How Developmental Research and Contextual Theory Drive Clinical Work with Adolescents with Addiction

Howard Liddle, EdD, ABPP, and Henk Rigter, PhD

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Elsewhere in this issue of the *Harvard Review of Psychiatry*, Graham Danzer[1] presents a thoughtful assessment of Multidimensional Family Therapy (MDFT), an approach developed by one of the authors of this brief essay (HL). We are happy to have the opportunity to provide a short response to his article and also to extend a few specific points of his analysis.

BACKGROUND FACTORS AND RECENT DEVELOPMENTS

The main title of Danzer's article—"Just Say No to Drugs"—invites clarification of both the orientation and specific methods of MDFT.[1] In virtually any context, simply invoking youth and drug use easily prompts associations to historically significant U.S. cultural events such as the War on Drugs and the Just Say No to Drugs campaigns. While planting adolescent substance abuse in our nation's consciousness, the intervention strategies accompanying these efforts were starkly dissimilar to today's research-supported approaches. Contemporary thinking and techniques rely on contextual and developmental frameworks; dynamic systems conceptualizations of human and multisystem processes; interventions that include logic models of change incorporating theoretical and empirical elements; and manual-guided prescriptions about an intervener's multifaceted role and the intervention's social context.[2–4] Today's notions about treating youth drug misuse represent a paradigm shift apart from a "Just Say No" strategy.

Early reviews of research on teen drug treatment bemoaned methodological imperfections and, more fundamentally, the scarcity of controlled studies.[5,6] Over the years a generation of work accumulated; state-of-the-science studies on youth substance abuse outcomes are no longer sparse. Among family-based therapies alone, this landscape includes efficacy and effectiveness trials in community settings (and combinations of these two), a few multisite studies, mechanisms of change research, and implementation and training studies. Many studies now evaluate a treatment's capacity to perform in nonresearch environments that present intersecting and often competing financial, policy, and public/private interests and agendas.[7] Advances in adolescent treatment research are well documented.[8] But these accomplishments should be seen as connected to, if not driven by, the specialty's transformation of its root assumptions, conceptual frameworks, and intervention recommendations and methods. Each of these elements has been shaped profoundly by developmental psychology and psychopathology,[9,10] as well as by the wealth of findings about adolescent substance abuse and delinquency.[11–13]

CLINICAL THEORY, APPROACH, AND METHODS

Primus Inter Pares

MDFT is contextual and developmental in philosophy, conceptualization, and clinical methodology. It takes a "first among equals" position about the family's role in understanding and treating youth substance abuse. MDFT is known as a family therapy–derived intervention, with its deepest connections to structural and strategic family therapies.[14] While this characterization is true enough, the approach also has strong roots in family psychology or even systems psychology.[15,16] Not surprising, an assessment of family functioning plays a central role in MDFT, where *family functioning* is construed broadly to include each individual's mental state, emotional functioning, history, and life activities in addition to his or her role as a family member. Individual and multi-person subsystem work are basic to MDFT[17,18]—and may, more generally, be growing in popularity in contemporary clinical work with families.[19]

Working with the inner, or private, world of the adolescent and the parent is essential to MDFT as a matter of

From the Center for Treatment Research on Adolescent Drug Abuse, University of Miami Miller School of Medicine (Dr. Liddle); Department of Child and Adolescent Psychiatry, Leiden University Medical Center, the Netherlands (Dr. Rigter).

Correspondence: Howard Liddle, EdD, ABPP, University of Miami Miller School of Medicine, Miami, FL 33156. Email: hliddle@med.miami.edu

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developmental and clinical-change theory, empirical outcomes (positive multiple alliances predict MDFT outcomes), and practice and strategy (the value of multiple perspectives). Dichotomous, either/or thinking—for example, about the primacy of individuals versus systems, emotions versus cognitions, or behavior change versus individual reflection/personal examination—is avoided. It is not that these concepts and phenomena are incapable of definition, measurement, conceptualization, and use in the intervention process. But each exists both as a *whole*—that is, as a separate entity or process—and as a *part*—that is, of a broader system. Likewise, the foci of assessment and intervention—the adolescent, parent, family, and community or extrafamilial—are understood as *holons*,[20] as both wholes and parts. Each is a realm of life activity, clinical relevance, and intervention potential in and of itself, but each is also understood in relation to, and in dynamic, real-time interaction with, the others.

MDFT clinicians and trainers report that practicing the approach offers challenging, but welcome, opportunities for clinical creativity.[21] For instance, individual sessions with youth focus on their hopes, dreams, current pressures, and all the rest, but they also focus on thoughts, feelings, and behaviors that have next-day or next-session relevance for the youth's parents or, more broadly, for the youth's living environment. A full session or a brief phone conversation with parents that follows a session with their child may yield details from the parents about how they have responded to what their child has said or done of late. The parents might then be advised or even coached, if that seems indicated, about a revised response to what has just been learned or experienced. A full individual session with parents may focus on parenting practices per se, but it may also include, for example, discussion of the mother's despair about parenting.[22] Other times, treatment brings up experiences about parents' families of origin—experiences that parents might believe are handicapping their capacity to love and feel compassion for their child. MDFT is not a traditional family therapy, at least according to the early incarnations of the term. MDFT could be described as a family-based subsystem therapy—as a treatment that works not only with and inside the various "constituent parts" of broader systems (reflecting, deliberating, coaching), but also at their intersections in shaping interactions directly.

The MDFT approach emphasizes understanding the current clinical phenomenon first. Clinicians need to think about how they receive and interpret a clinical presentation, which naturally includes diagnoses, previous history, individual functioning, and current circumstances in the families' and youth's multiple environments.[23] Clinicians cannot become preoccupied with problem-solving interventions or moving to such interventions prematurely. The clinical phenomena, seen through the developmentalist's lens, illuminates what is important, what is urgent, and what the priorities should be. This mind-set, which serves as a launching pad for all interventions, is partly a matter of attitudes and beliefs, but it also relies, of course, on a sound foundation of medical and psychological knowledge and clinical judgment.[24] In a way, therapists are developmentalists before they are interventionists, since the inextricable link of accurate knowledge about adolescent development, a parent's development, family development—all from a dynamic systems or developmental-contextual frame—are present throughout every aspect of training and subsequent supervision.[25] Clinicians see treatment less as a problem-solving activity and more as a quest to offer, through an instrumental and close partnership with youth and parents (as well as with outsiders who are involved with the youth in one way or another), a time-bounded relationship with unique features. This relationship and focused set of activities (treatment's multiple conversations, formally called *sessions*) take into account many perspectives and agendas. Shaped and accentuated through individual and multi-person conversations, therapeutic attention and participation cohere around a central objective—namely, the significant improvement of the health and well-being of the youth and families. Training in communication and other skills and communication are included, when needed, as part of the approach, but we aim to sponsor a more profound, promotive process within the youth and family. Participation in treatment yields an increased caring about, and investment in, their own and each others' lives.[26] Adolescents and parents find their own enhanced reasons to live, go on, try again, and develop alternatives to present circumstances.

Logic Model of Change

The processes involved in MDFT will result, it is to be hoped, in renewed, day-to-day motivation. But they also include the articulation and discussion of the "big picture" that encompasses each individual and the family as a whole. Focusing on and using emotion is one way of bringing conscious attention to the desired processes.[27] When we watch a film, read a novel, or view a work of art, the experience can stimulate emotion, create certain experiences, and affect us in various ways or at different levels. Likewise, therapy can have a multiplicity of effects on our experience, emotions, and understanding. MDFT develops and uses what individuals consider larger life themes,[28,29] weaving these together with behaviorally oriented work in skills training and problem solving. Youth, parents, and even outsiders become engaged at both broader, thematic levels. That is, they join together to stop the youth's slide toward more drug use and delinquency, and they listen to the youth's experiences and reflections on their lives and circumstances. The therapist's collaboration in thematic development and articulation has generic and idiosyncratic elements. Common themes include the "culture of the streets" or "of drug use," "having the kind of family I always wanted to have," and "doing better with my

children than my parents did with me." But these general themes come to life, and are expressed and experienced concretely, through the real-life stories of family members. While serving motivational purposes, this kind of work also creates thematic continuity in the treatment, offering participants a readily available and practically useful touchstone as all move individually and together through the multiple, but connected, conversations of treatment.

Alliance and Engagement

Since adolescents often enter treatment under coercion, our aim in MDFT is create an environment of respect, curiosity, and potential for youth, as we say, to "get something out of this for yourself." At the outset, we do not expect the adolescent to be enthusiastic or highly motivated regarding therapy. Shame, stigma, and legal troubles—compounded by the lack of experience or understanding as to what therapy can do (or even by previous negative experiences with therapy) —are among the various issues that may be at play. In this context we reach out directly to youth and to parents to build motivation and to establish a positive and practically focused working conception of what treatment might accomplish. While resistance to therapy is a recurring topic in the adolescent literature, we find that most adolescents respond well our efforts to bring them into the therapy process. Perhaps it is better to say that the MDFT therapist stimulates a process within the youth and the parent, and then with the family together. And so it is those intrapersonal and interpersonal processes that are, taken together, "engaging," personally meaningful, and hope producing. Resistance is understandable in a punitive, moralistic, system-mandated, parent-centered therapy that presents no or insufficient opportunity for the youth to have a voice and to receive an empathetic response. But when treatment attends skillfully to the needs and demands of individual youth, their parents, and their families (as well as those of relevant others), adolescents do more than comply; they participate.[30]

Effective therapy creates positive feedback spirals of individual and familial processes. The promotive forces are "grown" to elbow out malleable risk factors, wherever possible. When adolescents show themselves to be reasonable responders to therapy's demands, adults experience previously unseen, unused, or insufficiently developed aspects of their teenagers. The issues, stresses, unhappiness, gripes, and the pressures as felt by youth are all topics for exploration and expression in MDFT. What is involved here, however, is more than a joining or relationship-enhancement technique; this kind of work is fundamental to a multifaceted change process. Development-enhancing individual milestones become overt in discussion and in targeting areas of change. Matters of particular concern include how an individual thinks about, defines, and actualizes identity formation, sexual matters, evolving family relations, and the desire for more freedom and for more of a say in defining the structure and details of their everyday lives. Individual sessions allow youth and therapists to explore the youth's individual life experiences, but they also allow them to decide what to express and what not to discuss in family sessions.

Parents themselves need and receive individual attention, as noted earlier, and their functioning as adults, outside of their caregiving roles and responsibilities, is examined and worked with directly in the same treatment by the same therapist. Relationship difficulties, health concerns, money problems and stresses, and individual developmental challenges are grist for the mill of the individual work with parents. The multiple therapeutic alliances—where each person buys into treatment in their own way, as well as in a collective way—are foundational structures and processes that establish a scaffolding for behavioral change.

Aftercare

Although diverse articles, including quality of evidence reviews and that Mr. Danzer himself, find MDFT to contain the recommended components of adolescent treatment, Danzer wonders why MDFT does not have an aftercare component. He is correct that we have not written about an aftercare component in the usual way, but that is because we use other language; the program design does include an aftercare component, albeit in a different way than is usually understood.[31] MDFT is a *treatment system*, which refers to its design as a flexible approach that has been adapted with beneficial and consistent outcomes across different age ranges, symptom intensity levels, juvenile justice samples, and cultural and geographic treatment settings. With samples of severely impaired, clinically referred youth, MDFT is offered in a more intensive mode that can include several formal sessions per week, along with other therapeutic contacts such as phone calls, in the first three months of the intervention. MDFT is carried out in three phases, with phases 1 and 2 being relatively intensive in sessions and interventions. Fewer sessions are used in phase 3, the final month of treatment. This last phase is meant to "seal" the progress made. It is aftercare, so to speak, incorporated in the treatment program itself. Some aftercare models include attention to extra-therapeutic or case-management details, such as other services that the youth or families might need. MDFT generally attends to these details throughout the standard course of the program, although some versions of MDFT without extra-therapeutic or cases-management elements have been tested and yielded strong outcomes, including over one-two-year follow-up periods.[32,33]

Research Outcomes

Another issue raised by Mr. Danzer concerns the mechanisms through MDFT achieves its effects. Although we have

addressed this issue in MDFT theory, program design and research, and training, we still have much to learn about the moderators and mediators of treatment process and bottom-line outcomes. Many process dimensions can be defined and measured behaviorally—for example, particular therapist-response styles, different types of interventions, and the use of cultural fine-tuning. And, critically, these processes relate to outcomes of interest. These studies[34] have been instrumental in the clinical model's development program.

Mr. Danzer concludes that MDFT ought to be considered the preferred treatment approach for adolescents with comorbid conditions, but he does point to negative findings in the form of an article that, while produced by a member of the MDFT research, is not actually about treatment outcomes. The published outcome studies on MDFT, however—comparative reviews,[35] independent scientific appraisals,[36] and evaluations by private foundations[37] and government entities[38]—found effectiveness with heterogeneous, including comorbid, samples, and consistency in the treatment's capacity to maintain its effects over time. The durability of the changes in MDFT have also been singled out by other independent reviewers. Austin and colleagues[39] conclude: "Overall, MDFT emerges as the only family-based intervention with empirical support for changes in substance use behaviors that are both statistically significant and clinically significant immediately following treatment and at one year post-treatment." Another analysis concluded: "Multidimensional Family Therapy in particular has distinguished itself by the sustainability and even the growth of the gains made during treatment; typically the reverse is the case in adolescent substance use treatment."[40] A National Institute on Drug Abuse[41] publication also referenced the durability of outcomes: "MDFT treatment outcomes are among the best there are for adolescents. Not only does it work, but it joins the category of behavioral interventions whose effects seem to endure after treatment ends." Another comparative review concluded: "The strongest empirical support has been provided for Multidimensional Family Therapy."[42] The authors also singled out the "replicated sustained results," the program's capacity to be implemented as an office-based model," and consequently "its potential as a less costly and labor-intensive model."[42] Further support for the economic feasibility of MDFT can be seen in the growth of training programs in the United States and Canada,[43] and in the uptake of MDFT in eight Western European countries[44] following a multi-country controlled trial (European Monitoring Centre for Drugs and Drug Addiction, http://www.emcdda.europa.eu/best-practice/treatment/cannabis-users [2013]).[45]

MDFT is a customizable treatment system rather than a one-size-fits-all model. It has been constructed and tested with development and context in mind—and not only the contexts of the youth and family, but also the contexts in which treatments are being offered.[46,47] Unfortunately, research-proven, family-based treatments remains underutilized despite improved and accumulating studies that support their use, consistent evidence from different models and research groups, high-level government recommendations, funding initiatives by federal agencies and private foundations, and advocacy efforts on behalf of youth and families.[48,49]

Can anything contribute to, or even accelerate, the overall progress of the movement toward evidence-based practice? Across disciplines, professional *training as usual* continues, yielding minimal progress on whether and how to integrate evidence-based treatments into core curricula.[50] Comprehensive, multifaceted, multi-target treatments show feasibility and promise in clinical outcomes. Likewise, implementation research promises to unlock some of the mysteries in understanding the systemic influences on the growth and change in services in regular care settings. But there is yet another element to consider. Instruction on how to use evidence-based treatments should be integrated more fully into professional training and also professional development activities. Instruction methods should be multimethod. Given what we know about the inability of standard workshop presentations to change clinicians' behavior in any lasting way, what is needed is interactive, Web-based training that focuses on clinical-skill acquisition rather than content mastery. Progress in the realms of training and professional development can nudge us closer to offering the best available care to patients and their families.

Declaration of interest: Dr. Liddle is the developer of Multidimensional Family Therapy. Dr. Rigter founded and currently serves as Director of the MDFT Academy, a nonprofit institution for disseminating MDFT that is associated with Curium, Department of Child and Adolescent Psychiatry, Leiden University Medical Center, the Netherlands.

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