CHAPTER 7

Multidimensional Family Prevention for At-Risk Adolescents

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The science of mental health prevention has made significant conceptual and empirical advances over the past two decades (Bryant, Windle, & West, 1997). During that time, prevention has emerged as a major focus of programmatic, research, and policy work in the mental health arena (Munoz, Mrazek, & Haggerty, 1996). These efforts are aimed at preventing, delaying, or moderating the onset of psychological disorders in the general population and within high-risk subgroups. Specifically, mental health prevention is concerned with (1) investigating the etiology, developmental course, and psychosocial correlates of psychological disorders; (2) identifying risk factors that predict future disorders and protective factors that buffer against psychological dysfunction in given populations; and (3) developing interventions for insulating persons against the onset of disorder and ameliorating risk factors and incipient behavioral symptoms. This last focus of prevention is known as *preventive intervention*. Preventive interventions are directed at preventing or delaying the onset of behavioral problems, whereas *treatment interventions* attempt to alleviate or eliminate disorders in persons who meet criteria for psychiatric diagnosis or have significant impairment in functioning (Institute of Medicine, 1994).

Substance use and antisocial behavior problems such as aggression, delinquency, and violence have received the greatest attention in the prevention field. Recent national surveys provide strong evidence that adolescent drug use and delinquency are prevalent and on the rise. For example, the National Household Survey of Drug Abuse (Gfroerer, 1995) found that 16% of teens age 12 to 17 reported marijuana use and 2% reported cocaine use. The Monitoring the Future study (Johnston, O'Malley, & Bachman, 1995) found that among eighth-graders, 59%

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had used alcohol, 46% cigarettes, 17% marijuana, and 20% inhalants; moreover, between 1992 and 1995, rates of use increased 37% for marijuana, 60% for hallucinogens, and 115% for cocaine. A recent household probability study (Kilpatrick et al., 2000) sampled teenagers age 12 to 17 who had five or more drinks at one sitting or had used an illicit drug on at least four occasions. Among this subpopulation of nonincidental drug users, 4% reported disorder-level symptoms of alcohol or marijuana abuse/dependence and 1% reported abuse/dependence on harder drugs. National rates of delinquency and violence are alarmingly high as well; arrests for juvenile violent offenses rose over 60% between 1988 and 1994 (Loeber & Stouthamer-Loeber, 1998; Osofsky, 1997). Drug use and antisocial behavior exert a tremendous toll on the families and communities in which troubled youth reside, and the financial costs of interdiction, institutionalization, and treatment are substantial. For these reasons, the dissemination of effective programs for preventing antisocial behavior in adolescence has become a top priority in the prevention field (Elias, 1997).

This chapter describes a family-based, developmental-ecological preventive intervention for drug use and delinquency: multidimensional family prevention (MDFP; Liddle & Hogue, 2000). MDFP has two characteristics that set it apart from most family-based preventions for antisocial behavior. First, it is an individualized model implemented exclusively in one-to-one (versus parent group or multifamily) settings. This allows for development of a prevention agenda that reflects the unique needs and goals of each family. Second, it targets a population that is notoriously difficult to treat: at-risk adolescents and their families. Adolescents are among the most underserved populations in both prevention and treatment settings (Kazdin, 1993), and families of at-risk teens present multiple challenges to recruitment and intervention design (Prinz & Miller, 1996).

As an individualized prevention model for at-risk youth and families, MDFP is something of a hybrid between traditional preventive and treatment interventions. This is no accident. The conceptual framework and intervention components of MDFP were adapted directly from our experience in developing a family-based treatment for adolescent substance abuse: multidimensional family therapy (MDFT; Liddle, 2000). It was reasoned that the basic intervention principles of an empirically supported family therapy model would be highly effective if revised for use in prevention settings, wherein at-risk youth are in earlier and (theoretically) more malleable stages of problematic behavior (Reid, 1993). In this spirit, MDFP combines the curriculum-based and protection-focused methods of standard prevention models with the assessment-based and symptom-focused methods of psychotherapy. Such an approach may offer the best hope for working with multiproblem adolescents who have not yet developed clinical disorders.

HISTORY OF THE INTERVENTION APPROACH

TREATMENT AND PREVENTION: THE MENTAL HEALTH INTERVENTION SPECTRUM

Multidimensional family therapy has been recognized as one of a handful of multicomponent, theoretically derived treatments for adolescent drug abuse with empirical evidence of treatment efficacy (Stanton & Shadish, 1997; Weinberg, Rahdert, Colliver, & Glantz, 1998). MDFT is an outpatient, multisystemic intervention that focuses on changing both within-family interactional patterns and interactions between the family and relevant social systems. Research support has come from controlled outcome studies of drug-using adolescents (Liddle et al., in press) and process research

studies investigating mechanisms of therapeutic change (G. S. Diamond & Liddle, 1996; G. M. Diamond, Liddle, Hogue, & Dakof, 1999; Schmidt, Liddle, & Dakof, 1996).

MDFT's solid empirical record for treating adolescent substance use and conduct problems made it an appealing model of preventive intervention for these symptoms. Two additional factors strengthened this appeal. First, MDFT treatment principles and techniques are grounded in basic developmental theory regarding mechanisms of risk and protection (Liddle, Rowe, Dakof, & Lyke, 1998; Liddle et al., 2000). MDFT targets the multiple ecologies of adolescent development and, within these ecologies, the various developmental processes known to produce adaptation versus dysfunction as they are manifested in any adolescent and family. This focus on risk and protection within multiple ecologies is also a central organizing principle of contemporary prevention science (Masten & Coatsworth, 1995). Thus, the core theories constituting MDFT's developmental base—risk and protection theory, developmental psychopathology, and developmental-ecological theory—are also guiding frameworks of MDFP.

Second, prevention science has recently made great theoretical strides in articulating the link between prevention and treatment; these approaches are now seen as two poles defining a single continuum of mental health intervention services. As depicted in Figure 7.1, the mental health intervention spectrum (see also Institute of Medicine, 1994; National Advisory Mental Health Council [NAMHC], 1998) spans the range of mental health services from preintervention epidemiological research on mechanisms of risk and protection, to preventive interventions for nonsymptomatic or subclinical populations, to prevention services that are concurrent with treatment interventions (comorbidity, disability, and relapse prevention), to treatment for clinical disorders and maintenance of treatment gains. It thereby formalizes a theoretical continuity between preventive and treatment interventions—they are members of the same species, so to speak. This theoretical connection allows for fluid adaptation of principles and practices from one tradition to the other. Intervention techniques, training and supervision procedures, and methodological innovations can be productively shared back and forth between the prevention and treatment
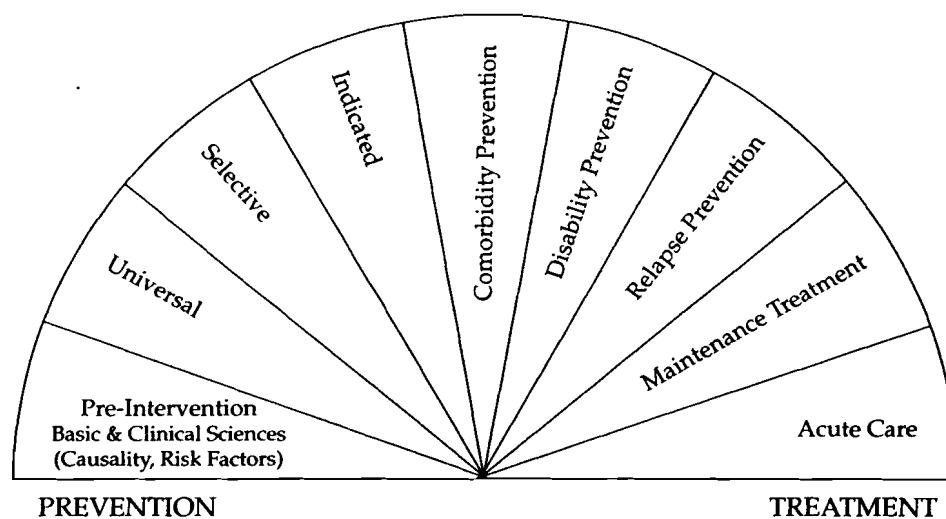

Figure 7.1   The mental health intervention spectrum.

sciences. Of course, the feasibility and utility of a knowledge-practice transfer between any two particular models can be demonstrated only through rigorous developmental work and empirical testing. This was our challenge in developing MDFP.

There are also important, indelible distinctions between preventive and treatment interventions, two of which are salient to MDFP. First, there is a population distinction. Preventive intervention is directed at preventing or delaying the onset of mental health problems in persons who do not have a psychiatric disorder, whereas treatment intervention targets persons who meet (or almost meet) clinical diagnostic criteria. As a result, prevention populations on average exhibit less severe and less entrenched psychological symptoms, if any, than treatment populations. Second, there is an intentional distinction. The ultimate aim of prevention is to lessen the likelihood of possible or anticipated symptoms. Thus, for individual cases and entire samples, intervention goals are expressed in terms of outcome probabilities (i.e., odds that targeted persons will eventually develop a given disorder; Institute of Medicine, 1994). The ultimate aim of treatment is to alleviate symptoms or reduce their severity immediately, so that therapeutic progress can be judged in large measure at termination.

Finally, as Figure 7.1 shows, there are important distinctions in target populations within the prevention field itself.* Universal preventions are designed for the general population or a specific subpopulation in which all members are included (e.g., advertising campaigns about the dangers of drug use). Selective preventions target subgroups identified as having higher-than-average risk based on group characteristics with empirically established links to a given disorder (e.g., children of adult drug users). Indicated preventions are for persons identified as high risk based on an individual risk assessment that detects prediagnostic levels of behavioral problems (e.g., children who have experimented with drugs). MDFP is an indicated preventive intervention; this has concrete implications for model design and implementation, as discussed below.

FAMILY-BASED PREVENTIVE INTERVENTION

Family-based preventive interventions such as MDFP seek to promote healthy functioning in individual children primarily through addressing the risk and protective factors that characterize their parents and families (Hogue & Liddle, 1999). Family-based prevention is widely endorsed as a key component of comprehensive prevention planning for adolescent drug abuse (Etz, Robertson, & Ashery, 1998) and antisocial behavior (Kazdin, 1993). The emergence of the family-based approach has been buoyed by studies underscoring the significance of family socialization processes for the onset and course

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*The terminology for describing mental health prevention efforts has changed in recent years. Prevention efforts have traditionally been classified according to the following system developed in medicine and public health (Caplan, 1964; Commission on Chronic Illness, 1957). Primary preventions are intended for healthy populations and are aimed at preventing the occurrence of disease. Secondary preventions are intended for persons with early symptoms of disease and are aimed at forestalling its progression. Tertiary preventions are intended for persons with an existing disease and are

aimed at reducing its duration and the amount of associated disability. However, this classification system has been criticized on two counts: for its overemphasis on the causes and mechanisms of disease, at the expense of risk-benefit decisions about who should receive prevention services (Institute of Medicine, 1994); and for its confusion about differences among tertiary prevention, treatment, and rehabilitation (Durlak, 1997). Most mental health preventionists have therefore adopted the terminology recommended by the Institute of Medicine: universal, selective, and indicated prevention.

of youth problem behaviors (Brook, Brook, Gordon, Whiteman, & Cohen, 1990; Hawkins, Catalano, & Miller, 1992). Research on the efficacy of family-based prevention models offers limited but credible support for this approach. Such programs have demonstrated noteworthy successes in the difficult primary task of engaging and retaining parents in program activities (Hogue, Johnson-Leckrone, & Liddle, 1999; Spoth, Redmond, Hockaday, & Shin, 1996). Outcome studies provide convergent evidence of prevention effects across several family-based models: parenting skills workshops (Kosterman, Hawkins, Spoth, Haggerty, & Zhu, 1997; Spoth, Reyes, Redmond, & Shin, 1999), parent training alone and in combination with child skills training (Dishion & Andrews, 1995; Tremblay, Pagani-Kurtz, Masse, Vitaro, & Pihl, 1995), and family skills training (Kumpfer & Alvarado, 1995; Spoth et al., 1999). Moreover, empirically supported family prevention programs have been promoted and disseminated at the national level (National Institute on Drug Abuse [NIDA], 1997; Substance Abuse and Mental Health Services Administration [SAMHSA], 1998).

MDFP: An Individualized Approach to Family Prevention

Akin to its psychotherapy cousin MDFT, MDFP is an individualized intervention model. Individualized models are predicated on client-specific assessment and intervention planning. For this reason, they appear well-suited for working with high-risk populations in particular (Hogue & Liddle, 1999; Tolan & McKay, 1996). In contrast to standardized psychoeducational models, individualized counseling models employ a flexible intervention format that features (1) sessions held primarily in one-to-one (versus group) settings; (2) clinical assessment of the unique profile of risk and protection factors for every client;

(3) collaborative formulation and periodic revision of counseling needs and goals. The individualized format has many potential benefits for prevention work with at-risk families. It promotes specification and monitoring of a family-specific prevention agenda, allows each family member to articulate personally relevant goals, and provides opportunities for extensive interaction between counselor and family around multiple issues.

Empirical support for an individualized approach to family-based prevention can be found in two sources. First, family-based psychotherapies, almost all of which use an individualized format, have an excellent track record for treating substance abuse (Stanton & Shadish, 1997) and antisocial behavior (Henggeler, 1996) in children and adolescents. Some family therapy models have even shown preventive effects in siblings of the targeted youths (e.g., Klein, Alexander, & Parsons, 1977). Second, a few studies have tested the efficacy of family prevention counseling for at-risk youths. Fast Track (Conduct Problems Prevention Research Group, 1999) has demonstrated good prevention outcomes for a national sample of high-risk first-graders. As one feature of a multicomponent intervention plan, each family received home-based family counseling that included biweekly sessions and weekly phone contacts. Catalano and associates (described in Bry, Catalano, Kumpfer, Lochman, & Szapocznik, 1998) reported small prevention gains following an intensive counseling prevention for children of substance users that included a five-hour family retreat, a 32-session parent training module, and a nine-month home-based case management module. Santisteban et al. (1997) found that brief structural/strategic family counseling (12 to 16 sessions over four to six months) reduced early-stage behavior problems and improved family functioning for indicated-risk, inner-city African American and Hispanic young adolescents.

THEORETICAL CONSTRUCTS OF MDFP

MDFP is a behaviorally oriented prevention model grounded in three theoretical frameworks: risk and protection theory, developmental psychopathology, and developmental-ecological theory. It incorporates research knowledge from these theories about adaptive developmental trajectories and ecological risk into prevention work with individual families. Also, as a behavioral prevention model with a family focus, this approach adheres to the basic tenets of behavioral family intervention.

RISK AND PROTECTION THEORY

Risk and protection theory is the dominant framework in the prevention field (Jessor, Van Den Bos, Vanderryn, Costa, & Turbin, 1995). Psychological dysfunction is thought to be determined by the interaction between risk factors, which predispose an individual to the development of disorder, and protective factors, which predispose positive outcomes and buffer individuals against disorder. Thus, complex behavior problems such as substance abuse and delinquency do not stem from a single set of specifiable precursors; instead, there are several pathways to genesis of these disorders, and various risk and protective influences can be identified in the psychological, biological, and environmental realms. Risk factors are thought to have a multiplicative effect, such that overall risk increases exponentially with the addition of each risk factor, whereas protective factors exert both a direct positive influence on behavior and a moderating influence on the relation between risk factors and behavior.

Profiles of risk and protective factors are used to identify individuals who are at risk for behavioral problems so that appropriate intervention steps can be taken. Family-based preventions focus on risk and protective factors in the family

arena. There are several family factors that create serious vulnerabilities for problem behavior: deficiencies in parental monitoring and discipline practices, high rates of family conflict and low rates of communication and involvement, poor parental attachment to children, and parental attitudes about and history of drug use (Dishion, French, & Patterson, 1995; Hawkins et al., 1992). The quality of the parent-child relationship is a particularly critical factor. Emotional support from family members and the perceived quality of the affective relationship with parents are strong predictors of adolescent well-being that insulate youths from drug use and negative environmental influences (Baumrind, 1985; Resnick et al., 1997).

DEVELOPMENTAL PSYCHOPATHOLOGY

The goal of developmental psychopathology is to examine the course of individual adaptation and dysfunction through the lens of normative development, so that truly maladaptive behavior patterns can be distinguished from expectable variations within the normative range (Sroufe & Rutter, 1984). Developmental psychopathology is concerned not so much with specific symptoms in a given youth as with the youth's ability to cope with the developmental tasks at hand and the implications of stressful experiences in one developmental period for (mal)adaptation in future periods. Because multiple pathways of adjustment and deviation may unfold from any given point, emphasis is placed equally on understanding competence and resilience in the face of great risk. Developmental psychopathology underscores the advantages of designing prevention programs for high-risk children before the onset of mental health disorders, so that developmental trajectories may be changed while more adaptive pathways remain available. Normative developmental issues most relevant to drug use prevention include self-regulation and exploratory

behavior (Hill & Holmbeck, 1986), autonomy seeking and emotional stress within the family (Steinberg, 1990), and involvement with peer groups (B. Brown, 1990).

DEVELOPMENTAL-ECOLOGICAL THEORY

Developmental-ecological theory is concerned with understanding the intersecting web of social influences that form the context of human development (Bronfenbrenner, 1986; Tolan, Guerra, & Kendall, 1995). Developmental-ecological theory regards the family as the principal social system for human development, but in addition, it emphasizes how individual development is directly and indirectly affected by many extrafamilial factors. Therefore, developmental-ecological preventions seek to intervene simultaneously in multiple social systems that are salient to adolescent functioning, so that developmental contexts outside the family (e.g., school, peer, neighborhood) are routinely subject to assessment and intervention. Specifically, interventions aim to influence how family members relate to (i.e., think about and interact with) these extrafamilial systems (Liddle, 1995).

BEHAVIORAL FAMILY INTERVENTION

Behavioral family interventions have received a wealth of empirical support for treating childhood conduct problems and improving child-rearing practices (Taylor & Biglan, 1998). Likewise, in the prevention field, family-based interventions that follow a behavioral approach have demonstrated greater success than interventions that simply educate parents about recommended parenting techniques (Etz et al., 1998; Kosterman et al., 1997). Behavioral family interventions teach families about principles of behavioral reinforcement and address both parent management skills, such as discipline techniques and child monitoring, and family

relationship characteristics, such as emotional climate, communication, and parent-child bonding (Alexander & Parsons, 1982; Patterson, Reid, & Dishion, 1992). The hallmark of behavioral family intervention is use of practitioner modeling and feedback to participants following attempts to practice specific skills in the home or office setting. Behavioral family approaches foster a collaborative, interactive atmosphere that encourages family members to critique, refine, and modify learned strategies based on their observed applicability and effectiveness (Taylor & Biglan, 1998).

MDFP PRINCIPLES OF ASSESSMENT AND INTERVENTION

The distinctive character of any given intervention model is defined by two separate features: intervention *parameters* and intervention *techniques* (Kazdin, 1994). Intervention parameters are program-delivery aspects of the intervention that determine its timing, intensity, duration, and persons targeted. Intervention techniques are the essential counselor behaviors utilized during case contacts: the various interventions, combinations, and phases of work that are implemented in response to given client problems. The intervention parameters and techniques of MDFP are summarized in this section: service delivery and recruitment strategies, assessment procedures, and multimodule intervention guidelines. The section that follows describes the target population and the fundamental intervention goals of MDFP.

INTERVENTION PARAMETERS

Service Delivery
MDFP is both a home-based and community-based intervention. Sessions occur primarily in the home of the family. Home-based delivery

offers several advantages over office-based models: It circumvents transportation barriers (especially for economically disadvantaged families), affords flexibility in scheduling sessions that can enhance recruitment and participation rates, allows the counselor to make use of all available resources in the home and community (including family members not predisposed to clinic visits), and supports the acceptability and generalizability of interventions in the everyday environment of the family. MDFP counselors also function as de facto case managers who make visits to schools, places of worship, and other local institutions to broker services for the family. The overarching goal of case management is to facilitate the family's increased involvement with local agencies and competence in acquiring various supportive services.

Sessions occur with single families, not in group format. Decisions about session composition are made on a case-by-case and session-by-session basis. Both individual and conjoint sessions are regularly used, and it is common for a given session to contain a blend of individual and conjoint minisessions. Families typically receive services for three to four months, and counselors make an average of three substantive contacts per week for every case. Each family receives a total of 15 to 25 sessions that take place either in person or (occasionally) by phone and last 30 to 90 minutes. Counselors also make in-person contacts with extrafamilial resources on behalf of the family as needed. Depending on the exigencies of the case, the intensity of program delivery varies: Families that present relatively few distressing issues may be scheduled for one session per week; those that present with greater needs or are in crisis during counseling may receive two in-person sessions and several phone contacts per week.

Recruitment Strategies

The prevention model's commitment to home-based, intensive intervention is extended to its program recruitment procedures (see Hogue et al., 1999). Recruitment is conducted by the MDFP counselors themselves, rather than by adjunctive staff, so that sophisticated clinical skills are brought to bear on the manifold challenges of family recruitment. Counselors recruit families using empirically based systemic engagement techniques (Szapocznik et al., 1988) that include phone contact(s) with functional parents followed by an in-home recruitment visit. The recruitment process is marked by counselor flexibility and persistence, sensitivity to the unique circumstances of each family, and readiness to allocate substantial program resources to enlist families.

ASSESSMENT PROCEDURES

Assessing Multiple Domains of Functioning

MDFP utilizes a multidomain, multisystems assessment strategy for evaluating various dimensions of the adolescent's and family's psychosocial functioning. MDFP focuses on seven domains of functioning that are linked to the development of risk and protective mechanisms in adolescent populations and that represent critical foci of concern for families with high-risk youth, who typically demonstrate elevated risk levels in more than one domain (Hawkins et al., 1992; Jessor, 1993; Petraitis, Flay, & Miller, 1995). Counselors assess each domain of functioning to identify major problem areas and protective supports in the life of the adolescent and to map out the nature of parent/family involvement in each domain. These include:

1. *Family relationships:* History and patterns of positive and negative interactions, strength of attachment bonds between members, roles played by extended or estranged members in family life, child caretaking and monitoring arrangements, family coping and communication style.

2. *School involvement:* School grades and conduct, educational goals, homework habits, learning disabilities, relationships with teachers or school mentors.
3. *Prosocial activities:* Involvement in extracurricular youth activities and community institutions such as sporting and social clubs, tutoring and academic enrichment programs, leadership and vocational programs, and religious institutions.
4. *Peer relationships:* Friendship attitudes and experiences, identification with peer values, activities favored by close friends and larger peer groups, parental contact with friends and the parents of friends.
5. *Drug issues:* Parental and adolescent attitudes about and exposure to drugs, drug involvement by other family members, drug use by peers, drug-related activity in school and neighborhood.
6. *Cultural themes:* Family values regarding racial/ethnic history, emergence of the adolescent's cultural identity, hardships and coping mechanisms related to racial/ethnic bias.
7. *Adolescent health and sexuality:* Physical problems (e.g., diabetes, weight issues), psychological problems (e.g., depression, anxiety, aggression, impulsivity), self-concept and self-care, family attitudes about adolescent dating and sex, and sexual activities of the adolescent.

An informal assessment of the family's risk and protective factors within each of these domains occurs in the program's initial sessions. Domains are not assessed in a predetermined, programmatic fashion. Instead, the idiosyncratic characteristics of the family determine the priority, timing, and depth with which each domain is explored. As the assessment progresses, some domains may loom large in the family landscape and become a focal area of work, whereas other domains with lesser relevance may recede into the background. In assessing each domain, the counselor pursues three avenues of inquiry simultaneously: history and perspective of the adolescent, history and perspective of the functional parents, and history and status of the adolescent-parents relationship. The assessment is managed so that sensitive issues can be addressed in a respectful manner; careful consideration is given to when topics should be raised with individuals alone, raised with all members present, or raised first in private and then again (with preparation) in a conjoint setting. In all situations, the counselor is interested in identifying risk and protective factors that bear directly on the adolescent's key developmental challenges.

Crafting the Counseling Agenda

The main goal of assessing risk and protection domains during initial sessions is to crystallize family-specific issues that will become the focus of intervention. MDFP is an individualized model whose assessment and intervention techniques are applied according to counselor judgment about the status and needs of a given family. As such, MDFP centralizes the unique history, values, identified problems, interactional patterns, and socialization goals of the family and its members in crafting a counseling agenda. To set a tone of counselor-family collaboration, it is made clear that parental investment in counseling is the cornerstone of program success. Attention is paid to dispelling any preconceptions that the program is meant to "straighten out" the adolescent, and the importance of continued parental influence and parent-adolescent communication for adolescent development is underscored. Also, connections among parent well-being, parenting competence, and adolescent adjustment are discussed.

Especially with at-risk prevention populations, assessment of risk and protection domains often uncovers one or more risk factors that exert a significant negative influence on the family and are perceived as highly stressful,

resistant to change, and requiring immediate intervention. In short, high-risk prevention populations often present with difficulties in adaptation that command a treatment-like urgency (Tolan, 1996). It is therefore imperative that practitioners who work with high-risk populations have sufficient training and skills, flexibility within the model in choosing and adapting interventions, and supervisory support from the program to address clinical-level problems in a competent manner.

What if the assessment phase reveals that a family has few problems or concerns of alarming magnitude? Even at-risk adolescents and their families may present with relatively mild risk factors and stable coping mechanisms in some or most domains. For such cases, protection-oriented themes receive the bulk of attention in counseling. Protection-oriented themes are generated from the counselor's expertise in general risk and protective mechanisms and normative family psychology, coupled with knowledge of the particular family gained from the assessment process. Protection-oriented themes take the generic form: What every family should know and do to manage normative adolescent transitions. They assume the functions of curbing mild symptoms or nascent problems and building individual and family coping skills as an inoculation against future risk. This is intended to foster a more protective family context in which developmental needs are recognized and integrated within the governing family system. Note that protection-oriented themes are pursued with all families, including those with few coping skills and a multitude of daily stressors.

INTERVENTION MODULES

MDFP features four integrated modules of intervention, each associated with core intervention goals and techniques. Counselors rely on training, experience, and knowledge of the

family to coordinate intervention efforts within and among the modules. Depending on the family's risk and protection profile, more time may be devoted to some modules than to others. Modules are not meant to be implemented in a sequential or prearranged fashion; instead, progress in one module is used to support or potentiate work in others, and critical themes are cycled throughout different modules and sometimes recycled within a given module over the course of intervention.

Adolescent Module

This module focuses on the role of the individual adolescent within the family system as well as his or her membership in other social systems, principally school and peer groups. Normative developmental issues such as school achievement, family support and stress, emotional and physical maturation, friendship and romantic interests, and prosocial and antisocial influences in the peer group and neighborhood are discussed for their personal relevance to the teen and their suitability as focal topics for family sessions. This module also includes social competence training for adolescents with deficiencies in social processing and interaction skills. Anxieties or social problems in relationships within and outside the family are targeted for individual skills building activities (e.g., relaxation training, problem-solving exercises) that can be used in multiple sessions.

It is crucial that the counselor help adolescents paint a detailed picture of personally meaningful issues in their everyday social life: how they make decisions about family and peer relations, how stable and supportive their social network is, how they are adjusting to achievement and maturity demands. In doing so, the counselor gains better access to the ecological world of the adolescent and the risk and protective factors found there, and this information becomes the basis for designing practical and relevant prevention strategies. In addition, these details are natural building blocks for establishing a strong

working alliance with the teenager (G. M. Diamond et al., 1999). Adolescents should be convinced that prevention counseling can be worthwhile, a vehicle for thinking about their unique issues and working on self-defined goals that may be quite different from those of parents and other adults. This realization facilitates work with the adolescent and increases motivation to participate in conjoint sessions.

Parent Module

The parent module uses individual sessions with parents to establish a counselor-parent working alliance, review their history of perceived successes and failures as parents, and present a developmentally informed perspective on adolescent functioning. When indicated, parenting skills are enhanced in the areas of monitoring, limit setting, fostering a supportive emotional climate, and modeling coping strategies. Counselors endeavor to translate established principles of effective parenting into practical strategies that mesh with the ecological niche and everyday parenting routine of the family (Liddle et al., 1998). The main goal of this work is to clarify how parents can, and cannot, affect their teen's behavior. Parents need to receive accurate information about how much influence they actually wield on adolescent behavior and about the most efficient means for using this influence.

In addition, intrapersonal and interpersonal experiences apart from the parenting realm are explored so that impediments to effective parenting can be addressed. Parents of high-risk adolescents are often under considerable stress from a variety of sources. Many are single parents with multiple children, some struggle with considerable relationship problems or economic hardships, and some exhibit depression or other forms of psychopathology, all of which can precipitate and/or exacerbate symptoms in the adolescent and constitute part of the adolescent's risk profile (Robinson & Garber, 1995). In such cases, a significant portion of the parent module may be devoted to (1) identifying how these stressors affect the parenting environment; (2) determining how the adolescent (and other children) can be better shielded from their effects; and (3) helping parents access various social (and, if needed, psychiatric) resources for themselves and their families. Also, parents sometimes harbor strong negative feelings about the parenting they received in their own family of origin; these historical issues usually need to be addressed prior to, or concurrent with, helping them transform the current parenting climate.

Family Interaction Module

The family interaction module facilitates change in family relationship patterns by providing an interactional context for families to develop the motivation, skills, and experience to modify interpersonal bonds and interact in more adaptive ways. Family members are helped to understand and validate the values and perspectives of other members. Adolescents and parents are asked to evaluate their attachment bonds and the balance they have achieved between autonomy and connectedness. Also, siblings, older-generation adults, and influential family members not living in the home (including estranged parents) are invited to take part in family sessions, when appropriate.

Family relationships and interactional patterns are the main foci of intervention in MDFP, with greatest emphasis placed on the parent-adolescent relationship. Counselors seek to understand and ultimately modify the parent-adolescent relationship by evaluating and coaching their interactions in session. Conversations are sometimes prompted by the counselor in direct attempts to change interactional patterns, and thus to change the relationship; at other times, the conversations occur spontaneously. The counselor watches how parents and adolescent communicate, how they solve or fail to solve problems, and how the viewpoint of

each is validated or thwarted. The counselor then shapes interactions in an attempt to provide new experiences within existing relationships and to develop more functional relationship habits. As families practice adaptive relationship behaviors in session, they become better able to recognize what good conversations feel like; this fosters the generalizability of these behaviors to novel situations.

Parents and adolescents generally spend a small amount of daily time together in conversation (Larson & Richards, 1994), and the task of conversing "naturally" about emotional or conflictual topics in the alien environment of a counseling session can be formidable (G. S. Diamond & Liddle, 1996). Especially for families with a history of negative or impoverished communication, teenagers and parents may need considerable coaching from the counselor before they can begin productive in-session conversations. This coaching is carried out in one-to-one sessions dedicated to preparing participants for later, mutually planned interactions in session. The overall objectives of preparatory individual coaching include helping each participant to formulate the content and tone of what is to be said, prepare for potential reactions by other participants, and solidify a mutual agreement that enables the counselor to challenge participants to follow through as planned once the interaction begins.

Extrafamilial Module
In this module, the counselor seeks to develop a high level of collaboration between the family and other social systems to which the adolescent is connected, such as school, peer, and recreational. Interventions take one of two basic forms: discussion about the parents' contacts with and knowledge of the adolescent's life outside the family, with emphasis on the protective benefits of parents remaining personally involved in those systems; helping parents appreciate the importance of remaining knowledgeable about the adolescent's subjective

experience of those systems. MDFP counselors work to boost parental involvement by encouraging parents to attend school conferences, arrange independent meetings with teachers, visit the sites of extracurricular activities, meet best friends, and meet the parents of best friends. For parents who are already active in the adolescent's school and peer networks, counselors discuss strategies for remaining engaged in these systems even as new demands for independence and responsibility emerge in later years. Counselors also routinely accompany family members in meeting with mentoring adults invested in the adolescent, and they investigate community resources available to both teens and parents. In this way, the counselor acts as a direct support for the family and helps parents become more competent advocates on behalf of the adolescent.

POPULATIONS AND PROBLEMS TARGETED

RISK FACTORS FOR ADOLESCENT DRUG USE AND ANTISOCIAL BEHAVIOR

Multidimensional family prevention is designed to prevent substance abuse and delinquency in young and middle adolescents (ages 11 to 15) exhibiting nascent psychosocial problems that are empirically established precursors to drug use and antisocial behavior disorders, such as declining school performance, significant aggression and negative emotionality, minor delinquent acts, association with drug-using or antisocial peers, and early drug experimentation (Masten et al., 1999; Newcomb & Felix-Ortiz, 1992; O'Donnell, Hawkins, & Abbott, 1995). The challenge of preventing drug use and antisocial behavior in adolescents is considerable, given the complex and entrenched individual and environmental risk factors that predispose development of these disorders. Epidemiological, clinical, and

basic research studies confirm that adolescent drug use is a multidimensional problem. Both experimental substance use by adolescents not yet committed to continued use (Petraitis et al., 1995) and clinical substance abuse and dependence (Weinberg et al., 1998) result from a confluence of etiological factors. Contemporary studies on the correlates of drug use and abuse typically encompass several domains of functioning: individual, family, peer, school, community, and societal. Both macrolevel, distal factors such as economic deprivation and neighborhood influences and proximal ones such as family conflict and parental antisocial behavior (Hawkins et al., 1992; Jessor, 1993) are implicated. Individual adolescent factors such as school disengagement and failure, emotional dysregulation, and poor social skills are also risk factors (Jessor et al., 1995; Newcomb & Felix-Ortiz, 1992). In addition, substance abuse portends myriad negative consequences for the adolescent, including physical health risks (Daily, 1992), delayed emotional development and problem-solving ability (Baumrind & Moselle, 1985), impaired interpersonal relations (Newcomb & Bentler, 1988), and poor investment in prosocial activities (Steinberg, 1991), to name a few. In short, there are multiple pathways to, and multiple consequences of, adolescent drug problems.

Likewise, serious conduct problems in adolescence—aggression, Conduct Disorder, delinquency and violence—are known to arise from an amalgamation of biological, dispositional, and environmental factors. Genetic and temperament traits, cognitive and interpersonal skills deficits, coercive and highly inconsistent parenting practices, poor attachments with prosocial adults, and antisocial peer relations all predispose antisocial behavior (Dishion et al., 1995). Along with substance abuse, these behavioral problems belong to the externalizing dimension of childhood psychopathology, the class of outer-directed psychological problems whose core symptoms are associated with socially disruptive behavior (Achenbach, Howell, Quay, & Conners, 1991). Moreover, at the most severe levels, these problems make up a cluster of co-occurring symptoms that exacerbate one another and endure as an "antisocial trait" that assumes various age-specific guises across the developmental span (Patterson, 1993). The co-occurrence of conduct problems, school failure, social skills deficits, and substance use has been labeled "problem behavior syndrome" (Jessor et al., 1995) to emphasize the overlapping risk profiles and multifaceted behavioral problems that typically afflict youths with significant externalizing symptoms.

TARGETING AT-RISK ADOLESCENTS

At-risk adolescents might be the most difficult population for family prevention to address. Parents in the highest-risk groups are least likely to access family-based programs because they are less involved in their children's lives and less capable of utilizing extrafamilial resources (Resnik & Wojcicki, 1991). Also, family-based models have traditionally taken a narrow-band approach that underplays the broader ecological stresses experienced by high-risk families (Miller & Prinz, 1990). Most programs do not consistently address extrafamilial stressors that high-risk populations encounter in multiple contexts and that inevitably compromise youth and family functioning. Finally, there is some evidence that parent training, the most widely used model in family prevention, is less effective with adolescents than with younger children. Families with adolescents are more likely to drop out of parent training (Dishion & Patterson, 1992), require specialized engagement procedures (Dishion, Andrews, Kavanagh, & Soberman, 1996), and require extensive alterations in program implementation (Bank, Marlowe, Reid, Patterson, & Weinrott, 1991).

Several concrete recommendations can be made for developing family-based prevention

programs specifically for at-risk adolescents (Hogue & Liddle, 1999). First, such programs should feature individualized assessment and intervention planning. Most family prevention programs favor standardized intervention curricula that are suitable for a broad constituency and are expected to generalize to a variety of situations. Standardized curricula contain a fixed roster of generic skills and rely on a structured, didactic presentation (Pizzolongo, 1996). However, as described above, families of at-risk youths benefit from more flexible planning that attends to their unique profile of deficits and strengths. Second, programs should intervene in extrafamilial social systems. Family prevention programs have traditionally focused on intrafamilial issues such as problem solving, communicating, and bonding. However, we know that multiple social systems outside the family affect the course of externalizing behavior. To protect against or counteract these risks, prevention counselors should look to build and reinforce prosocial support systems that are available to the teen. Third, several developmentally geared prevention techniques have been endorsed particularly for families with at-risk adolescents (Bank et al., 1991; Dishion et al., 1996; McMahon, Slough, & CPPRG, 1996). These involve less focus on behavior management and more focus on parent-child interactional skills, establishment of an appropriately egalitarian parent-child relationship, attention to the unique perspective and autonomy needs of the adolescent, and promotion of parental involvement in peer activities.

FUNDAMENTAL PREVENTION GOALS

The previous two sections highlight the difficult task of aiming prevention efforts toward adolescents at greatest risk for developing substance abuse and conduct problems. Given what we know about risk and resiliency in adolescents, it follows that two general prevention goals are essential for boosting protective factors in this population: helping the adolescent achieve a redefined, interdependent attachment bond to parents and the family, and helping the adolescent forge durable connections with prosocial institutions. These fundamental prevention goals serve to direct and organize the diverse intervention activities for every family in MDFP.

Regarding bonding to the family, MDFP counselors help families negotiate the changing but continuing bond that exists between adolescents and parents. As adolescents mature, their relationship with their parents should graduate from emotional dependence to an increasing emotional interdependence that respects both the autonomy and connectedness needs of adolescents (Silverberg & Gondoli, 1996). This transformation unfolds in conjunction with adolescent striving for increased responsibility and self-determination, which gives rise to increases in parent-teen bickering and minor conflict (Steinberg, 1990). However, emotional detachment from parents is not a developmentally sound status for teenagers, even those in highly conflicted families. Evidence clearly indicates that families marked by negative emotional expression and disengaged parent-child relationships are associated with antisocial outcomes (Volk, Edwards, Lewis, & Sprenkle, 1989). In contrast, strong parent-adolescent attachment bonds are known to provide a secure base from which adolescents can build psychosocial competency and self-reliance in novel behavioral and emotional environments (Resnick et al., 1997).

Regarding bonding to prosocial institutions, counselors are especially concerned with the role that parents take in securing adolescent involvement in positive extrafamilial environments. Parents who actively participate in school and extracurricular activities boost the performance of their children in these areas (Epstein, 1987; Fletcher, Elder, & Mekos, 2000). Also, parents who maintain contact with the

adolescent's closest friends and their friends' parents are able to build an informal "parenting community" that enhances the effectiveness of their own parenting efforts (Fletcher, Darling, Steinberg, & Dornbusch, 1995). MDFP counselors therefore attempt to help parents become a more knowledgeable and active presence in the adolescent's various extrafamilial contexts; in other words, parents are asked to engage in regular prevention activities for their own teens.

CASE EXAMPLE

ENGAGEMENT AND ASSESSMENT

Ms. J., an African American single mother with five children, volunteered to participate in the MDFP program with her daughter, Taisha, age 14. In the process of recruitment, Ms. J. understood that the purpose of the program was to help keep her daughter "on the right track." Prior to the first session, she spoke with the counselor who would work with her and Taisha for approximately four months—a young, White man who had recently received his master's degree in family therapy and had just completed the first phase of his training in the MDFP model.

The First Session
In the first session, the counselor, as he does throughout the course of counseling, validates Ms. J.'s story of parental hardship and resilience. The children's father had died eight years earlier, leaving Ms. J. with five young children and little money. Ms. J.'s own father had died when she was young, leaving her mother with five children as well. However, in contrast to her mother, who, after her husband's death, began to drink and frequently neglected her children, Ms. J. describes herself as someone who wants to "be there" for her children in a way that her mother was not. This discussion about the contrasts between Ms. J.'s parenting and that of her mother serves an important assessment function at this early stage, yielding information about her care and concern for her children and demonstrating her capacity to articulate her ideas about parenting. She explains how she monitors Taisha's behavior and how she discusses important subjects with her.

During this first session, the counselor asks Ms. J. about her concerns for Taisha. She is clear that she does not want her daughter to get pregnant, to drop out of school, or to get high. However, she states that she really has "no problems" with Taisha, apart from the fact that Taisha's grades are falling and that she occasionally has a "spunky" attitude. As he will do in future sessions, in addition to meeting with mother and daughter together, the counselor also meets with Taisha alone to gain a more thorough understanding of her world and its challenges and, at times, to help work through impediments to difficult but important conversations with her mother. As the two talk, Taisha refers back to the school problem that her mother had identified, telling the counselor that she wants to attend one of the city's better high schools, but that her grades have been poor lately. In answer to the counselor's question about what she makes of this, Taisha talks about how difficult she finds it when the teachers "go too fast." "Do you talk to your mother about these difficulties at school?" the counselor asks. Taisha responds that she "gets smart" with her mother. The counselor uses this conversation about school performance as a gateway to exploring the adolescent's unique point of view, thereby furthering the process of alliance building, while he simultaneously gains information about interactions between mother and daughter. He does not attempt to help Taisha solve problems at this time; he is just beginning to learn something about the mother-daughter and family-school relationships. However, he is aware that it will be important by the end of the session to remind Ms. J. that he is available to

give the family support and assistance in working with the school.

The Second Session
By the second session, it is evident that mother and daughter are capable of talking to each other respectfully and about difficult topics, although it is not clear how they approach difficult subjects when they are on their own. It has also become apparent that Ms. J. is quite isolated socially, that she has endured chronic poverty, and that her relationships with her own family are sometimes volatile and frequently unsupportive. In addition, it is clear that the counselor's alliance with the family is not yet solid. The family has already missed one appointment. When mother and daughter arrive, the counselor, who senses Taisha's disaffection with the process, attempts to initiate a discussion with her about dissatisfactions she has with the program or her part in it. He lets Taisha know that he realizes that coming to these meetings may not be her favorite activity and, to his surprise, Ms. J. states that she feels the same way. The counselor decides first to meet with Taisha alone in an attempt to establish a stronger relationship with her. Taisha, who seems to take on the role of mother's protector, quickly lets him know that her mother does not want to go back into the past, that "the past is gone." She and her mother do not discuss the past when they are together. When asked what she likes to talk about with her mother, she says she likes discussing her mother's problems. Although she mentions a recent incident in which a girl at school "picked on" her, she insists that she does not want to discuss this event because it, too, occurred in the past.

For Ms. J., discussion of painful events in the past, including the hardships of parenting, the loss of the children's father, and her own difficult childhood, is not part of what the prevention program seemed to promise. Asked about her reluctance to revisit the past, she declares plainly, "I buried it." When the counselor

applauds the courage she displayed in returning for another session, she tells him that she would not have come back had he not stopped by the house and left her a note and bus tokens. A number of sessions later, when the counselor asked Ms. J. what had caused her to decide to return to counseling, she replies, "It seemed like you cared, so that's why I came back." For all his caring behavior, however, had the counselor failed to ask in sufficient detail the reasons for her disaffection with counseling and the subjects that had caused her particular pain, Ms. J.'s return might have been short-lived. Although the counselor is tempted to promise that no painful subjects will be broached in the future, such a promise could well compromise the work ahead and limit the scope of exploration of several key areas of family life. Instead, he states that there might be times when, to proceed in the present, it will be necessary to revisit the past, and he asks if, on those occasions, he might request her consent to proceed. Ms. J. is able to agree to this more limited use of the past. Discussion of the past for its own sake is not a part of the MDFP approach, but the past is often explored in the service of illuminating the present.

COURSE OF PREVENTION COUNSELING

Beginning Phase
In the first few sessions of counseling, care is taken to explore a number of facets of Taisha's and Ms. J.'s experiences, both as individuals and as members of a family. This exploration is accompanied by great attention to the nature and quality of the relationship between the two and between each of them and the counselor. Increasingly, the counselor seeks detail in those areas revealed by the assessment to have particular salience for the family as well as strong protective value for Taisha as she enters her later adolescent years. In this case, assessment in the risk and protective factor domains point the way

to a primary focus on the connections among parental well-being, the parent-adolescent relationship, and adolescent adjustment.

The problem of Taisha's declining grades and her being teased by a classmate pose less of a challenge for the counselor than addressing other contextual factors that might adversely affect Taisha as she faces entry to high school. Ms. J. requires only minimal to moderate support to maintain contact with school personnel and to discuss school-related matters with her daughter. Ms. J. is aware that supervising her children, monitoring their homework, enrolling them in after-school activities, and expressing interest in their lives both in and outside of school are tasks essential to good parenting. However, Taisha's worry about her mother's well-being and Ms. J.'s depression and sense of social isolation are more difficult to tackle. For example, Ms. J. is not accustomed to considering the effect of her moods on her children. In the fourth session, with Ms. J. present, the counselor helps Taisha to articulate this connection for the first time:

COUNSELOR: I was just wondering how that is for you—seeing your mom and your older sister get into a little argument. How was that for you?

TAISHA: They was just arguin'. . . .

COUNSELOR: It just sounded like your mom was upset with her; she was sad because she didn't come [for Christmas dinner]. I was wondering, maybe, were you sad also; were you sad that your mom was upset with your sister. . . .

TAISHA: I was sad because she took it out on me.

MOM: Yeah . . . How? (Taisha giggles)

MOM: You can say, go ahead. . . . Maybe I didn't realize I was taking it out on you.

TAISHA: (unclear) . . . your attitude.

MOM: Well, what'd I say?

TAISHA: I don't know. I forgot (unintelligible). But you was just. . . . You was just hollering

stuff . . . not all like that, but every time someone said something you disapproved of, you just started hollering.

COUNSELOR: So that probably made it hard for you, then.

The counselor has taken every opportunity to emphasize Ms. J.'s importance in her daughter's life, and at this point, he and Ms. J. are in agreement that the quality of the relationship between her and her daughter will largely determine the amount of influence she will retain as Taisha faces the challenges of later adolescence. They are beginning to discuss the fact that sometimes Ms. J. feels quite depressed, that she has a habit of hiding away in her room when she is upset, and that she lacks social supports, all of which may prevent her from attaining the personal goals she has mentioned in previous sessions: returning to school and living in better surroundings.

Middle Phase
Over a period of weeks, a shared understanding begins to take root that these and other factors have and will continue to have an impact on Ms. J.'s relationship with her daughter. Taisha worries about finances. For example, what will mother do when the youngest child turns 18 and she can no longer collect Social Security? Taisha worries that her mother is not enjoying life and that she has no friends and a difficult relationship with her own mother and sister. She reports that it is difficult to study in the house when there is no heat other than that provided by the stove. If her mother is unable to work, no other housing will be provided. Discussions on these subjects build on each other, and conversations with the counselor and Taisha alone about her worries for mother develop into mother-daughter dialogues in which Taisha is encouraged to reveal her worries and her mother is asked to listen and respond to them. Alone with Ms. J., the counselor suggests that Taisha's sensitivity to mother's

distress may sometimes prevent her from approaching Ms. J. with her own concerns. Mother, too, is concerned about this and recalls an instance when she was depressed and withdrew to her room. Shortly thereafter, she heard Taisha's footsteps on the stairs, but heard her quickly retreat. Ms. J. did not call out to her daughter. The counselor suggests that Ms. J. might have to encourage Taisha repeatedly to come to her if this pattern of protectiveness is to change. This conversation with mother leads to an in-session dialogue between mother and daughter.

The counselor takes care never to imply that, in her depression, Ms. J. is failing her children. It is important for Ms. J. to be consistently validated for what is working well, and to know that the counselor understands the constraints and burdens she has in mothering. He lets her know that he does not want the counseling to be yet another burden for her and repeatedly inquires about how she is experiencing the difficult emotional moments in counseling. During one session, after he encourages her to tell Taisha how she always wants to "be there" for her, he asks what this experience was like for her. Ms. J. has gradually become a convert to this way of talking. She replies that it is getting easier to express herself: "It felt good to come out and really say how I was feeling." Despite this transformation, however, Ms. J. finds it difficult to hear her daughter's frustrations and disappointments about matters that cannot be readily resolved, such as the impact of the family's chronic poverty on her life.

In addition to helping Ms. J. and Taisha open up new content areas for discussion and increase the emotional range of their exchanges, the counselor works with Ms. J. alone to address some critical problems. Having made the connection between care for her children and care for herself, mother and counselor can proceed to discuss her depression and reclusiveness as impediments to self-care. The counselor encourages Ms. J. to consider calling him when she gets "in the hole." Doing so would represent

a dramatic change in behavior for Ms. J., who resolutely maintained early in counseling, "I don't want to put my problems on anybody else." The counselor repeatedly discusses with her the dilemma posed by the lack of social support. In family prevention work, increasing protective factors through the shoring up of an existing social network or the creation of new ones is deemed essential.

Ms. J. states, "I've just been on my own all my life." The counselor asks, "Who's out there to help you out?" "Just me," she responds. She says that she has spent most of her adulthood in the house and it feels strange to come out of the house when she has been inside it for so long. She has stopped going to church, and the counselor asks about her plans to return, encouraging her both to state her fears about stepping out in public and to consider what she can do to work through them. Toward the later stages of counseling, Ms. J. goes to her neighborhood church and contemplates returning to the church that most of her family attends. This represents not only an acceptance of the need to move out into the world, but also her growing willingness to revisit some unfinished family business. Already, Ms. J. is talking to her own mother more often and differently; instead of merely tolerating her mother's negativity and stewing about it later or withdrawing from all contact with her, she tells her mother to listen and "Don't be giving me that negative stuff." Ms J. signs up for a job training program that offers the opportunity for her to obtain her high school equivalency diploma, and her eyes sparkle as she recounts the details of her involvement.

The counselor also tracks in detail those behaviors, cognitions, emotions, and interactions that contribute to or accompany positive outcomes. On the day Ms. J. triumphantly hands the counselor Taisha's report card to read, telling him that Taisha has brought up every grade, the counselor asks Taisha in great detail how she managed to accomplish this feat. When

Taisha gives a global response, answering that she was just "taking care of business," the counselor continues to question her: "Were you doing your work more? Were you studying more?" He asks whether she studied in the same way and in the same place, and whether she wants to study. He asks Ms. J. what she felt when she saw the report card and how she thinks her daughter did it. When the counselor asks Ms. J. how she thinks she helped her, her response demonstrates some real faith in the process of talking with her daughter: "I just talked with her; yeah, told her how important this is." The counselor then turns to Taisha, asking her if this helped. Her response: "Yeah. And coming here talking with you." Ms. J. chimes in, "And now that we talk more too, so that probably has a lot to do with it too. And plus coming up here."

Ending Phase

With only a few counseling sessions left, Taisha brings to the counselor a problem that has recently cropped up between her mother and older sister. Ms. J. slumps in her chair, tearful and deflated. It soon becomes evident that she would not have discussed the incident with the counselor had Taisha not brought it up. The counselor remarks that Taisha has sometimes been the vehicle for bringing up material that her mother did not want to discuss. He talks about the connection between Taisha's raising these subjects and her worry for her mother, and goes on to state that the antidote to Taisha's worry lies in Ms. J.'s taking care of herself. He says that Ms. J. is always quick to reassure her daughter that she can take care of herself, but he doesn't know if it will be so easy: "It doesn't seem like it's working for you, doing everything for yourself. . . . It's taking a toll; the kids are worrying about you."

It is clear that, despite the considerable investment made by Ms. J. in the process of counseling, it remains difficult for her to find and use social supports that will benefit her personally and help her meet her stated goal of "being there" for Taisha as she faces the challenges of later adolescence. Her social network is still very small, venturing into the world is still new to her, and she can be easily discouraged by even relatively minor setbacks. As counseling nears an end, the counselor asks Ms. J. to consider the possibility of continuing to talk to another counselor on her own. By the final session, she has agreed, and the therapist will accompany her to the first meeting. A few sessions earlier, when the counselor remarked to her, "You know how it is. You don't get through much when you're by yourself," Ms. J. had responded emphatically, "You don't get through nothing."

EMPIRICAL SUPPORT FOR MDFP

IMMEDIATE OUTCOMES

MDFP has been tested in a demonstration trial that evaluated immediate postintervention outcomes for a group of at-risk, inner-city young adolescents and their families (Hogue, Liddle, Becker, & Johnson-Leckrone, in press). Adolescents were recruited from a community youth program in which every member completed a risk factor screening measure that assessed individual risk in four areas: adolescent drug use history and attitudes and history of delinquent behavior; peer drug use history and attitudes; family drug use history and attitudes and history of police involvement; and adolescent school attendance, performance, and behavior. Youths were then randomly assigned to an MDFP ($n = 61$) or control ($n = 63$) condition. The study sample comprised early adolescents (mean age 12.5 years), predominantly girls (56%), almost entirely African American (97%), and mostly lower income (57% of families reported annual income less than $15,000, and 53% received public assistance).

Intervention effects were examined for nine targeted outcomes in four domains of functioning: self-competence, family functioning, school involvement, and peer associations. These domains are considered to be proximal mediators (indices of risk and protection) of the ultimate behavioral symptoms to be prevented: substance use and antisocial behavior. The immediate efficacy of MDFP was investigated by testing the within-subjects interaction (group × time) term of repeated measures ANOVA. Testing the interaction term indicates whether there is a significant difference between groups in change over time on the target variable. Intervention cases showed greater gains than controls on four of the nine outcomes. This represents one outcome apiece within each of the four domains: increased self-concept [$F(1,112) = 6.44$, $p < .05$], a trend toward increased family cohesion [$F(1,122) = 3.21$, $p < .10$], increased bonding to school [$F(1,122) = 5.60$, $p < .05$], and decreased antisocial behavior by peers [$F(1,122) = 7.29$, $p < .01$]. Effect size estimates for these improvements were in the small to moderate range ($\eta^2 = .03 - .06$).

These results offer preliminary evidence for the short-term efficacy of family-based prevention counseling for at-risk young adolescents. In comparison to controls, adolescents and their families who received MDFP showed gains in four key indicators of adolescent well-being. Results also suggest that MDFP enjoyed some success in reversing negative developmental trends. Whereas controls experienced decreases in family cohesion and school bonding and an increase in peer delinquency, those receiving MDFP reported strengthened family and school bonds and reduced peer delinquency. Overall, these gains were small to moderate in magnitude, and they were evident regardless of the adolescent's sex, age, or initial severity of behavioral symptoms. This initial study demonstrates that an individually tailored, family-based prevention model can be successfully implemented with at-risk minority youth.

Furthermore, family prevention counseling can foster change in multiple behavioral domains that represent critical mediational influences on the ultimate development of problem behaviors.

INTERVENTION FIDELITY

Intervention fidelity—the degree to which an intervention is implemented in accordance with essential theoretical and procedural aspects of the model—is a particularly salient issue for studies that utilize manualized treatments (Hogue, Liddle, & Rowe, 1996). Treatment manuals are intended to facilitate internal consistency and model specificity in the delivery of interventions. The intervention fidelity of MDFP in the demonstration trial described above was examined using observationally based adherence process evaluation procedures (Hogue, Johnson-Leckrone, & Liddle, 2001). The fidelity evaluation compared interventions utilized in MDFP sessions to those utilized in two empirically based treatment interventions for adolescent substance abuse: MDFT (Liddle & Hogue, in press) and cognitive-behavioral therapy (CBT; Turner, 1992). The goal was to determine whether MDFP counselors emphasized signature family-based intervention techniques prescribed by MDFP and avoided individual-based cognitive-behavioral techniques proscribed by MDFP, in comparison to two psychotherapy models with established intervention fidelity (Hogue et al., 1998). The MDFT and CBT models were implemented in the same inner-city community as the MDFP model. However, in accord with their status as treatment (versus prevention) models, MDFT and CBT were used with a sample that was older (mean age 15 years), more male (72%), and troubled by more severe behavioral symptoms (all had substance abuse disorders and 53% were on juvenile court probation).

Every available MDFP case from the demonstration study was included in the fidelity evaluation (10 cases were unavailable because the

family attended no sessions or refused to be videotaped). The final study pool included 110 MDFP sessions from 51 cases, 57 MDFT sessions from 28 cases, and 32 CBT sessions from 16 cases. Sessions were rated by trained nonparticipant judges according to the thoroughness and frequency with which counselors used 20 model-specific intervention techniques throughout the entire session, with each item anchored on a 7-point Likert scale ranging from 1 (never) to 7 (extensively). Factor analysis of the 20 items supported a three-factor solution: 7-item CBT scale (sample items: utilizes behavioral reward systems and structured protocols, helps client amend cognitive distortions), 8-item Family Intervention scale (coaches multiparticipant interactions, works on family communication), and 4-item Prevention scale (explores connection between parent and adolescent ecosystem, helps develop a future orientation). The scales showed acceptable internal consistency (Cronbach's $\alpha =$ .74 for CBT, .74 for Family, .49 for Prevention) and interrater reliability ($ICC_{(1,2)} = .84$ for CBT, .74 for Family, and .73 for Prevention).

Analyses of variance tested how counselors trained in the three models compared in their utilization of interventions from the three factor scales. On the CBT scale, CBT counselors ($M = 3.72, SD = 1.06$) used significantly more interventions than either MDFT ($M = 1.93, SD = .52$) or MDFP ($M = 1.81, SD = .46$) counselors, who did not differ from one another [$F(2,196) = 126.58, p < .001$]. On the Family scale, MDFT ($M = 3.93, SD = .70$) and MDFP ($M = 3.84, SD = .89$) counselors again did not differ from one another, and both used these interventions to a greater extent than did CBT counselors ($M = 3.16, SD = .59; F(2,196) = 10.78, p < .001$). On the Prevention scale, surprisingly, MDFT counselors ($M = 2.44, SD = .81$) were stronger than MDFP counselors ($M = 2.05, SD = .76$), with CBT counselors ($M = 2.12, SD = .63$) performing in the middle [$F(2,196) = 5.04, p < .01$]. These results attest to the basic fidelity of MDFP as a family-based intervention model, in that

MDFP counselors emphasized core family-based techniques and eschewed individual cognitive-behavioral interventions. However, results also suggest that much more must be learned about what intervention techniques are uniquely *preventive* when contrasting family prevention models with family therapy models.

SUMMARY

Relatively intensive, individually tailored preventions such as MDFP may have a natural home in the mental health intervention spectrum. Contemporary prevention theories favor a stratified, assessment-based strategy for determining the scope and intensity of prevention programs offered to various populations. According to this strategy, known as a unified or multiple gating model of prevention (C. Brown & Liao, 1999; Dishion et al., 1996), all persons within a given population are screened for the presence of known risk and protective factors salient for the disorder being prevented. Then, those with higher-risk profiles—a greater number of risk factors or risk factors of greater severity—are targeted to receive selective or indicated preventions that provide more intensive and multifaceted services. In some cases, prevention programs initially implement a universal model and then look to implement an additional selective or indicated model for subgroups of participants who demonstrate greater need.

In this scheme, individualized prevention models appear well-suited for meeting the idiosyncratic prevention goals of high-risk adolescents and their caretakers. Family-based counseling models such as MDFP may therefore be a valuable third option within a unified prevention initiative. Family prevention counseling offers an acute alternative for adolescents with indicated risk profiles or for those who do not respond to universal or selective prevention efforts. In addition, this approach

also has an excellent theoretical and strategic fit with comprehensive, ecological prevention strategies that seek to intervene in an integrated manner across multiple systems of influence on the development of problem behavior in adolescence. Of course, it remains to be seen whether prevention counseling models for indicated populations will stand the tests of empirical validation, clinical practicality, and cost-effectiveness over time. If they do, MDFP and similar models can become integral components of a mental health services agenda that strives to provide the right intervention for the right client at the right time.

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