the therapist knew these influences had to be addressed to achieve success. School failure was one of the biggest potential threats to James's long-term success.

Stage 2: Work the Themes in the Four Domains-Create and deepen change.

Despite a strong start to therapy, mid-way through the process, Mrs. Jackson became increasingly disappointed and frustrated with James for not responding to the changes she was making with her parenting. She became more adamant that she was going to give up on him. Mrs. Jackson and the therapist met alone to deeply explore her discouragement with reports that James was not attending classes. She was tired of monitoring her son constantly. When the therapist alleged that taking care of herself and setting James on the right path were not mutually exclusive, Mrs. Jackson disagreed and spun quickly into the vortex of parental abdication. In response to this, the therapist expressed understanding and compassion towards the mother's frustration while also attempting to revive mother's previously stated desire to hang in with her son. Alone with James, the therapist emphasized how his mother was getting ready to give up on him and how he needed to "show her something" that might counter her stance and give her motivation and hope for continuing to stick it out with him.

This type of conversation trades on an alliance that had been built with the teenager, who, understanding that the therapist was indeed trying to help the parent "hang in," was able to tolerate her pressing him for some behavior change. James felt that his mother did not really want him at home, since she locked the door to her room when he came home. With mother and son together, the discussion about mom's locking her door provoked angry interchanges between James and Mrs. Jackson. The therapist was able to help the two calm down and interrupt some of

their negativity, softened the mother's stance towards her son, and shaped a more productive discussion of what was needed for increased trust and connection. The therapist frequently came back to Mrs. Jackson's worry and concern for James when she presented with complaints and upsets about his misbehavior, staying out late and not calling home. She constantly focused on the connection between James and his mother by highlighting the love and fear for his safety that fueled her anger. James was encouraged to let his mother know more about his friends and his activities so that she would worry less about what he was doing when he was out of the house. Mother and son perceptibly altered their positions over time. Throughout this phase of work, the therapist helped both James and his mother set forth and focus on concrete goals that each would work to achieve (e.g., for James to respect curfew, do his chores, attend school, discuss his drug use, agree to a plan to cut back his smoking; and or Mrs. Jackson to manage her anger differently and listen more to what James had to say).

Stage 3: Solidify Changes and Exit

Therapy increasingly attended to what James hoped for in his life and what tangible steps he would take to reach his dreams. As therapy ended, Mrs. Jackson and James focused on his plans to attend Job Corps. Mrs. Jackson was relieved that James would be getting training in an area of his interest. James was feeling optimistic and glad to be leaving the school where he felt physically threatened on a daily basis. In their last sessions, the mother and son engaged in affectionate banter. The therapist reminded them of the tense climate that existed between them when they first came to therapy. Mrs. Jackson was proud of her son. The therapist was quick to point out how mother had really "gone to bat" for him. The therapist reinforced the high stakes of this opportunity for James at this stage of his life, and they all discussed the possibility of James finding new role models at Job Corps, as well as new possibilities for getting into trouble.

Mother talked about her new role in James's life now that he would be leaving home for Job Corps, and James was able to express his appreciation for her in hanging in with him through it all and how he would continue to need her support.

The Take-Away:

James' case demonstrates the importance of addressing both parental despair and hopelessness as well as parenting skills, improving the emotional relationship between mother and son, addressing neighborhood risk factors, and helping the youth discover his healthy and positive self.

References

- Liddle, H. A. (2015). Multidimensional Family Therapy. In T. Sexton & J. Lebow (Editors), *Handbook of Family Therapy*. NY: Routledge.
- Liddle, H. A. (2016). Multidimensional Family Therapy: Evidence base for transdiagnostic treatment outcomes, change mechanisms, and implementation in community settings. *Family Process*, 55(3), 558-576.